



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

Greenlake Management Renton, LLC
Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

RE: Renton Assisted Living License # 2614

Dear Administrator:

This letter addresses Compliance Determination(s) 39827 (Completion Date 04/16/2024) and 37096 (Completion Date 02/26/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/16/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-2-c, WAC 388-78A-2320-3, WAC 388-78A-2320-3-a, WAC 388-78A-2320-3-b, WAC 388-78A-2320-3-c, WAC 388-78A-2320-3-d, WAC 388-78A-2320-3-e

The Department staff who did the on-site verification:
Michelle Yip, ALF Licenser

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

Sincerely,

Laurie Anderson

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



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

Statement of Deficiencies	License #: 2614	Compliance Determination #37096
Plan of Correction	Renton Assisted Living	Completion Date
Page 1 of 5	Licensee: Greenlake Management Renton, LLC	02/26/2024

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 follow-up on 02/21/2024, 02/21/2024, and 02/21/2024 of:

Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

This document references the following SOD dated: 02/26/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 88 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Yip, ALF Licenser
Thomas Forkgen, ALF Licenser

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

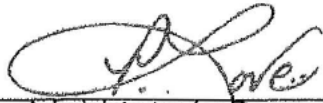
Residential Care Services

03/07/2024

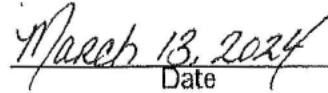
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

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



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:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(c) Initial and on-going assessments of the nursing needs of each resident;

(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:

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.88A RCW, Nursing assistants;

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

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

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure all staff completed and met the nurse delegation requirements for 4 of 4 sampled residents (Resident 11, Resident 25, Resident 48, and Resident 49). This failure placed the residents at risk for harm and compromised health from potential medication errors from undelegated staff.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 04/03/2023, the Assisted Living Facility (ALF) received an initial citation for this regulation for 19 residents. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/17/2023. On 08/10/2023, the ALF received a recurring (occurred again or repeated) citation for this regulation for 16 residents. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/15/2023. On 12/08/2023, the ALF received a recurring citation

Statement of Deficiencies	License # 2614	Compliance Determination #37096
Plan of Correction	Renton Assisted Living	Completion Date
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for this regulation for three residents. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/22/2024.

Review of the facility's Clinical Policy and Procedure Manual for Washington showed the manual contained the facility's policy titled, "Nurse Delegation Policy", dated 08/10/2021. The policy showed that the Registered Nurse Delegator (RND) was responsible to determine the competency of the individual to perform the tasks. The policy showed that the RND was responsible for supervising the actions of the person performing the delegated task. The policy showed that for the delegation of insulin (medication used to lower blood sugar level) injections, the registered nurse delegator must instruct the individual about the proper injection procedures and the use of insulin, demonstrate to the individual the proper injection procedures, and must supervise and evaluate the individual to perform the delegated task weekly for the first four weeks of insulin injection delegation.

Review of the facility's Registered Nurse Delegation binder showed the binder contained the Department of Social and Health Services (DSHS) Nurse Delegation: Nursing Visit forms, one form for each resident: Resident 11, Resident 25, Resident 48, and Resident 49. Review of the forms showed that Staff NNN, Medication Technician (unlicensed staff who dispensed and administered delegated medications); Staff UUU, Medication Technician; and Staff VVV, Medication Technician, were not listed on Resident 11, Resident 25, Resident 48, and Resident 49's Nurse Delegation form as a delegated staff to administer insulin. There was no documentation that showed Staff NNN, Staff UUU, and Staff VVV completed credential verification, DSHS Nurse Delegation certifications, and Nurse Delegation training to include weekly RND supervision and evaluation for the first four weeks.

RESIDENT 11

Review of Resident 11's January 2024 and February 2024 electronic Medication Administration Records (eMAR) showed that Resident 11 received Humalog (insulin) injected subcutaneously (under the skin), per sliding scales (insulin dose based on blood glucose levels), three times daily. The eMARs showed Resident 11 received Lantus (insulin), 10 units, subcutaneously at bedtime. The eMARs showed that between 01/22/2024 and 02/21/2024, Staff NNN administered insulin twice; Staff UUU administered insulin 22 times; and Staff VVV administered insulin three times to Resident 11.

Review of the Nurse Delegation form, dated 11/30/2023 and 01/03/2024, showed that Resident 11 received nurse delegation services for insulin administration. The form did not list Staff NNN, Staff UUU, and Staff VVV as delegated staff to assist Resident 11 with insulin administration.

RESIDENT 25

Review of Resident 25's January 2024 and February 2024 eMARs showed that Resident 25 received Lantus, 14 units injected subcutaneously every morning. The eMARs showed Resident 25 received Lantus 12 units injected subcutaneously every evening. The eMARs showed that between 01/22/2024 and 02/21/2024, Staff NNN administered insulin one time; Staff UUU administered insulin 17 times; and Staff VVV administered insulin four times to Resident 25.

Statement of Deficiencies	License #: 2614	Compliance Determination #37096
Plan of Correction	Renton Assisted Living	Completion Date
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Review of the Nurse Delegation form, dated 11/30/2023, showed that Resident 25 received nurse delegation services for insulin administration. The form did not list Staff NNN, Staff UUU, and Staff VVV as delegated staff to assist Resident 25 with insulin administration.

RESIDENT 48

Review of Resident 48's January 2024 and February 2024 eMARs showed that Resident 48 received Glargine (insulin), 30 units injected subcutaneously, nightly. The eMARs showed Resident 48 received Lispro (insulin), 10 units injected subcutaneously, three times daily with meals. The eMARs showed Resident 48 received Lantus, 20 units injected subcutaneously, every morning. The eMARs showed Resident 48 received Lantus, 25 units inject subcutaneously, at bedtime". The eMAR showed that between 01/22/2024 and 02/21/2024, Staff UUU administered insulin 12 times and Staff VVV administered insulin six times to Resident 48.

Review of the Nurse Delegation form, dated 09/28/2023 and 12/05/2023, showed that Resident 48 received nurse delegation for insulin administration. The form did not show Staff UUU and Staff VVV as delegated staff to assist Resident 48 with insulin administration.

RESIDENT 49

Review of Resident 49's January 2024 and February 2024 eMARs showed that Resident 49 received Glargine (insulin), 27 units injected subcutaneously, every morning. The eMARs showed that Staff NNN administered insulin to Resident 49 one time.

Review of the Nurse Delegation form, dated 10/19/2023 and 12/28/2023, showed that Resident 49 received nurse delegation for insulin administration. The form did not show Staff NNN as delegated staff to assist Resident 48 with insulin administration.

During an interview on 02/21/2024 at 3:00 PM, Staff PPP, Executive Director, stated that the facility contracted with an outside company for nurse delegation services for all residents. Staff PPP stated that they were aware Staff NNN, Staff UUU, and Staff VVV were not delegated by the RND. Staff PPP stated that Staff UUU and Staff VVV did not complete the required DSHS Nurse Delegation Certification training. Staff PPP stated that Staff NNN, Staff UUU, and Staff VVV did not complete RND's supervision and evaluation. Staff PPP stated that they did not know why Staff NNN, Staff UUU, and Staff VVV were assigned to give insulin injections to residents.

During an interview on 02/22/2024 at 8:58 AM, Collateral Contact 4 (CC 4), RND, stated that the facility contracted with their agency to provide nurse delegation services. CC 4 stated that they started the nurse delegation services at the facility in September 2023. CC 4 stated that Staff NNN, Staff UUU, and Staff VVV did not complete the RND supervision and evaluation. RND stated that they did not delegate to Staff NNN, Staff UUU, and Staff VVV.

Statement of Deficiencies	License #: 2614	Compliance Determination #37096
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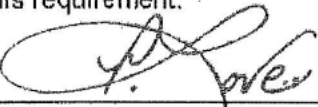
Review of an email communication with Staff PPP, dated 02/23/2024, showed no documentation that Staff UUU and Staff VVV completed the DSHS Nurse Delegation Core Certification training and DSHS Nurse Delegation Diabetes Certification training.

This is a recurring deficiency previously cited on 04/03/2023 and an uncorrected deficiency previously cited on 08/10/2023 and 12/08/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 03/29/2024.

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


 Administrator (or Representative)

03/13/2024
 Date



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

Statement of Deficiencies	License #: 2614	Compliance Determination # 32999
Plan of Correction	Renton Assisted Living	Completion Date
Page 1 of 13	Licensee: Greenlake Management Renton, LLC	12/08/2023

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 follow-up on 11/27/2023, 11/27/2023, and 11/27/2023 of:

Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

This document references the following SOD dated: 12/08/2023

The following sample was selected for review during the unannounced on-site visit: 12 of 107 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Yip, ALF Licensors
Steven Garrett, LTC Licensors
Thomas Forkgen, ALF Licensors
Jane Hermano, NCI
Claudia Machado, Community Complaint Investigator
Angelica Rios, ALF Licensors
Kathy Young, Licensors

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.

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to submit a Washington state name and date of birth background inquiry (BGI) when hiring 1 of 1 sampled new staff on the first business day after their employment date. This failure placed all residents at risk of abuse, neglect, or exploitation from staff with an unknown background.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023 for Staff B and Staff C. STARS showed that the ALF received a recurring (occurred again or repeated) citation for this regulation on 08/10/2023 for Staff VV and Staff XX. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 09/24/2023. The facility requested an extension, which was approved for an updated back in compliance date of 11/15/2023.

Review of the facility's, "Resident Characteristic Roster", dated 11/27/2023, showed the facility provided care and services to 107 residents.

Review of the facility's, "Employee Roster" showed the facility hired Staff OOO on 10/16/2023 as a Dietary Aide.

Review of the facility's personnel records showed no documentation Staff OOO completed a Washington State name and date of birth background check inquiry. Further review showed the Department of Social and Health Services' (DSHS) document titled, "Entity Notification Additional Information Requested", dated 11/20/2023, showed that Staff OOO was not permitted unsupervised access to vulnerable individuals until the background check was completed and the results were reviewed by the facility.

Observation on 11/27/2023 at 1:05 PM, showed Staff OOO in the residents' dining room interacting with residents. Further observation showed no other staff members were present providing supervised resident access.

During an interview on 11/27/2023 at 3:15 PM, Staff PPP, Area Operations Specialist, stated that they were familiar with the Washington state regulations to complete BGI for all staff. Staff PPP acknowledged that they did not meet the 11/15/2023 Plan of Correction (POC) date.

This is a recurring deficiency previously cited on 04/03/2023 and an uncorrected deficiency previously cited on 08/10/2023.

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, Renton Assisted Living 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-2480 Tuberculosis Testing Required.

- (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.
- (2) For purposes of WAC 388-78A-2481 through 388-78A-2489, "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement a system to ensure that 3 of 3 sampled staff were screened for tuberculosis (TB) within three

days of employment. This failure placed all residents at risk of exposure to tuberculosis, an infectious disease.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023 for Staff B, Staff TT, Staff VV, Staff WW, and Staff XX. STARS showed that the ALF received a recurring (occurred again or repeated) citation for this regulation on 08/10/2023 for Staff C, Staff D, Staff E, and Staff F. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 09/24/2023. The facility requested an extension, which was approved for 11/15/2023."

Review of the facility's document, titled "Tuberculosis (TB) – Care Staff", dated 08/10/2021, showed that the facility required each newly hired care staff be screened for TB infection and disease within three days. The document showed that the facility followed the Washington Administrative Code (WAC) for TB testing requirements.

Review of the facility's Resident Characteristic Roster showed the facility provided care and services to 107 residents.

Review of the facility's Employee Roster showed the facility hired Staff B, Caregiver, on 06/01/2022, Staff NNN, Medication Technician, on 08/16/2023, and Staff OOO, Dietary Aid on 10/16/2023.

STAFF B

Review of the facility's personnel records showed no documentation that Staff B completed any TB test. Review of the facility's care schedule for November 2023, showed Staff B worked 18 shifts during the month.

Observation on 11/27/2023 at 2:10 PM, showed Staff B was in the first-floor hall of the facility. Observations showed residents in the same area.

During an interview on 11/27/2023, Staff B stated that they were a caregiver. Staff B stated that they provided care and services to residents.

STAFF NNN

Review of the facility's personnel records showed the facility administered the first of two required TB skin tests for Staff NNN on 11/15/2023, 91 days past the first day of employment. There was no documentation that showed Staff NNN completed the second skin test. Review of the facility's care schedule for November 2023, showed Staff NNN worked 23 shifts during the month.

STAFF OOO

Review of the facility's personnel records showed the facility administered the first of two required TB skin tests for Staff OOO on 11/13/2023, 28 days past the first day of employment. There was no documentation that showed Staff OOO completed the second skin test.

Observation on 11/27/2023 at 1:05 PM, showed Staff OOO worked in the residents' dining room. Observation showed Staff OOO interacted with residents in the dining room.

During an interview on 11/27/2023 at 1:08 PM, Staff OOO stated that they had direct contact with residents when they served residents food at their tables in the dining room. Staff OOO further stated that when they were hired, they were told they needed to be tested for TB.

This is a recurring deficiency previously cited on 04/03/2023 and an uncorrected deficiency previously cited on 08/10/2023.

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, Renton Assisted Living 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-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 1 of 3 medication rooms was locked when left unsupervised by staff. This failure placed the residents at risk for harm or illness if the medications were accessed and swallowed.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed that on 04/03/2023, the Assisted Living Facility (ALF) received an initial citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/17/2023. On 08/10/2023, the ALF received a recurring (occurred again or repeated) citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/15/2023.

Review of the facility's Resident Characteristics Roster showed that 107 residents resided in the Assisted Living area of the facility. All 107 residents ambulated independently or independently used a mobility device, such as a manual wheelchair, electric wheelchair, or an electric scooter. The roster showed 24 of the residents were diagnosed with [REDACTED] or [REDACTED].

Observation on 11/27/2023 at 10:47 AM showed Staff RRR, Resident Care Coordinator (RCC), Medication Technician (unlicensed staff who administer and dispense medications), in the third floor Wellness Office behind an office desk. During an interview at this time, Staff RRR stated that they were the Med Tech that dispensed medications for the third-floor residents.

Observation on 11/27/2023 at 10:49 AM showed the door to the Medication Room on the third floor was unlocked and propped wide open. Inside the room there was an unlocked refrigerator that stored medications which included insulin. There was an unlocked cupboard below a counter which contained bottles of liquid medication. An unlocked floor to ceiling cabinet against the far wall was full of medications, both over the counter and prescription. The unlocked door provided opportunity for residents to access the room and the medications stored in the various cabinets. Observation showed there were no facility staff present in the room or in vicinity of the room.

During an interview on 11/27/2023 at 3:20 PM, Staff PPP, Area Operations Specialist, stated that the expectation was for the medication carts to be locked, narcotics were to be double locked, and the medication rooms were to be locked when unsupervised.

During an interview on 11/27/2023 at 3:48 PM, Staff RRR, stated that they ensured the medication carts on the third-floor hallway were locked. Staff RRR stated that they were busy running back and forth and confirmed that they failed to close and lock the door to the medication room in their absence. Staff RRR stated that they should have closed and locked the third-floor medication room before leaving the room unsupervised. Staff RRR confirmed that they were the Medication Technician for the third floor that morning and were responsible for securing the medication room.

This is a recurring deficiency previously cited on 04/03/2023 and an uncorrected deficiency previously cited on 08/10/2023.

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, Renton Assisted Living 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
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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:
- (a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and
 - (b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.
- (2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:
- (c) Initial and on-going assessments of the nursing needs of each resident;
 - (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:
 - (a) Chapter 18.79 RCW, Nursing care;
 - (b) Chapter 18.88A RCW, Nursing assistants;
 - (c) Chapter 246-840 WAC, Practical and registered nursing;
 - (d) Chapter 246-841 WAC, Nursing assistants; and
 - (e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to monitor nurse delegation services for 3 of 16 sampled residents (Resident 11, Resident 48, and Resident 49). This failure placed the residents at risk for harm and compromised health from potential medication errors from undelegated staff.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed that on 04/03/2023, the Assisted Living Facility (ALF) received an initial citation for this regulation for 19 residents. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/17/2023. On 08/10/2023, the ALF received a recurring (occurred again or repeated) citation for this regulation for 16 residents. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 11/15/2023.

NURSE DELEGATION MONITORING

Review of the facility's undated policy titled "Clinical Policy and Procedure Manual" for Washington showed the manual contained the facility's "Nurse Delegation Policy", dated 08/10/2021. The nurse delegation policy showed that the Registered Nurse Delegator (RND) was responsible to determine the competency of the individual to perform the tasks. The policy showed that the RND was responsible for supervising the actions for the person performing the delegated task. The policy showed that when delegating insulin injections, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task weekly during the first four weeks of delegation of insulin injections.

On 11/27/2023, review of the facility's Registered Nurse Delegation binder showed three Department of Social and Health Services (DSHS) "Nurse Delegation: Nursing Visit" forms, one form for each: Resident 11, Resident 48, and Resident 49. Review of the documents showed that Staff TTT, Medication Technician (unlicensed staff who dispensed and administered delegated medications) was not listed on Nurse Delegation: Nursing Visit form as a delegated staff to administer insulin to Resident 11, Resident 48, and Resident 49. There was no documentation that showed Staff TTT completed Nurse Delegation training to include weekly RND supervision and evaluation for the first four weeks.

RESIDENT 11

Review of the "Nurse Delegation: Nursing Visit" form dated 10/19/2023 showed that Resident 11 received nurse delegation services for insulin administration. The form did not list Staff TTT as a delegated person to assist Resident 11 with insulin administration.

Review of Resident 11's November 2023 electronic Medication Administration Record (eMAR) showed that Staff TTT administered insulin to Resident 11 eight times.

RESIDENT 48

Review of the "Nurse Delegation: Nursing Visit" form dated 10/19/2023 showed that Resident 48 received nurse delegation for insulin administration. The form did not show Staff TT as a delegated person to assist Resident 48 with insulin administration.

Review of Resident 48's November 2023 electronic Medication Administration Record (eMAR) showed that Staff TTT administered insulin to Resident 48 twice.

RESIDENT 49

Review of the "Nurse Delegation: Nursing Visit" form dated 10/05/2023 showed that Resident 49 received nurse delegation for insulin administration. The form did not show Staff TTT as a delegated person to assist Resident 48 with insulin administration.

Review of Resident 49's eMAR for November 2023, showed that Staff TTT administered

insulin to Resident 49 ten times.

During an interview on 11/27/2023 at 3:15 PM, Staff PPP, Area Operations Specialist, stated that the facility contracted out their nurse delegation services with an outside company for all residents.

Review of an email communication with Staff PPP, dated 12/08/2023, showed that the contracted RND service did not have any records to show Staff TTT was delegated to assist Resident 11, Resident 48, and Resident 49 with insulin administration prior to 11/27/2023.

This is a recurring deficiency previously cited on 04/03/2023 and an uncorrected deficiency previously cited on 08/10/2023.

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, Renton Assisted Living 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-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:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 25 of 50 staff were trained to the facility's policy and procedures related to identifying and reporting suspected abandonment, abuse, neglect, exploitation, and financial exploitation. This failure placed all residents at risk of potential abuse, neglect, and exploitation from unreported and uninvestigated allegations.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. STARS showed that the ALF received a recurring (occurred again or repeated) citation for this regulation on 08/10/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 09/24/2023. The facility requested an extension, which was approved for 11/15/2023.

Record review of the facility's policy titled, "Elder Abuse, Neglect, and Exploitation", dated 12/15/2021, stated that all staff and volunteers were "mandated reporters". The policy stated that when there was reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department. The policy stated that all Resident Care Assistants would receive annual in-service training on elder abuse.

Review of the facility's, "Resident Characteristic Roster" showed the facility provided care and services to 107 residents.

Review of the facility's Employee Roster showed the facility employed 50 staff. Review of the facility's in-service training records related to abuse, neglect, and reporting showed the facility completed two in-service trainings on 09/22/2023 and 10/27/2023. The training records showed the facility provided training to 25 of the 50 total staff members.

Observation on 11/27/2023 showed on 11/27/2023 at 4:10 PM, Staff SSS, Concierge, interacted with residents. During an interview at that time, Staff SSS stated that they had not received facility training related to reporting of suspected abandonment, abuse, neglect, exploitation, and financial exploitation.

During an interview on 11/27/2023 at 12:15 PM, Staff MMM, Executive Director, stated that they were aware the facility had not completed the required training for at least half of current the staff.

This is a recurring deficiency previously cited on 04/03/2023 and an uncorrected deficiency previously cited on 08/10/2023.

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, Renton Assisted Living 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-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

- (1) Develop, implement and disclose to potential and current residents, policies regarding:
 - (b) The conditions under which pets may be in the assisted living facility.
- (2) Ensure animals living on the assisted living facility premises:
 - (a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;
 - (b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 5 of 5 sampled pets living in the facility had regular veterinary examinations and vaccinations appropriate for the species and were veterinarian certified to be free of diseases transmittable to humans. These failures placed residents at risk of contracting illnesses spread by pets.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. STARS showed that the ALF received a recurring (occurred again or repeated) citation for this regulation on 08/10/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 09/24/2023. The facility requested an extension, which was approved for 11/15/2023.

Record review of the facility's "Disclosure of Services" showed the facility permitted pets. The Disclosure of Services stated that pets must have regular veterinary examinations and vaccinations and be free of diseases transmittable to humans.

Review of the facility's undated document titled, "Pet Policy" showed that pets must have regular examinations and immunizations appropriate for their species, by a licensed veterinarian. The policy also showed that proof of the visits and immunizations must be given to the Administrator and kept on file. The policy did not show the requirement that pets to be certified by a veterinarian to be free of diseases transmittable by humans.

Review of the facility's, "Resident Characteristic Roster" showed the facility provided care and services to 107 residents.

PET 1

Review of Pet 1's veterinary records maintained by the facility, showed a current rabies vaccine. There was no documentation that showed Pet 1 was current on other vaccinations appropriate for the species. There was no documentation that showed Pet 1 received regular veterinarian examinations.

PET 2

Record review of veterinary records maintained by the facility, showed no documentation that Pet 2 was veterinarian certified to be free of diseases transmittable to humans. The records showed only a current rabies vaccine. There was no documentation that showed Pet 2 was current on other vaccinations. There was no documentation that showed Pet 2 received regular examinations.

PET 3

Record review of veterinary records maintained by the facility, showed no documentation that Pet 3 was certified to be free of diseases transmittable to humans.

Observation on 11/27/2023 at 2:32 PM, showed Pet 3 on the resident's bed.

During an interview on 11/27/2023 at 2:32 PM, Pet 3's owner (resident) was very friendly. The owner stated that Pet 3 allowed the other residents to pet her.

PET 4

Record review of veterinary records maintained by the facility, showed no documentation that Pet 4 was veterinarian certified to be free of diseases transmittable to humans. The record showed that Pet 4 was past due for a veterinary examination as well as of 08/05/2022. The record showed that on 08/05/2022, Pet 4 was due for three vaccinations.

Observation on 11/27/2023 at 2:40 PM, showed Pet 4 on the owner's (resident) bed.

PET 5

Record review of veterinary records maintained by the facility, showed no documentation that Pet 5 was veterinarian certified to be free of diseases transmittable to humans. The record showed that Pet 5 was past due for veterinarian examination. The records showed that on 10/20/2020, Pet 5 was due for one vaccination.

During an interview on 11/27/2023, Staff QQQ, Business Office Manager, stated that they were the responsible staff for ensuring all the residents' pets were current with the requirements. Staff QQQ stated that they had not reviewed the pet records since starting in the role over three months ago. Staff QQQ stated that they had not corrected the previous deficiencies related to residents' pets.

This is an uncorrected deficiency previously cited 04/03/2023 and 08/10/2023.

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, Renton Assisted Living 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



DSHS/ALISA
Residential Care Services

SEP 15 2023

Received

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 #: 2614	Compliance Determination #27622
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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 follow-up on 08/03/2023, 08/03/2023, 08/04/2023, and 08/04/2023 of:

Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

This document references the following SOD dated: 08/10/2023

The following sample was selected for review during the unannounced on-site visit: 36 of 109 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Jane Hermano, NCI
Michelle Yip, ALF Licenser
Claudia Machado, Community Complaint Investigator
Angelica Rios, ALF Licenser
Steven Garrett, LTC Licenser

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

08/23/2023

Date

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

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.

Sherry Sue - Tom
Administrator (or Representative)

9/05/2023
Date

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

(1) Submits the background authorization form for the person to the department ^{DSHS} ~~at least~~ ^{within} one business day after he or she starts working;

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit a Washington state name and date of birth background inquiry (BGI) on the first business after the staff started working for 2 of 8 sampled staff (Staff VV, Executive Director, and Staff XX, Dietary Aide). This failure placed all residents at risk of potential abuse or neglect from staff with unknown backgrounds.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested an extension and it was approved for a new date of 07/01/2023.

Review of the facility's documents titled "Personal Care Assistant Job Description", dated April 2020, and "Dietary Aide Job Description", dated April 2020, showed that the facility required all employees complete a criminal record clearance prior to presence in the facility. Record review of the facility's undated document titled "Staff Roster" showed that the facility hired Staff VV on 04/24/2023 and Staff XX on 07/04/2023.

Review of the facility's personnel records showed no documentation Staff VV completed an initial BGI on the day Staff VV started work in the facility. Further review of the personnel records showed that Staff VV completed a BGI on 06/16/2023, 54 days after Staff VV's first day of work.

Review of the facility's personnel records showed no documentation Staff XX completed an initial BGI on the day Staff XX started work in the facility. Further review of the personnel records showed that Staff XX completed a BGI on 07/10/2023, 10 days after Staff XX's first day of work.

During an interview on 08/04/2023 at 2:35 PM, Staff VV, Executive Director, stated that they were familiar with the Washington state regulations to complete a BGI on all staff. Staff VV stated that the facility did not have an accurate system in place to track the staff BGI applications and results.

DSHS/ALIC
Residential Care Sr

This is an uncorrected deficiency previously cited on 04/03/2023.

SEP 15 2023

Received

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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

Sherry Su-Town
Administrator (or Representative)

9/5/2023
Sherry Su-Town
Date

WAC 388-78A-2480 Tuberculosis Testing Required.

- (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.
- (2) For purposes of WAC 388-78A-2481 through 388-78A-2489, "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement a system to ensure 5 of 8 sampled staff (Staff B, Caregiver, Staff TT, Health Services Director, Staff VV, Executive Director, Staff WW, Medication Technician, Staff XX, Dietary Aide) were screened for tuberculosis. This failure placed all residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and

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Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested and extension and it was approved for a new date of 07/01/2023.

Review of the facility's document, titled "Tuberculosis (TB) – Care Staff", dated 08/10/2021, showed that the facility required each newly hired care staff be screened for TB infection and disease. The document also showed that the facility followed the Washington Administrative Code (WAC) on tuberculosis testing requirements.

Record review of the facility's undated "Staff Roster" showed that the facility hired Staff B on 06/01/2022; Staff TT on 05/17/2023; Staff VV on 04/24/2023; Staff WW on 07/02/2023; and Staff XX on 07/04/2023.

Record review of the facility's personnel records showed documentation that Staff VV was initially screened for tuberculosis on 06/16/2023, 54 days after the date of hire. Records showed Staff XX was initially screened for tuberculosis on 07/14/2023, 10 days after the date of hire. Further review of the personnel records showed no documentation that Staff B, Staff WW, and Staff TT were screened for tuberculosis.

Review of the facility's "Food Services Schedules" showed that Staff XX worked in the facility in July 2023 and August 2023. Review of the facility's "Caregiver Schedules" showed Staff B and Staff WW worked in the facility in July 2023 and August 2023.

Observations on 08/03/2023 at 10:50 AM and 08/04/2023 at 11:12 AM showed that Staff TT and Staff VV were present in the facility. Observation showed Staff TT and Staff VV interacted with residents and staff throughout each of those days.

During an interview on 08/04/2023 at 1:40 PM, Staff VV stated they were aware of the State regulation requirements on TB testing and the facility's TB testing policy. Staff VV stated that the facility did not follow the TB testing requirements to complete TB testing for their staff.

This is an uncorrected deficiency previously cited on 04/03/2023.

Plan/Attestation Statement

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

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Received

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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

Shem/ Sue-Toma
Administrator (or Representative)

9/5/2023
Date

WAC 388-78A-2610 Infection control.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their respiratory protection program (RPP) for 30 of 43 staff (Staff B, Caregiver; Staff C, Housekeeper; Staff D, Caregiver; Staff H, Medication Technician; Staff I, Food Service Director; Staff J, Cook; Staff M, Cook; Staff N, Dishwasher; Staff P, Medication Technician; Staff X, Caregiver; Staff DD, Medication Technician; Staff GG, Dietary Aide; Staff II, Caregiver; Staff JJ, Medication Technician; Staff QQ, Caregiver; Staff TT, Health Services Director; Staff VV, Executive Director; Staff WW, Medication Technician; Staff XX, Dietary Aide; Staff AAA, Maintenance Director; Staff BBB, Business Office Manager; Staff CCC, Resident Care Director; Staff DDD, Caregiver; Staff EEE, Caregiver; Staff FFF, Caregiver; Staff GGG, Medication Technician; Staff HHH, Dishwasher; Staff III, Dishwasher; Staff JJJ, Medication Technician; and Staff KKK, Activity Director) to reduce the potential spread of infectious diseases. This failure placed all residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

Record review of the Department of Social and Health Services (DSHS)'s, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023 for Staff B, Staff C, Staff D, Staff H, Staff P, Staff X, Staff DD, Staff GG, Staff II, Staff JJ, and Staff QQ. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested and extension and it was approved for a new date of 07/01/2023.

Review of the Washington State Department of Health (DOH) website, titled "Respiratory Protection Program for Long-Term Care Facilities", (<https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program>), showed that facilities were required to identify

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Received 08/10/2023

which employees would be exposed to a respiratory hazard, to fit test those employees who could potentially be exposed to a respiratory hazard, and to maintain the employees' fit test records. Facilities were required to provide initial and annual fit tests and to provide fit tested respirators to their employees.

Review of the facility's document titled "Infection Control 17-Respiratory Illness Outbreak", dated 12-15-2021, showed that the facility would take steps to reduce the risk of and respond to outbreaks of respiratory illnesses. The document showed that the facility would always follow guidelines and recommendations from the Centers for Disease Control and Prevention (CDC) and state and local public health departments. The document further showed that all staff would be trained on the use of Personal Protective Equipment (PPE).

Review of the facility's undated "Employee Roster" showed that the facility hired 43 employees to provide care and services to the assisted living (AL) residents. The document showed that the facility hired Staff B on 06/01/2022; Staff C on 06/01/2022; Staff D on 01/05/2023; Staff H on 06/01/2022; Staff I on 06/01/2022; Staff J on 06/01/2022; Staff M on 06/01/2022; Staff N on 06/01/2022; Staff P on 06/01/2022; Staff X on 06/01/2022; Staff DD on 06/01/2022; Staff GG on 07/20/2022; Staff II on 06/01/2022; Staff JJ on 06/01/2022; Staff QQ on 09/16/2022; Staff TT on 05/17/2023; Staff VV on 04/24/2023; Staff WW on 07/02/2023; Staff XX on 07/04/2023; Staff BBB on 05/01/2023; Staff CCC on 06/21/2023; Staff DDD on 04/17/2023; Staff EEE on 06/17/2023; Staff HHH on 10/25/2022; Staff III on 06/01/2022; Staff JJJ on 06/17/2023; and Staff KKK on 05/17/2023. Further review of the roster showed no hire dates documented for Staff AAA, Staff FFF, and Staff GGG.

Review of the facility's RPP documentation showed that facility kept staff respirator fit testing records, which included the medical evaluation and fit test results. Review of the documentation showed there was no respirator fit test records documentation for Staff B, Staff I, Staff J, Staff M, Staff N, Staff P, Staff X, Staff DD, Staff GG, Staff II, Staff JJ, Staff QQ, Staff WW, Staff XX, Staff AAA, Staff CCC, Staff FFF, Staff GGG, Staff HHH, and Staff III. Additionally, the documentation showed no medical evaluation for Staff C, Staff D, Staff H, Staff I, Staff J, Staff N, Staff GG, Staff JJ, Staff TT, Staff VV, Staff WW, Staff XX, Staff AAA, Staff BBB, Staff CCC, Staff DDD, Staff EEE, Staff FFF, Staff GGG, Staff JJJ, and Staff KKK.

During an interview on 08/04/2023 at 11:00 AM, Staff YY, Western Washington Clinical Services Director, stated that they were the RPP Administrator. Staff YY stated that they were aware of the fit test requirements for all facility staff. Staff YY further stated that they were aware the facility did not complete fit testing for all staff that were required to be fit tested.

This is an uncorrected deficiency previously cited on 04/03/2023.

Plan/Attestation Statement

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Licensee: Greenlake Management Renton, LLC

Received 9/15/2023

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/14/2023

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

Sherry Su-Toma
Administrator (or Representative)

9/5/2023
Date

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

- (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
- (2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 8 sampled staff (Staff TT, Health Services Director) completed a national fingerprint background check prior to provisional hire at the facility. The facility also failed to ensure Staff TT did not have unsupervised access to residents pending the results of a national fingerprint background check. These failures resulted in the residents receiving care from disqualified staff.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested and extension and it was approved for a new date of 07/01/2023.

Review of the facility's document titled "Job Description – California Addendum", dated April 2020, showed that the facility's management company required all employees complete a criminal record clearance prior to presence in the facility. The document also showed that all employees prior to working in the facility, were fingerprinted, and signed a criminal record statement under penalty of perjury.

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Record review of the facility's undated "Staff Roster" showed that the facility hired Staff TT on 05/17/2023. Review of the facility's "Schedule" showed that Staff TT worked in the facility during the day shifts, between April 2023 and August 2023.

Review of the facility's personnel files showed documentation that on 05/17/2023, Staff TT completed a Washington state name and date of birth background check with disqualifying results. Review showed documentation that Staff TT completed the National Fingerprint Background Check on 06/12/2023 with disqualifying results. The facility maintained the documentation of all staff background check results.

Further review of the facility's personnel files showed that Staff TT remained on the personnel roster and worked 53 days after the facility received the disqualifying name and date of birth background check and another 26 days after the facility received the results of the disqualifying national fingerprint check results. Staff TT worked unsupervised with residents for a total of 79 days after the facility received both background check results.

Observations on 08/03/2023 and 08/04/2023 showed that Staff TT was present in the facility. Observation showed Staff TT interacted with residents throughout the day, with no supervision.

During an interview on 08/03/2023 at 2:45 PM, Staff VV stated that Staff T, Director of Compliance – Corporate, was notified of the disqualifying results of Staff TT's Washington State Name and Date of Birth Background Check and the disqualifying results of the National Fingerprint Background Check.

This is an uncorrected deficiency previously cited on 04/03/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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

Shum Su-Tom
Administrator (or Representative)

9/5/2023
Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons;

Received

and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 1 of 4 sampled medication carts (Cart 1, located on the second floor) was locked when left unsupervised by staff. This failure placed the residents at risk for harm or illness if the medications were accessed and swallowed.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested an extension, and it was approved for a new date of 07/01/2023.

Review of the facility's undated "Assisted Living Resident Characteristics Roster" showed that 107 residents resided in the Assisted Living section of the facility. The Roster identified 9 of the 107 residents were diagnosed with [REDACTED] or [REDACTED] and [REDACTED]. All 107 residents ambulated independently or independently used a mobility device, such as a manual wheelchair, electric wheelchair, or an electric scooter.

Observation on 08/03/2023 at 10:52 AM, showed the door to the medication room on the second floor and Cart 1 left inside the medication room was unlocked. Cart 1 contained drawers of prescribed and over-the-counter medications in blister packs (form of packaging in a card with clear plastic for unit-dose tablets or capsules). There were no staff members present. Observation showed the medication room, located in a busy hallway, close to the elevator and the activity/television (TV) area. Further observation showed constant presence and movement of residents that passed by the unlocked medication room.

On 08/03/2023 at 1:55 PM, observation showed the door to the medication room on the second floor was unlocked. The medication Cart 1 inside the medication room was locked. Further observation showed six blister packs with medications in each pack, sat on top of Cart 1. There were no staff members inside the medication room.

During an interview on 08/03/2023 at 11:02 AM, Health Services Director, Licensed Practical Nurse, stated that the facility required the medication room be locked when staff were not present.

During an interview on 08/03/2023 at 2:00 PM, Staff UU, Medication Technician, stated that the facility did not provide them with the key to lock and unlock the second-floor

medication room. Staff UU acknowledged that they left the medication ^{DSHS/ALSA} ~~Residential Care Services~~ unopened due to not having a key.

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This is an uncorrected deficiency previously cited on 04/03/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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


Administrator (or Representative)

9/5/2023
Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 or 2 sampled resident (Resident 4 and Resident 22) received medications as prescribed to meet their medical needs. This failure resulted in medication errors and placed Resident 4 and Resident 22 at risk for health complications and decreased quality of life due to medication mismanagement.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that

stated the facility would have a system in place and the deficiency corrected by 08/16/2023. The facility requested an extension, and it was approved for a new date of 07/01/2023.

During an interview on 08/03/2023 at 11:55 AM, Staff TT, Health Services Director, Licensed Practical Nurse, stated that nurse delegated Health Care Assistants (HCA) administered medications to all residents living in the facility. Staff TT added that the staff used the Electronic Medication Administration Record (eMAR) system to document medication management.

Review of the facility's undated document "Resident Characteristics Roster" showed the facility admitted Resident 4 in [REDACTED] of 2021 and Resident 22 in [REDACTED] of 2017.

RESIDENT 4

Review of Resident 4's "Department of Social and Health Services Current Annual Assessment", dated 06/28/2022, showed Resident 4 required medication management assistance. Further review showed Resident 4 was diagnosed with [REDACTED]. Review of Resident 4's facility undated "Washington Resident Assessment" showed Resident 4 required "significant, total" medication assistance.

Review of Resident 4's July 2023 eMAR showed that Resident 4 received Humalog (fast-acting insulin) to be given subcutaneously (under the skin [SQ]) based on a sliding scale (insulin dose administered according to blood glucose level test results) to be administered four times daily, before meals and at bedtime. Resident 4's sliding scale order, dated 05/03/2023, showed Humalog was to be administered for a blood sugar result as follows: 201-250 = 5 units; 251-300 = 7 units; 301-350 = 9 units.

Further review of Resident 4's July 2023 eMAR showed that on 07/16/2023 at 4:00 PM, Resident 4's blood sugar test result was 149. The eMAR showed Staff LLL, Medication Technician, signed the eMAR for the administration of 5 units of Humalog insulin. On 07/16/2023 at 8:00 PM, Resident 4's blood sugar test result was 146. The eMAR showed Staff LLL, the same Medication Technician signed the eMAR for the administration of 4 units of Humalog insulin. Based on the sliding scale order, no insulin was needed either time as the blood sugar test results were below 200.

During an interview on 08/03/2023 at 11:55 AM, Staff TT confirmed that Resident 4 used an insulin dosage sliding scale for management of their diabetes. Staff TT stated that they were unaware of medication error on 07/16/2023.

RESIDENT 22

Review of Resident 22's July 2023 eMAR showed that Resident 22 received a base dose of Humalog SQ, 15 units, three times daily before meals and an additional dose based on the physician established sliding scale. Resident 22's sliding scale order, dated 07/22/2023, showed Humalog was to be administered for a blood sugar as follows: 100-200 = 0 units; 201-250 = 1 unit; 251-300 = 3 units; 301-350 = 5 units; 351-400 = 11 units; greater

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than 400 = 13 units. The order showed Resident 22 was allowed up to 28 units of insulin per day.

Further review of Resident 22's July 2023 eMAR showed that on 07/23/2023, Resident 22's blood sugar test result was 204. The eMAR showed Staff VVV, Medication Technician, signed the eMAR for the administration of 15 units of Humalog insulin. Based on the sliding scale order, Resident 22 needed one additional unit of insulin.

During an interview on 08/03/2023 at 11:56 AM, Staff TT stated that they were unaware of the medication error. Staff TT stated that they found no other documentation that Resident 22 received one additional unit of insulin as written in the sliding scale order.

This is an uncorrected deficiency previously cited on 04/03/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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

Sherry Sue-Tamm
Administrator (or Representative)

9/5/2023
Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to communicate with the physician for 1 of 1 sampled resident's (Resident 26) the blood sugar results in accordance with the physician order and the resident's service agreement. This failure placed the residents at risk for compromised health.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by

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05/01/2023. The facility requested an extension and it was approved for a new date of 07/01/2023.

Review of the facility's document titled "Clinical Policy and Procedure Manual - Washington", updated 08/10/2021, defined a medication error as staff did not correctly process a physician's order. The policy showed that the facility required staff documented and followed instructions given by the resident's physician. The policy also showed that the facility would coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

RESIDENT 26

Review of the facility's undated document titled "Assisted Living Facility Resident Characteristic Roster" showed that the facility admitted Resident 26 in August 2019.

Review of Resident 26's "Personal Service Plan (PSP)", dated 03/07/2023, showed that Resident 26's medical diagnoses included [REDACTED]. The document showed the facility assisted Resident 26 with medication administration, which included coordination of care between the health care providers and the pharmacy. The plan also stated that any changes in Resident 26's condition were to be reported to the physician.

Review of Resident 26's undated "Nurse Delegation" documentation showed that the facility provided nurse delegation to Resident 26. The documentation showed that the facility's Registered Nurse Delegator (RND) delegated blood sugar checks and insulin administration to Medication Technicians (trained unlicensed assistive personnel).

Review of Resident 26's eMAR, dated July 2023 and August 2023, showed an order of Admelog (fast acting insulin) to be administered subcutaneously [under the skin (SQ)] three times daily before meals based on a sliding scale (number of insulin units administered according to blood glucose level result based on a scale). The order showed that staff would notify the physician if Resident 26's blood sugar level result was less than 80 or greater than 350. The July 2023 eMAR showed that on 07/01/2023 at 4:00 PM, Resident 26's blood sugar level was below 80. Further review of the July 2023 and August 2023 eMARs showed that the 7:00 AM blood sugar checks were greater than 350 on 07/26/2023 and 08/02/2023; the 11:00 AM blood sugar checks were greater than 350 on 07/06/2023, 07/07/2023, 07/10/2023, 07/13/2023, 07/15/2023, 07/19/2023, 07/20/2023, 07/26/2023, 07/28/2023, 08/01/2023, 08/04/2023, and 08/05/2023; and the 4:00 PM blood sugar checks were greater than 350 on 07/13/2023, 07/14/2023, 07/29/2023, and 07/30/2023. The eMAR showed no documentation that showed the assigned Medication Technicians notified the physician for any of these blood sugar results.

Review of Resident 26's "Progress Notes", dated between 07/01/2023 and 08/09/2023, showed that the facility sent a fax to Resident 26's primary care physician one time on 07/10/2023, when the blood sugar level was 446. There was no documentation that showed the facility notified the primary care physician any of the other days and times when Resident 26's blood sugar level was less than 80 or greater than 350.

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During an interview on 08/03/2023 at 11:40 AM, Staff YY, RND, Western Washington Clinical Services Director, stated that they did not delegate to any agency staff.

During an interview on 08/04/2023 at 12:25 PM, Resident 26 stated that they could not believe their blood sugar was that high. Resident 26 stated that lately their blood sugars have been elevated and they did not know why. Resident 26 stated they had just finished lunch, but they only ate half a sandwich and a few bites of salad. Observation showed that a plate of partially eaten salad on the table in Resident 26's apartment. Resident 26 also stated that there were times the staff administered them the sliding scale insulin after they had eaten a meal.

During an interview on 08/04/2023 at 12:42 PM, Staff YY stated that they were unaware of Resident 26's physician orders, which instructed staff to notify the physician when Resident 26's blood sugar was less than 80 or greater than 350. During a follow-up interview on 08/10/2023 at 8:52 AM, Staff YY stated that the Medication Technicians assigned to Resident 26 were responsible to read the blood sugar results, notify the physician, and document the physician communication on the progress notes. Staff YY acknowledged that based on the documentation, the staff did not follow the physician orders. Staff YY reported that after the Department's full inspection in April 2023, the facility updated their Clinical Policies and Procedures Manual and provided staff an in-service training on medication services. Staff YY stated that even after the in-service training, some staff continued to not follow the physician orders, as required. Staff YY also stated that the facility required regular medication reviews, which included review of all medication services and eMAR documentation. Staff YY stated that they did not complete the review as required.

This is an uncorrected deficiency previously cited on 04/03/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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

Spem/Su-Tomm
Administrator (or Representative)

9/5/2023
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:

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- (a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and
- (b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.
- (2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:
 - (c) Initial and on-going assessments of the nursing needs of each resident;
 - (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:
 - (a) Chapter 18.79 RCW, Nursing care;
 - (b) Chapter 18.88A RCW, Nursing assistants;
 - (c) Chapter 246-840 WAC, Practical and registered nursing;
 - (d) Chapter 246-841 WAC, Nursing assistants; and
 - (e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to monitor nurse delegation services for 16 of 16 sampled residents (Resident 4, Resident 5, Resident 7, Resident 20, Resident 22, Resident 24, Resident 25, Resident 27, Resident 36, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, and Resident 47). This failure placed all 16 residents at risk for harm and compromised health from potential medication errors from undelegated staff.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested an extension and it was approved for a new date of 07/01/2023.

NURSE DELEGATION MONITORING

Review of the facility's "Clinical Policy and Procedure Manual" for Washington contained the "Nurse Delegation Policy" dated 08/10/2021. The policy showed "before delegating a task, the registered nurse delegator determines that specific criteria are met, and the patient is in a stable predictable condition." Further review showed that the Registered Nurse delegator (RND) was responsible to determine the competency of the individual to perform the tasks. The policy also showed that the RND was responsible for supervising the actions for the person performing the delegated task. The policy also showed that "when delegating insulin injections, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task

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weekly during the first four weeks of delegation of insulin injections".

On 08/03/2023, review of the facility's "Registered Nurse Delegation binder" showed several Department of Social and Health Services (DSHS) "Nurse Delegation: Nursing Visit" forms for Resident 4, Resident 5, Resident 7, Resident 20, Resident 22, Resident 24, Resident 25, Resident 27, Resident 36, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, and Resident 47.

NURSING SUPERVISION AND EVALUATION VISITS

Resident 24

Review of the "Nurse Delegation: Nursing Visit" form dated 07/05/2023 showed that Resident 24 received nurse delegation for insulin administration. The form showed Staff P, Med Tech, Staff Z, Med Tech, Staff CC, Med Tech, Staff DD, Med Tech, and Staff JJ, Med Tech each received the initial RND visit, for week one. No further documentation was found to show additional visits for a total of four visits occurred, as required.

Resident 42

Review of the "Nurse Delegation: Nursing Visit" form dated 07/05/2023 showed that Resident 42 received nurse delegation for insulin administration. The form showed Staff P, Staff Z, Staff CC, Staff DD, and Staff JJ, each received the initial RND visit, week one. No further documentation was found to show additional visits for a total of four visits occurred, as required.

RESIDENT 4, RESIDENT 5, RESIDENT 6, RESIDENT 20, RESIDENT 22, RESIDENT 25, RESIDENT 27, RESIDENT 36, RESIDENT 41, RESIDENT 43, RESIDENT 45, RESIDENT 46, and RESIDENT 47

Review of the "Nurse Delegation: Nursing Visit" forms dated 07/05/2023 showed that Resident 4, Resident 5, Resident 6, Resident 20, Resident 22, Resident 25, Resident 27, Resident 36, Resident 41, Resident 43, Resident 45, Resident 46, and Resident 47 all received nurse delegation for insulin administration. The form showed three staff were delegated for insulin administration, Staff WW, Med Tech, Staff AAA, Med Tech, and Staff BBB, Resident Care Coordinator. The delegation forms showed that Staff WW, received the initial week RND visit, Staff AAA received week one, week two, and week three RND visits, and Staff BBB received week one and week two RND visits. No further documentation was found to show that all three staff received additional visits by the RND for a total of four visits, as required.

Observation on 08/03/2023 at 11:30 AM, 12:30 PM, 2:00 PM, and 08/04/2023 at 9:30 AM, showed Staff CCC inside the third-floor nursing office. During an interview on 08/04/2023 at 1:30 PM, Staff CCC stated that they were delegated to administer insulin.

Observation on 08/04/2023 at 9:30 AM, showed Staff WW dispensed medications from the third-floor medication room. During an interview on 08/04/2023 at 10:00 AM, Staff WW confirmed that earlier in the morning, they dispensed medications and administered insulin to residents.

During an interview on 08/03/2023 at 1:45 PM, Staff YY, Western Washington Clinical Services Director, stated that they, along with the corporate staff, reviewed Substitute House Bill 1124 Chapter 14, Laws of 2022 regarding glucose monitoring and testing – nurse delegation. Staff YY stated that the bill showed the that the "weekly during the first four weeks" was lined out. Staff YY stated that the language changed to "an interval

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determined by the commission by rule". Staff YY stated that it was their interpretation that the four visits were no longer required per RCW (Revised Code of Washington) 18.79.260. Staff YY stated that based on their interpretation, the four supervisory and evaluation visits were no longer necessary and were not completed.

On 08/03/2023 and 08/04/2023, review of an email communication with Collateral Contact 3, Department of Social and Health Services Nurse Delegation Program Manager, showed that the four supervision and evaluation visits were still in effect and required per the WAC (Washington Administrative Code) 246-840-910 through 246-840-970.

NO DELEGATION

On 08/03/2023, review of the facility's "Registered Nurse Delegation binder" showed no delegation documentation to show Staff UU was delegated to administer insulin. Further review showed no documentation that Staff UU completed the Department of Social and Health Services required training for core nurse delegation or nurse delegation for diabetes.

On the second floor of the facility, observation on 08/03/2023 at 11:00 AM showed Staff UU next to the medication cart. Observation showed Staff UU dispensed medications for the residents.

During an interview on 08/03/2023 at 2:00 PM, Staff UU, Med Tech, Agency staff, stated that they administered morning insulin for two residents, Resident 4 and Resident 47. Staff UU stated that they were not delegated by the facility RND.

During an interview on 08/03/2023 at 11:40 AM, Staff YY stated that they were the Registered Nurse Delegator for the facility. Staff YY confirmed Staff UU was not delegated to administer insulin. Staff YY stated that they did not delegate any agency staff who worked at the facility. Staff YY stated that they planned to delegate Staff UU that day.

Observation on 08/04/2023 at 12:19 PM, showed Staff UU administered 11 units of insulin subcutaneously (the injection is administered in the fatty tissue, just under the skin) with an insulin pen to Resident 26. During an interview on this same date and time, Staff UU stated that during the morning medication pass, Staff UU administered insulin to two residents. Staff UU stated that they still were not delegated for insulin administration.

During an interview on 08/04/2023 12:42 PM, Staff YY stated that they did not complete Staff UU's delegation. Staff YY stated that they had planned to observe Staff UU administer insulin that morning. Staff YY stated that they were unable to complete the observation.

This is an uncorrected deficiency previously cited on 04/03/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023.

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

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Sherry S. Tom
 Administrator (or Representative)

9/5/2023
 Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

- (7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.
- (8) Medical and nursing services provided by the assisted living facility for a resident, including:
 - (a) A record of providing medication assistance and medication administration, which contains:
 - (iii) The signature or initials of the person providing any medication assistance or administration; and
 - (b) A record of any nursing treatments, including the signature or initials of the person providing them.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to accurately document in the medication administration record the medication assistance and administration provided to 1 of 1 resident (Resident 6). This failure placed Resident 6 at risk for increased health issues from improper medication assistance and potential medication errors.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested an extension and it was approved for a new date of 07/01/2023.

DOCUMENTATION OF ANTIBIOTIC OINTMENT NOT GIVEN

Review of the facility's document titled "Medication Services", dated 08/10/2021, showed staff were responsible to follow the procedure to ensure "all medications that staff members handle, store, and assist with will be documented on the Medication Assistance Record (MAR) and in accordance with state regulations". Further review showed that "when assisting the resident with self-administration, the Nurse/Med Tech will: a) check and compare the information on the medication label with the MAR." The policy also showed

that when a medication clarification was required, the physician was to be notified via fax and the physician office was to be called and alerted a fax was sent.

RESIDENT 6

Review of the facility undated document titled "Assisted Living Resident Characteristics Roster" showed the facility admitted Resident 6 in [REDACTED] 2015.

Review of Resident 6's July 2023 and August 2023 electronic Medication Administration Records (eMAR) showed an order dated 11/02/2022 for double antibiotic ointment. The order showed the ointment was to be applied to "affected areas topically every day." The order did not state where the ointment was to be applied or for how long. Further review of the eMARs showed that staff signed the eMAR, which indicated that staff applied the antibiotic ointment every day from 07/01/2023 through 08/03/2023, as ordered. There was no documentation on the eMARs that showed where the staff applied the antibiotic ointment.

On 08/03/2023 at 2:05 PM, review of Resident 6's eMAR showed that the double antibiotic ointment was applied at 8:00 AM. The eMAR showed Staff ZZ, Licensed Practical Nurse, Agency initialed the eMAR to document that the ointment was applied.

During an interview on 08/03/2023 at 2:05 PM, Staff ZZ confirmed they signed the eMAR on 08/03/2023 to show the double antibiotic ointment was applied. Staff ZZ stated that even though the eMAR on the computer screen showed they had signed for the antibiotic ointment as given, Staff ZZ stated that in fact, they did not apply the antibiotic ointment. Staff ZZ stated that they thought Resident 6 applied the ointment to themselves. Staff ZZ then stated they were unsure. Staff ZZ also stated they did not know where on Resident 6's body that the double antibiotic ointment was to be applied. Observation on this same date and time showed Staff ZZ was unable to locate the double antibiotic ointment in the medication cart.

During an interview on 08/04/2023 at 10:32 AM, Resident 6 stated that the double antibiotic ointment was applied to the upper thigh and buttocks area. Resident 6 stated that they applied the antibiotic ointment to themselves. Resident 6 stated that the staff did not provide any assistance. Resident 6 stated that they no longer used the double antibiotic ointment, for almost a year now. Resident 6 stated that there was no antibiotic ointment in their room.

During an interview on 08/04/2023 at 10:36 AM, Staff VW, Medication Technician, confirmed that at 8:00 AM that morning, they signed the eMAR that they administered Resident 6's double antibiotic ointment. Staff VW stated that they did not know where on Resident 6's body that the antibiotic ointment was to be applied. Staff VW then stated that Resident 6 applied the ointment themselves. Staff VW stated that when they dispensed Resident 6's morning medications, Resident 6 stated that they would apply the antibiotic ointment without staff assistance. Staff VW declined to accompany the Department Representative (Licensor) to speak with Resident 6 and clarify the conflicting information. Staff VW stated that there was "no need to."

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This is an uncorrected deficiency previously cited on 04/03/2023.

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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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023.

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

Sperry Joe-Tomr
Administrator (or Representative)

9/5/2023
Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

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

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 8 sampled staff (Staff C, Housekeeper, and Staff F, Medication Technician, and Staff VV, Medication Technician) completed facility orientation as required. These failures placed all the residents at risk of abuse, neglect, and receiving care and services from staff without the required qualifications and training.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested an extension and it was approved for a new date of 07/01/2023.

Record review of the facility's undated "Staff Roster" showed that the facility hired Staff C on 06/01/2022; Staff F on 12/05/2022; and Staff VV on 07/02/2023.

Review the facility's undated document titled "New Employee Orientation" showed that new employee orientation included training on the care setting, resident care, safety, communication skills, infection control, and resident rights. Further review of the document showed that the facility required all new employee orientation be completed, signed, and dated by the employee and their manager.

Review of the facility's undated document titled "Caregiver Orientation Skills Checklist" showed that the caregiver orientation included additional training on health service policy and procedures, infection control, and incident management. Further review of the document showed that the facility required all new caregivers be oriented to skills, show competency, and be signed and dated by the employee, their preceptor (trainer), and the Health Services Director.

Review of the facility's personnel files showed that the facility maintained the orientation documentation for all staff. Further review of the personnel files for Staff C, Staff F, and Staff VV showed no documentation that staff completed the "New Employee Orientation". Additionally, the personnel files for Staff C, Staff F, and Staff VV showed no documentation the care staff completed the "Caregiver Orientation".

During an interview on 08/04/2023 at 1:30 PM, Staff VV, Executive Director, stated that they were aware the facility provided a facility orientation checklist for all new employees and an additional orientation checklist for new caregivers. Staff VV further stated that they were unaware Staff C, Staff F, and Staff VV failed to complete the required facility training when hired.

This is an uncorrected deficiency previously cited on 04/03/2023.

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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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) <u>9/24/2023</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Sperry Sue-Tom</u> Administrator (or Representative)	<u>9/5/2023</u> 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:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure all staff were trained to the facility's policy and procedures related to reporting suspected abandonment, abuse, neglect, exploitation, and financial exploitation. This failure placed all residents at risk of potential abuse, neglect, and exploitation from unreported and uninvestigated allegations.

Findings included...

Record review of the Department of Social and Health Services (DSHS)'s, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF signed an attestation statement that stated the facility would have a system in place and deficiency corrected by 05/01/2023. The facility requested an extension and it was approved for a new date of 07/01/2023.

Record review of the facility's policy titled, "GP 11 – Elder Abuse, Neglect, and Exploitation", dated 12/15/2021, stated that all staff and volunteers at Green Lake Senior Living were "mandated reporters". The policy stated that when there was reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department. The policy further stated that all Resident Care Assistants would receive in-service training on elder abuse, which would be repeated annually.

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During an interview, on 08/03/2023 at 12:50 PM, Staff KKK, Activity Director, stated that they were unaware of the term mandatory reporter. Staff KKK also stated that they were unaware of the required timeframe to make a report. Staff KKK further stated that the facility did not provide any training on the policy about mandatory reporting to the state hotline for reporting suspected or observed resident abuse, neglect, or exploitation.

During an interview, on 08/04/2023 at 10:20 AM, Staff WW, Medication Technician, stated that they were unaware of the facility's abuse and neglect policy. Staff WW further stated that the facility did not provide any training on the policy about staff responsibilities related to reporting of observed or suspected abuse and neglect.

During an interview, on 08/04/2023 at 10:35 AM, Staff UU, Medication Technician (Nurse Agency), stated that they were not trained on the facility policy and procedures related to reporting abuse and neglect.

During an interview, on 08/04/2023 at 12:32 PM, Staff XX, Dietary Aide, stated that they were unaware of what mandatory reporting meant. Staff XX stated that they were unaware they were a mandatory reporter. Staff XX stated that they were told to report any concerns to their supervisor or nurse. Staff XX was unaware of a department number to call for reporting any concerns of abuse or neglect.

During an interview, on 08/04/2023 at 10:10 AM, Staff VV, Executive Director, stated that they were aware of the training requirements for all facility staff regarding reporting of observed or suspected abuse, neglect or exploitation. Staff VV stated that the facility had a staff meeting with training on abuse, neglect, falls, and incident reporting. Staff VV further stated that the last training was on 03/30/2023. Staff VV further stated that newly employed staff were oriented to the facilities policy regarding abuse and neglect. Staff VV stated that they were unaware of any documentation that showed newly hired staff were trained to the facility abuse and neglect policy.

This is an uncorrected deficiency previously cited on 04/03/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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

Sherry Su-Tom
Administrator (or Representative)

9/5/2023
Date

Statement of Deficiencies

License #: 2614

Compliance Determination # 27622

Plan of Correction

Renton Assisted Living

Completion Date

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Licensee: Greenlake Management Renton LLC

08/10/2023

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WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

- (1) Develop, implement and disclose to potential and current residents, policies regarding:
 - (b) The conditions under which pets may be in the assisted living facility.
- (2) Ensure animals living on the assisted living facility premises:
 - (a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;
 - (b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain pet records for 5 of 13 pets (pet 6, Pet 8, Pet 9, Pet 12, and Pet 14) living in the facility including veterinarian certification that pets were free of disease transmittable to human and received regular examinations and vaccinations. This failure placed the residents at risk for contracting illnesses spread by pets.

Findings included...

Review of the Department of Social and Health Services (DSHS) "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/03/2023. The ALF originally signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 05/01/2023. The facility requested an extension and it was approved for a new date of 07/01/2023.

Record review of the facility's undated document titled "Disclosure of Services" showed the facility permitted pets. The Disclosure of Services stated that pets must have regular veterinary examinations and vaccinations and be free of diseases transmittable to humans.

Record review of the facility's undated pet policy showed pets must have current vaccination records on file with the Executive Director. The pet policy also stated that a regular review of the residents' ability to handle pet responsibilities would be conducted by a designated member of the facility's management team.

Pets 6, 8, 9, 12 and 14

Review of the facility's pet records showed no documentation that Pet 6 was current with exams and free of disease transmittable to humans. The pet records showed the facility failed to acquire veterinary records for Pet 8 that showed Pet 8 was current with exams, vaccines, and was free of diseases transmittable to humans. The records showed Pet 9's annual exam and vaccinations were due on 08/05/2022. There was no documentation that showed Pet 9 was current for the rabies vaccine and was certified by a veterinarian to be free of diseases transmittable to humans. Records showed no documentation that Pet 12

Statement of Deficiencies

License # 2614

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was current with exams, vaccines, and free of disease transmittable to humans. There was no documentation that Pet 14 was current with exams and free of disease transmittable to humans.

During an interview on 08/04/2023 at 1:30 PM, Staff VV, Executive Director, stated that the facility arranged for the "mobile vet" to come to the facility in June 2023 and vaccinate the pets of facility residents. Staff VV stated that in June, rabies immunizations were given at the time the "mobile vet" was at the facility.

This is an uncorrected deficiency previously cited on 04/03/2023.

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, Renton Assisted Living is or will be in compliance with this law and / or regulation on (Date) 9/24/2023

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

Sherry Su-Tom
Administrator (or Representative)

9/5/2023
Date



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

Statement of Deficiencies	License #: 2614	Compliance Determination # 20980
Plan of Correction	Renton Assisted Living	Completion Date
Page 1 of 54	Licensee: Greenlake Management Renton, LLC	04/03/2023

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

The department completed data collection for the unannounced on-site full inspection on 03/13/2023, 03/13/2023, 03/20/2023 and 03/20/2023 of:

Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

The following sample was selected for review during the unannounced on-site visit: 9 of 100 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licenser
Jane Hermano, NCI
Kathy Young, Licenser
Michelle Yip, ALF Licenser

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.

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-2180 Activities. The assisted living facility must:**

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

This requirement was not met as evidenced by:

Based on observations, interview, and record review, the facility failed to provide activities for 100 of 100 residents. This failure placed all Assisted Living residents at risk for a decreased quality of life.

Findings
included...

Review

of the facility's undated "Disclosure of Services" showed that the facility assisted residents to arrange social, recreational, religious, or other activities in the assisted living facility and in the community. The document also showed that the facility followed the Washington State law requirements to inform each resident, or their representative, in writing, of the services, items and activities customarily available in the facility and arranged for by the facility.

Review

of the facility's undated document titled "Resident Handbook" showed that the facility's Activity Program Director worked with the staff and the residents to plan activities. The Handbook further showed that the facility posted a calendar of scheduled activities on the wall next to the elevator.

Review

of the facility's "Assisted Living Facility Resident Characteristic Roster", dated 03/13/2023, showed that the facility provided care and services to 100 Assisted Living residents.

Observation

on 03/13/2023 between 9:00 AM and 11:30 AM showed no March 2023 activity calendar posted in any of the resident accessible areas within the assisted living premises. Further observation showed no posted activity calendar on the wall next to the elevator as stated in the Resident Handbook.

During

an interview on 03/13/2023 at 11:30 AM, Staff Z, Activities Director, stated that the facility hired them as the new Activities Director, with their first day in the position on 03/13/2023. Staff Z stated that they were aware there was no activity calendar for March 2023 posted anywhere in the facility. Staff Z stated that they were unable to find the March 2023 activity calendar in the facility's files. Staff Z stated that the Activities Director position was vacant for a period of time. Staff Z stated that due to the vacancy, for the month of March, the facility had not planned any activities for the residents.

During

an interview on 03/13/2023 at 2:00 PM, Staff A, Executive Director, stated that they started as the director of the facility on 03/01/2023. Staff A reported that the facility did not schedule any activities for the residents between 03/01/2023 and 03/12/2023 due to lack of staff available. Staff A reported that the facility did not have an Activities Director, and there were no program assistants to provide and support resident activities.

On

03/13/2023 at 2:00 PM, observation showed an updated March 2023 activity calendar posted in the facility. Review of the updated facility's March 2023 activities calendar showed there were no activities scheduled between 03/01/2023 and 03/13/2023. Further review of the updated March 2023 activities calendar showed that the facility added a daily fitness activity named "B-Fit in Activity Room (AR)" to 9:00 AM. The calendar showed the fitness activity scheduled daily from 03/14/2023 to 3/31/2023.

Observations

on 03/14/2023, 03/15/2023, 03/16/2023, and 03/17/2023 between 9:00 AM – noon, showed there were no fitness activities in the Activity Room. Further observation showed that during the scheduled fitness activity time, several unidentified residents were seated in the activity room and watched television.

During

the Resident Group Meeting on 03/14/2023 at 1:00 PM, 35 residents stated that there were no activities in the facility over the past several months. The residents stated that the only activity in the facility was resident-led bingo and poker once or twice a week. The residents stated that no staff led any activities, and no staff joined or supported the residents during the resident led activities. The residents further stated that they would like the facility to offer physical activities and an exercise area.

During

an interview on 03/14/2023 at 2:20 PM, Resident 9 stated that they were aware some residents organized and played bingo and poker. Resident 9 stated that no staff led and supported the bingo and poker activities.

During

an interview on 03/16/2023 at 1:15 PM, Resident 8 stated that the facility never asked them about what activities they wanted in the facility. Resident 8 said that they were only interested in exercise and

fitness activities. Resident 8 further stated that they were aware some residents played bingo games on their own. Resident 8 stated that they were not interested in bingo. Resident 8 stated that since June 2022, under the new management, the facility provided "no activities and nothing" for them.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit a Washington state name and date of birth background inquiry (BGI) on the first business after the staff started working for 2 of 6 sampled staff (Staff B and Staff C). This failure placed all residents at risk of abuse or neglect from staff with unknown backgrounds.

Findings included...

Review of the facility's documents titled "Personal Care Assistant Job Description", dated April 2020, and "Housekeeper Job Description", dated April 2020, showed that the facility required all employees complete a criminal record clearance prior to presence in the facility. Record review of the facility's undated document titled "Staff Roster" showed that the facility hired Staff B, Caregiver, on 06/01/2022, and Staff C, Housekeeper, on 06/01/2022.

Review of the facility's personnel records showed no documentation Staff B completed an initial BGI on the day Staff B started work in the facility. Further review of the personnel records showed that Staff B completed a BGI on 11/28/2022, 180 days after Staff B's first

day of work.

Review of the facility's personnel records showed no documentation Staff C completed an initial BGI on the day Staff C started work in the facility. Further review of the personnel records showed that Staff C completed a BGI on 12/01/2022, 182 days after Staff C's first day of work.

During an interview on 03/15/2023 at 9:00 AM, Staff A, Executive Director, stated that they were familiar with the Washington state regulations to complete BGI on all staff. Staff A stated that the facility appointed Staff AA, Business Office Manager, to track staff BGI application and results. Staff A stated that the facility did not have an accurate system in place to track the staff BGI applications and results.

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, Renton Assisted Living 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-2480 Tuberculosis Testing Required.

- (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.
- (2) For purposes of WAC 388-78A-2481 through 388-78A-2489, "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement a system to ensure 4 of 6 sampled staff (Staff C, Staff D, Staff E, and Staff F) were screened for tuberculosis. This failure placed all residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's document, titled "Tuberculosis (TB) – Care Staff", dated 08/10/2021, showed that the facility required each newly hired care staff be screened for TB infection

and disease. The document also showed that the facility followed the Washington Administrative Code (WAC) on tuberculosis testing requirements.

Record review of the facility's undated "Staff Roster" showed that the facility hired Staff C, Housekeeper, on 06/01/2022; Staff D, Caregiver, on 01/05/2023; Staff E, Health Services Director, on 02/27/2023; and Staff F, Medication Technician, on 12/05/2022.

Review of the facility's "Housekeeper Schedules" showed that Staff C worked in the facility in March 2023. Review of the facility's "Caregiver Schedules" showed Staff D and Staff F worked in the facility in February 2023 and March 2023.

Observations between 03/13/2023 – 03/20/2023 showed that Staff E were present in the facility. Observation showed Staff E interacted with residents throughout the day.

During an interview on 03/15/2023 at 9:00 AM, Staff A, Executive Director, stated they were aware of the State regulation requirements on TB testing and the facility's TB testing policy. Staff A stated that there was no documentation in the personnel files of the staff members (Staff C, Staff D, Staff E, and Staff F) that showed Staff C, Staff D, Staff E, and Staff F were screened for TB. Staff A reported that prior to Staff E's hire date, the facility did not have a licensed nurse to perform TB screening and testing in-house. Staff A stated that the facility did not follow the TB testing requirements to complete TB testing for their staff.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Renton Assisted Living 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-2610 Infection control.

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to develop and implement a respiratory protection program for 33 of 43 staff (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G, Staff H, Staff K, Staff L, Staff P, Staff Q, Staff R, Staff X, Staff Y, Staff Z, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff HH, Staff II, Staff JJ,

Staff KK, Staff LL, Staff MM, Staff NN, Staff OO, Staff PP, Staff QQ, and Staff RR). Additionally, the facility failed to follow the Department of Health (DOH) guidance on Aerosol Generating Procedures for 2 of 2 sampled residents (Resident28, Resident 29) in alignment with appropriate infection control practices. These failures placed all residents at risk of contracting and spreading a potentially life-threatening disease.

Findings included...

The Centers for Disease Control and Prevention (CDC) developed guidelines for agencywide response to the COVID-19 pandemic. The Washington State Governor's Office, the Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries (L&I), established the current standards of infection control to prevent and control the spread of COVID-19 in the community.

Review of the DOH publication, titled "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings" (<https://doh.wa.gov/sites/default/files/2022-06/420-391-SARS-CoV-2-InfectionPreventionControlHealthcareSettings.pdf?uid=635fe3e51bc64>), dated October 31, 2022, showed specific guidance around respiratory protection program that included medical evaluation and fit testing for respirator use. The documents showed that facilities were required to identify which employees would be exposed to a respiratory hazard and to fit test those employees who could potentially be exposed to a respiratory hazard. Facilities were required to provide initial and annual fit tests, to provide fit-tested respirators to their employees, and to maintain the fit test records. The DOH publication also included specific guidance around Aerosol Generating Procedure (AGP). The document listed Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) [CPAP and BiPAP are machines that provide air at a pressure to prevent the collapse of airway] as AGP.

Review of the facility's document titled "Coronavirus/COVID-19 Preparedness and Response Plan", dated 05/28/2021, showed that the facility followed the CDC and local health department recommendations on RPP. The document showed that the facility required staff members, who wore an N95 respirator, to have a medical evaluation and be fit tested, prior to initial use. Further review of the document showed there was no facility policy or guidance on AGP.

RESPIRATORY PROTECTION PROGRAM

Review of the facility's "Resident Characteristic Roster", dated 02/07/2023, showed that the facility provided care and services to 100 assisted living residents. Review of the facility's "Staff Roster" showed that the facility hired 43 employees to provide care and services to the assisted living residents. The document showed that the facility hired Staff A, Executive Director, on 03/01/2023; Staff B, Caregiver, on 06/01/2022; Staff C, Housekeeper, on 06/01/2022; Staff D, Caregiver, on 01/05/2023; Staff E, Health Services Director, on 02/27/2023; Staff F, Medication Technician, on 12/05/2022; Staff G, Maintenance Supervisor, on 06/01/2022; Staff H, Medication Technician, on 06/01/2023; Staff K, Housekeeper, on 09/06/2022; Staff L, Dietary Aide, on 07/07/2022; Staff P,

Medication Technician, on 06/01/2022; Staff Q, Caregiver, on 06/01/2022; Staff R, Medication Technician, on 06/01/2022; Staff X, Caregiver, on 06/01/2022; Staff Y, Medication Technician, on 11/28/2022; Staff Z, Activities Director, on 06/01/2022; Staff BB, Medication Technician, on 10/13/2022; Staff CC, Medication Technician, on 06/13/2022; Staff DD, Medication Technician, on 06/01/2022; Staff EE, Caregiver, on 12/02/2022; Staff FF, Housekeeper, on 01/09/2023; Staff GG, Dietary Aide, on 07/20/2022; Staff HH, Caregiver, on 11/02/2022; Staff II, Caregiver, on 06/01/2022; Staff JJ, Medication Technician, on 06/01/2022; Staff KK, Medication Technician, on 06/01/2022; Staff LL, Caregiver, on 09/16/2022; Staff MM, Caregiver, on 06/01/2022; Staff NN, Dietary Aide, on 12/16/2022; Staff OO, Caregiver, on 11/04/2022; Staff PP, Resident Care Coordinator, on 06/01/2022; Staff QQ, Caregiver, on 09/16/2022; and Staff RR, Caregiver, on 09/12/2022.

Review of the facility's RPP documentation and staff's personnel files showed that there was no medical evaluation and no fit test records for Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G, Staff H, Staff K, Staff L, Staff P, Staff Q, Staff R, Staff X, Staff Y, Staff Z, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff HH, Staff II, Staff JJ, Staff KK, Staff LL, Staff MM, Staff NN, Staff OO, Staff PP, Staff QQ, and Staff RR.

During an interview on 03/13/2023 at 9:30 AM, Staff A, Executive Director, and Staff E, Health Services Director, stated that they were unfamiliar with the facility's Respiratory Protection Program (RPP). Staff A reported that the facility did not have a designated RPP Program Administrator. During a follow-up interview at 1:15 PM, Staff A reported that the facility had no respiratory protection program in place. Staff A also stated that none of the staff in the community were fit tested.

During an interview on 03/17/2023 at 11:00 AM, Staff A stated that on 03/17/2023, the facility assigned Staff E, Licensed Practical Nurse, Health Services Director, as the RPP Program Administrator. Staff A stated that Staff E, who was a licensed nurse, oversaw the RPP in the facility. Additionally, Staff A stated that the facility's document titled "Coronavirus/COVID-19 Preparedness and Response Plan" was considered as their RPP.

During an interview on 03/20/2022 at 11:00 AM, Staff E stated that they were unfamiliar with the DOH guidance on RPP for long-term care settings. Staff E stated that the facility lacked a system to monitor the COVID-19 transmission for King County. Staff E stated that they were unaware of the current COVID-19 transmission in King County. Staff E also stated that they were unfamiliar with the required COVID-19 precaution measures when the COVID-19 transmission in King County was high. Staff E confirmed that they were unable to find the respirator fit test records for staff. Staff E stated that the facility did not complete respirator fit tests for the staff. Staff E stated that there was no documentation that showed the facility's tracking COVID-19 cases. Staff E also reported that the facility's last COVID-19 outbreak occurred in December 2022. Additionally, Staff E stated that they were unaware where the facility stored the personal protection equipment (PPE) and whether the facility's supply of PPE was adequate.

AEROSOL GENERATING PROCEDURE

Observation on 03/20/2023 at 11:30 AM showed that Resident 28 and Resident 29 resided

in the same apartment. Observation of Resident 28 and Resident 29's apartment showed there was a CPAP and a BiPAP machine in the bedroom, each one placed on a table on each side of the bed. Observation showed that each machine was connected to a mask and tubing. Further observation showed no sign outside the apartment that informed staff and visitors about the use of AGP within the apartment. Observations also showed there was no PPE available at the apartment entrance.

Review of the facility's "Resident Characteristic Roster," dated 03/13/2023, showed that the facility admitted Resident 28 in [REDACTED] 2022. Review of Resident 28's undated "Needs and Service Plan" showed no documentation that Resident 28 used a CPAP machine. Further review of Resident 28's service plan showed no documentation that provided staff instructions for the use of the CPAP, no documentation of Resident 28's scheduled use of the CPAP and no instructions that required staff use PPE during the CPAP procedure.

Review of the facility's "Resident Characteristic Roster," dated 03/13/2023, showed that the facility admitted Resident 29 in [REDACTED] 2022. Review of Resident 29's "Needs and Service Plan", dated 03/08/2023, showed no documentation that Resident 29 used a BiPAP machine. Further review of Resident 29's service plan showed no documentation that provided staff instructions for the use of the BiPAP, no documentation of Resident 29's scheduled use of the BiPAP and no instructions that required staff use PPE during the BiPAP procedure.

During an interview on 03/20/2023 at 11:30 AM, Staff E stated that they were unfamiliar with the DOH guidance on AGP. Staff E further stated that they were unaware of the required AGP precautions.

During an interview on 03/27/2023 at 11:08 AM, Resident 28 stated that they used a CPAP machine independently. Resident 28 stated that they used the CPAP machine at night and sometimes when they took a nap in the daytime. Resident 28 stated that the facility never asked them about their CPAP use.

During an interview on 03/27/2023 at 11:18 AM, Resident 29 stated that they used a BiPAP machine independently. Resident 29 stated that they used the BiPAP machine 4-8 hours at night. Resident 29 stated that the facility never asked them about their BiPAP use.

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, Renton Assisted Living 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-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

- (1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;
- (2) Be provided both orally and in writing in a language that the resident understands;
- (3) Be provided to prospective residents, before they are admitted to the home;
- (4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;
- (5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and
- (6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to disclose the facility's policy on accepting Medicaid payments and maintain the signed disclosure documentation in the residents' records for 9 of 9 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9). This failure placed the residents at risk of being discharged and unable to reside in the facility on State Medicaid assistance, when necessary.

Findings included...

Review of the facility's undated document titled "Disclosure of Services" showed that the facility accepted Medicaid payments for any resident. The document also showed that the facility's Medicaid contracts included Assisted Living Services (ALS), Adult Residential Care Services (ARC), and Enhanced Adult Residential Care Services (EARC).

Review of the facility's document titled "Assisted Living Facility Resident Characteristic Roster", dated 03/13/2023, showed that the facility provided care and services to 100 residents. The document showed that the facility admitted Resident 1 in [REDACTED] 2022, Resident 2 in [REDACTED] 2022, Resident 3 in [REDACTED] 2018, Resident 4 in [REDACTED] 2021, Resident 5 in [REDACTED] 2018, Resident 6 in [REDACTED] 2015, Resident 7 in [REDACTED] 2020, Resident 8 in [REDACTED] 2018, and Resident 9 in [REDACTED] 2021.

Review of the facility's records for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9 showed there was no documentation that the facility provided any of the residents with the facility's policy on accepting Medicaid as a payment source. Further review of the resident records showed no documentation that any of the residents signed the disclosure to confirm their receipt of the Medicaid policy.

During an interview on 03/14/2023 at 3:35 PM, Staff A, Executive Director, stated that they were aware of the State's regulation that required the facility to notify every resident about the facility's policy of accepting Medicaid as a payment source. Staff A stated that she reviewed the residents' files for the documentation. Staff A stated that they did not find the Medicaid disclosure form in any of the files for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9. Staff A reported that the facility changed the management company and operated under the new license in June 2022. Staff A stated that under the new license, the facility did not establish a procedure for the disclosure of the facility's Medicaid policy to the residents; did not initiate a disclosure form separated from the residency agreement for their residents; and did not inform and obtain signature on the disclosure form from their 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, Renton Assisted Living 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-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

- (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
- (2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 6 sampled staff (Staff A, Staff C, Staff D, Staff E, and Staff F) completed a national fingerprint background check prior to provisional hire at the facility. The facility also failed to ensure Staff A, Staff C, and Staff E did not have unsupervised access to residents pending the

results of a national fingerprint background check. These failures placed all the residents at risk of abuse or neglect from staff with unknown backgrounds.

Findings included...

Review of the facility's document titled "Job Description – California Addendum", dated April 2020, showed that the facility's management company required all employees complete a criminal record clearance prior to presence in the facility. The document also showed that all employees prior to working in the facility, were fingerprinted, and signed a criminal record statement under penalty of perjury.

Record review of the facility's undated "Staff Roster" showed that the facility hired Staff A, Executive Director, on 03/01/2023; Staff C, Housekeeper, on 06/01/2022; Staff D, Caregiver, on 01/05/2023; Staff E, Health Services Director, on 02/27/2023; and Staff F, Caregiver, on 12/05/2022. Review of the facility's "Caregiver Schedules" showed that Staff D and Staff F worked in the facility during the evening shifts in February 2023 and March 2023.

Review of the facility's personnel files showed documentation that Staff A, Staff C, Staff D, Staff E, and Staff F completed a Washington state name and date of birth background check with no disqualifying results. Further review of the files showed that the facility maintained the documentation of all staff background check results. Review of staff personnel files showed documentation that Staff A, Staff C, Staff D, Staff E, and Staff F were provided a "Department of Social and Health Services Fingerprint Appointment" form with directions to schedule a fingerprint appointment. The appointment forms were all blank. Additional review of the files showed no documentation that Staff A, Staff C, Staff D, Staff E, and Staff F completed a national fingerprint background check.

Observations between 03/13/2023 – 03/20/2023 showed that Staff A and Staff E were present in the facility. Observation showed Staff A and Staff E interacted with residents throughout the day, with no supervision. Observation on 03/20/2023 at 11:30 AM showed that Staff C provided housekeeping in a resident's room, which allowed unsupervised interactions with the unidentified resident.

During an interview on 03/15/2023 at 9:00 AM, Staff A reported that Staff AA, Business Office Manager, maintained the personnel files and kept track of the facility staffs' background check results. Staff A stated that they searched the personnel files for Staff A, Staff C, Staff D, Staff E, and Staff F. Staff A stated they were unable to find any documentation that showed Staff A, Staff C, Staff D, Staff E, and Staff F completed the national fingerprint check.

During an interview on 03/20/2023 at 9:00 AM, Staff A stated that they completed a national fingerprint check at their previous place of employment. Staff A stated that they

requested a copy of that record from their previous employer. Staff A stated that they were unable to obtain a copy to place in their current employee file. Staff A also stated that the facility did not follow up with Staff C, Staff D, Staff E, and Staff F to schedule the fingerprint appointment. Staff A confirmed that Staff A, Staff C, Staff D, Staff E, and Staff F did not complete the national fingerprint check as required.

During an interview on 03/20/2023 at 11:40 AM, Staff C stated that they did not complete a national fingerprint check after the facility hired them. Staff C stated that last week, the facility provided them with an appointment form which instructed them to schedule a fingerprint appointment. Staff C confirmed that they did not follow up with the appointment for a national fingerprint background check.

During an interview on 03/30/2023 at 11:53 AM, Staff S, Acting Executive Director, stated that the facility hired them as the Acting Executive Director. Staff S stated that they were unaware the facility kept a signed "California Addendum" by staff in the personnel files. Staff S stated that they did not know why the facility required staff sign the California Addendum, when they were hired. Staff S reported that the California Addendum form was inaccurate, and it should not be used in the facility. Staff S reported that the facility followed the Washington Administrative Code regulation requirements on national fingerprint background check. Staff S stated that they were unaware that Staff A, Staff C, Staff D, Staff E, and Staff F did not complete the national fingerprint background check.

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, Renton Assisted Living 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-2100 On-going assessments. The assisted living facility must:

- (1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;
- (2) Complete an assessment specifically focused on a resident's identified problems and related issues:
 - (a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;
 - (b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;
 - (c) 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 complete assessments 15 of 15 sampled residents (Resident 2, Resident 4, Resident 5, Resident 6, and Resident 7, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, and Resident 19). This failure placed all 15 residents at risk of injury or harm from unidentified care needs.

Findings included...

MEDICAL DEVICES ASSESSMENTS

Observation on 03/15/2023 at 9:18 AM in Resident 2's apartment showed a bed with a bed enabler (medical equipment designed to provide persons with stability to get out of bed). The medical device was not secured to the bed and was easily moved with minimal effort. Observation showed the enabler was partially pulled away from the bed which left a 16-inch gap between the mattress and the enabler rail. The unsecured medical device presented a potential for Resident 2 to be trapped or injured when the enabler was used.

Review of Resident 2's records showed there was no documentation that showed Resident 2 was assessed to properly use the medical device. There was no documentation that showed the risks and benefits for the medical device were discussed with Resident 2. The records showed no documentation Resident 2's physician approved and ordered the medical device.

Observation on 03/16/2023 at 1:32 PM of Resident 4's apartment showed Resident 4 lying in a hospital bed with a side bed rail attached at the head of the bed.

Review of Resident 4's records showed there was no documentation that showed Resident 4 was assessed to properly use the medical device. There was no documentation that showed the risks and benefits for the medical device were discussed with Resident 4. The records showed no documentation Resident 4's physician approved and ordered the medical device.

During an interview on 03/16/2023 at 1:32 PM, Resident 4 stated that they used the bed side rails for assistance with mobility while in the bed. Resident 4 stated that they have used the rails for over a year.

During an interview on 03/20/2023 at 11:00 AM, Staff E, Health Services Director, stated that Resident 2 and Resident 4 did not have an assessment to determine their need and ability to safely use the medical devices.

SELF-MEDICATION ADMINISTRATION ASSESSMENT

Review of Resident 7's medical records showed a diagnosis of [REDACTED]. The records showed Resident 7 self-administered two different insulins, one type before each meal and the other type before bedtime. Further review of Resident 7's records showed no documentation the facility completed an assessment to determine Resident 7

was safe and capable of administering their own insulin.

During an interview on 03/14/2023 at 2:53 PM, Resident 7 stated that when the facility obtained new management, the facility no longer used licensed nurses. Resident 7 stated that they did not feel comfortable with the Medication Technicians (Med Techs) administering the insulin. Resident 7 stated that the Med Techs were not supervised by anyone when the facility was without a Health Services Director. Staff 7 stated that for these reason, they administered their own insulin.

During an interview on 03/16/2023 at 9:30 AM, Staff E stated that there was no documentation in Resident 7's records that showed a self-medication assessment was completed. Staff E confirmed that Resident 7 self-administered their own insulin.

SMOKING ASSESSMENTS

Review of an undated facility document titled "Resident Characteristics Roster" identified 12 residents who smoked.

Observation on 03/17/2023 at 1:50 PM, showed a designated area for residents to smoke located in the facility's back parking lot. Additional observation showed a gazebo was provided to shelter the residents who smoked from the rain or sun. Further observation showed two unidentified residents were observed in wheelchairs smoking in the designated area.

Observation on 03/15/2023 at 9:58 AM, showed Resident 5 in their apartment. The apartment floor was covered with clothes, garbage, and tobacco. The apartment smelled strongly of cigarette smoke.

Review of Resident 5's records showed Resident 5 was identified as a smoker. The records showed no documentation that an assessment was completed to determine Resident 5's ability to smoke safely. There was no documentation that showed Resident 5 was informed of the facility's authorized smoking areas.

During an interview on 03/15/2023 at 9:58 AM, Staff E stated that the facility staff suspected Resident 5 smoked in their apartment. Staff E was unaware of any assessment completed for smoking safety with Resident 5.

Review of Resident 6's records showed Resident 6 was identified as a smoker. The records showed no documentation that an assessment was completed to determine Resident 6's ability to smoke safely. There was no documentation that showed Resident 6 was informed of the facility's authorized smoking areas.

Review of facility resident records for Residents 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19 showed these 10 residents were identified as smokers. Review of each resident's records

showed no documentation that an assessment was completed to determine the residents' ability to smoke safely. There was no documentation that showed the residents were informed of the facility's authorized smoking areas.

During an interview on 03/13/2023 at 3:00 PM, Staff A, Executive Director, confirmed that there were no assessments completed for the residents who smoked.

During an interview on 03/16/2023 at 9:30 AM, Staff E stated that were unaware if any assessments were completed for the 12 identified smokers. Staff E stated they were unable to locate any assessments in the residents' records for those residents identified as smokers.

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, Renton Assisted Living 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-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the negotiated services plans for 7 of 7 residents (Resident 1, Resident 2, Resident 4, Resident 6, Resident 7, Resident 8, and Resident 9) were developed, updated, and agreed upon as required. This failure placed Resident 1, Resident 2, Resident 4, Resident 6, Resident 7, Resident 8, and Resident 9 at risk of unmet care needs and a decreased quality of life.

Findings included...

RESIDENT 1

Review of the facility's document titled "Needs and Service Plan" (NSP), dated 03/07/2023, showed that Resident 1's medical diagnosis included [REDACTED] [REDACTED] [REDACTED]. Further review of the NSP showed no guidance for staff about the signs and symptoms of high or low blood sugar to monitor; there was no guidance or established acceptable blood sugar ranges; and no staff instructions about what actions staff take based upon their observations. Resident 1's NSP also showed that Resident 1 independently used a transfer pole at the bedside to aide in bed mobility and stability. The NSP showed no guidance for staff about how staff would assist Resident 1 when need and no requirements about how to maintain the transfer pole for stability. The NSP was last signed by Resident 1 on 03/12/2022. There was no documentation or signature that showed Resident 1 agreed with the NSP in 2023 for the required annual review.

Observation of Resident 1's apartment on 03/16/2023 at 2:40 PM showed a transfer pole beside the top end of the bed. The top of the pole was mounted to the ceiling and the bottom end of the pole was mounted to the floor. Further observation showed Resident 1 lying in bed. Resident 1 used the transfer pole beside their bed to pull up to a sitting position.

During an interview on 03/16/2023 at 2:40 PM, Resident 1 stated that they used the transfer pole for transfers between the bed and the wheelchair. Resident 1 stated that the caregivers assisted them with transfers at times they were unable to self-transfer. Resident 1 stated that the physical therapist recommended the transfer pole. The facility then installed the transfer pole for them. Resident 1 stated that they were unaware the transfer required regular assessment and maintenance.

During an interview on 03/17/2023 at 7:10 AM, Staff PP, Resident Care Coordinator, stated that they were aware Resident 1 used diabetic medications to treat their diabetes. Staff PP stated that they were unaware Resident 1's NSP did not provide guidance for their care staff to monitor for signs and symptoms of high and low blood sugar.

During an interview on 03/20/2023 at 12:30 PM, Staff G, Maintenance Supervisor, stated that the facility installed and maintained the transfer pole for Resident 1. Staff G stated that

they shook the pole to check stability. Staff G stated that the facility did not provide staff any instructions to monitor the stability of the transfer pole.

During an interview on 03/20/2023 at 1:00 PM, Staff E, Health Services Director, stated that they were unable to locate any records that showed Resident 1 was assessed for the safe use of a medical device. Staff E confirmed that Resident 1's NSP did not include staff guidance about the symptoms of high or low blood sugar and how to respond. Staff E also stated that there were no clear instructions for staff about how to assist Resident 1 with the transfer pole and how to monitor the pole for safety.

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 in [REDACTED] 2022. The records showed the facility received a copy of the most recent Department of Health and Social Services (DSHS) annual assessment, dated 12/02/2021, when the facility admitted the resident. There was no documentation that showed the NSP was completed within 30 days of admission based on the current assessment. The records showed that Resident 2's NSP was completed on [REDACTED]/2023, 86 days after Resident 2 moved into the facility.

During an interview on 03/15/2023 at 9:18 AM, Resident 2 they stated they received dialysis three times a week.

Review of Resident 2's NSP showed no documentation that Resident 2 had a dialysis port (an access port used for dialysis treatment, treatment used to clean blood of waste products) in the left arm. The NSP did not document that Resident 2 received dialysis three times per week. The NSP instructed staff to take Resident 2's blood pressure on the right arm, not on the left arm where the port was located. There was no documentation in the NSP that showed Resident 2 was on a renal diet, had impaired vision, received blood thinners, or had a bed side enabler. There were not instructions to staff about assistance Resident 2 needed for dialysis care. The NSP also did not document that Resident 2 had a cat and provided no instructions about who provided care for the cat.

During an interview on 03/20/2023 at 11:00 AM, Staff E stated that they were aware the NSP was incomplete.

RESIDENT 4

Review of the facility's document titled "Washington Resident Assessment", dated 03/13/2023, showed Resident 4 had diagnosis of [REDACTED] and required oxygen. The assessment did not provide any instructions related to the oxygen use, the company that supplied the oxygen tanks and serviced the oxygen concentrator, who was responsible for adjusting the oxygen flow rate, what the oxygen flow rate was supposed to be set at and who switched the oxygen tubing from the concentrator to the portable oxygen tanks. The assessment did not show Resident 4 used a hospital bed with half-length bed rails at the head of the bed. Further review of Resident 4's records showed there was no written NSP for Resident 4 that provided documentation of Resident 4's care needs and instructions to staff about the care needs related to Resident 4's diabetes and oxygen use.

Observation of Resident 4's apartment on 03/16/2023 at 1:32 PM, showed an oxygen concentrator located outside of Resident 4's bedroom door. Resident 4 was lying in their hospital bed with half-length bed rails position at the head of the bed. Resident 4 wore a nasal cannula (oxygen tubing with two prongs inserted in the nose to provide supplemental oxygen) attached to the oxygen concentrator for supplemental oxygen.

During an interview on 03/16/2023 at 1:32 PM, Resident 4 confirmed they received insulin several times per day. Resident 4 stated that the facility Med Techs checked their blood sugar and administered their insulin.

RESIDENT 6

Review of Resident 6's "Personal Service Plan", dated 02/22/2023, showed that the facility completed Resident 6's PSP on 02/22/2023. Further review of the PSP showed that it was not signed by the Resident, Resident representative, facility representative, or case manager. There was no documentation that showed when the last PSP was signed.

RESIDENT 7

Review of Resident 7's records showed a DSHS assessment, dated 08/20/2020, which documented Resident 7 was diagnosed with [REDACTED] and self-administered their insulin. The assessment also documented that Resident 7 had a pacemaker.

Review of Resident 7's records showed Resident 7's NSP was written on 02/22/2023. There was no documentation in the NSP that showed Resident 7 had a pacemaker, diabetes, and self-administered their own insulin, as documented in the DSHS assessment. Further review showed the NSP provided no guidance for staff about the signs and symptoms of high or low blood sugar to monitor, support needed for Resident 7 to self-administer insulin, and no guidance about pacemaker care that may be required.

RESIDENT 8

Review of Resident 8's records showed a completed NSP, dated 03/08/2023. Review of the NSP showed Resident 8 did not sign the plan.

RESIDENT 9

Review of Resident 9's records showed a completed "Personal Service Plan", dated 11/04/2021. Further review showed Resident 5 did not sign the plan.

During an interview on 03/15/2023 at 2:40 PM, Staff E stated the "Personal Care Plans" were the care plans developed by the previous management company. Staff E stated that the "Needs and Services Plans" were the negotiated service agreements developed by the current management company. Staff E stated that they were unaware of the requirement for residents to sign the annual or updated negotiated service agreements.

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, Renton Assisted Living 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-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure 2 of 6 sampled medication carts (Cart A and Cart B, both third floor medication carts) were locked when left unsupervised by staff. This failure placed the residents at risk for harm or illness if the medications were accessed and swallowed.

Findings included...

Review of the facility's undated "Assisted Living Resident Characteristics Roster" showed that 100 residents resided in the Assisted Living section of the facility. The Roster identified 24 of the 100 residents were diagnosed with [REDACTED] or [REDACTED]. All 100 residents ambulated independently or independently used a mobility device, such as a manual wheelchair, electric wheelchair or an electric scooter.

Observation on 03/13/2023 at 11:25 AM, showed the door to the Nurses Station on the third floor was unlocked. The unlocked door provided opportunity for residents to access the room. The room contained to an unlocked refrigerator which stored medications. Observation showed there were no facility staff were present in the room.

Observation on 03/13/2023 at 1:45 PM, showed several residents independently ambulated along the third-floor hallway, to the third-floor medication room to get their medications or ask staff a question. Further observation showed two medication carts in the medication room on the third floor. Each cart contained a drawer for medications and a drawer for narcotics (medication used to treat moderate to severe pain). The narcotics

drawer had an additional lock. The additional lock on the drawer allowed the narcotics to be stored with a double lock. Observation showed the door to the third-floor medication room was open. Further observation showed both medication carts were unlocked. The keys to each cart were inserted in the medication cart locks. The hanging keys included the key to the double locked narcotic drawer. Additional observation showed Staff P, Medication Technician/Aide, closed and locked the medication room door without removing the keys from the medication cart.

Observation on 03/20/2023 at 11:45 AM, showed several Assisted Living residents approach the third-floor medication room or seated outside of the third-floor medication room as they waited to receive their noon medications. Observation showed Staff P, Medication Technician, in the third-floor medication room. Both medication carts were unlocked and the keys to the carts dangled from the open locks. Observation showed Staff P left the medication room to speak with a resident in an apartment adjacent to the medication room. Further observation showed Staff P left the medication room door open and keys still in the cart. Additional observation showed Staff P returned to the medication room then, as they left the room, Staff closed the medication room door. Staff P did not lock carts and did not remove the keys from the medication carts.

During an interview on 03/13/2023 at 2:14 PM, Staff E, Licensed Practical Nurse, Health Services Director, stated that the narcotics stored inside of the medication cart should be secured and double locked. Staff E also stated that the medication cart keys, which included the key to the narcotic box, should not be left inserted in the medication cart lock. Staff E stated that leaving the keys in the cart defeated the purpose of a double locked system and allowed potential access to the narcotics. Staff E stated that keys left in medication carts and unlocked medication carts were not the procedure followed the facility. Staff E also confirmed that all Med Techs had access to the medication rooms on each of the floors.

During an interview on 03/13/2023 at 3:00 PM, Staff A, Executive Director, stated that they were aware that the medication carts were not always properly secured when they "ran into the same situation twice" the first week they were on the job. Staff A stated that they observed the medication room door unlocked and the keys inserted in locks of both unlocked medication carts. Staff A stated that they took the keys and locked them in the medication cart. Staff A stated that the issue was an ongoing problem and was frustrated.

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, Renton Assisted Living 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
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WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 7 of 7 sampled residents (Resident 4, Resident 5, Resident 21, Resident 22, Resident 23, Resident 24, and Resident 27) received medications as prescribed to meet their medical needs. This failure placed Resident 4, Resident 5, Resident 21, Resident 22, Resident 23, Resident 24, and Resident 27 at risk for health complications and decreased quality of life due to medication mismanagement.

Findings included...

Review of the facility's document titled "Clinical Policy & Procedure Manual – Washington Medication Refills", dated 08/21/2021, showed "Medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available". The Procedure showed the Nurse/Med Tech on duty would contact the dispensing pharmacy to obtain a refill at least seven (7) days prior to running out of a medication unless medication was on a cycle refill with the pharmacy. The document showed that, if necessary, the prescribing physician would be contacted for a new order. Further review of the policy and procedure showed that medications are never allowed to run out unless directed to by the physician. The Policy and Procedure further showed that the Wellness Director would be notified if there were any delays in medication delivery or the medication was unavailable.

During an interview on 03/14/2023 at 2:45 PM, Staff E, Health Services Director, Licensed Practical Nurse, Health Care Services Director, stated that nurse delegated Health Care Assistants (HCA) administered medications to all residents living in the facility. Staff E added that the staff used the eMAR (electronic Medication Administration Record) system

to document medication management.

Review of the facility's undated document "Resident Characteristics Roster" showed the facility admitted Resident 4 in [REDACTED] of 2021; Resident 5 in [REDACTED] 2018; Resident 21 in [REDACTED] 2022; Resident 22 in [REDACTED] 2017; Resident 23 in [REDACTED] 2022; Resident 24 in [REDACTED] 2022; and Resident 27 in [REDACTED] 2022.

RESIDENT 4

Review of Resident 4's "Department of Social and Health Services Current Annual Assessment", dated 06/28/2022, showed Resident 4 required medication management assistance. Further review showed Resident 4 was diagnosed with [REDACTED]. Review of Resident 4's facility undated "Washington Resident Assessment" showed Resident 4 required "significant, total" medication assistance.

Review of Resident 4's March 2023 electronic Medication Administration Record (eMAR) showed an order for Oxycodone (pain medication) 5 milligrams (mg) 1.5 tabs for a total of 7.5 mg was to be given every 6 hours, as needed. The eMAR showed Resident 4 requested and received Oxycodone two to four times a day for pain. Further review of Resident 4's March 2023 eMAR showed that Resident 4 received Lispro (short acting insulin) to be given subcutaneously (under the skin [SQ]) based on a sliding scale (insulin dose administered according to blood glucose level test results) to be administered four times a day, before meals and at bedtime. Resident 4's sliding scale order, dated 01/12/2023, showed Lispro was to be administered for a blood sugar result 201-250=5 units; 251-300=7 units; 301-350=9 units.

Review of Resident 4's narcotic record (a log that provided the documented times, days, and number of Oxycodone pills given and the amount of Oxycodone that remained in the prescription), dated 03/03/2023, showed that Resident 4 last received a dose of Oxycodone on 03/13/2023 at 11:39 AM. The narcotic record showed that on 03/13/2023, Resident 4 received the last dose of Oxycodone in the current prescription.

Review of Resident 4's March 2023 eMAR showed that on 03/02/2023 at 7:00 AM, Resident 4's blood sugar test result was 130. The eMAR showed Resident 4 received a dose of insulin. There was no documentation for the number of units given, only the site where of the insulin was injected was documented. On 03/02/2023 at 8:00 PM, Resident 4's blood sugar test result was 113. There was no documentation for the number of units given, only the site where the insulin was injected was documented. On 03/06/2023 at 5:00 PM, Resident 4's blood sugar test result was 128. There was no documentation for the number of units given, only the site where the insulin was injected was documented. On 03/15/2023 at 5:00 PM, the eMAR showed Resident 4 received a dose of insulin. There was no documentation for the number of units given, only the site where the insulin was injected was documented. Based on the sliding scale order, no insulin was required to be administered on these dates as the blood sugar test results were all below 200.

During an interview on 03/06/2023 at 1:32 PM, Resident 4 stated that the facility Med Techs administered their insulin.

During an interview on 03/17/2023 at 11:15 AM, Staff R, Medication Technician, confirmed Resident 4 was an insulin dependent diabetic. Staff R stated that they did

administer Resident 4's insulin. Staff R stated Resident 4 ran out of Oxycodone four days ago. Staff R stated that the doctor did not respond to any requests for a refill.

During an interview on 03/17/2023 at 11:25 AM, Resident 4 stated that they had not received any Oxycodone for several days. Resident 4 stated they had a history of polio which made it hard for them to walk. Resident 4 stated they were in pain. Resident 4 stated that they were informed by the Med Techs that Resident 4 was out of Oxycodone and the doctor did not respond to any requests for a refill. During a follow-up interview on 03/20/2023 at 10:30 AM, Resident 4 stated that their still legs hurt, and they had muscle pain. Resident 4 stated that they started to self-administer their own pain medication (Tylenol) over the weekend. Resident 4 stated that they felt irritable due to the pain.

During an interview on 03/17/2023 at 1:30 PM, Staff E, Licensed Nurse, and Staff PP, Resident Care Coordinator, stated that they were unaware that Resident 4 was out of Oxycodone. Staff E and Staff PP both stated that the Med Techs did not inform them that Resident 4 was out of pain medication. Staff E stated that they would follow up with Resident 4's physician for the Oxycodone refill. During an interview on 03/20/2023 at 11:00 AM, Staff E stated that there was no follow-up on Resident 4's Oxycodone. Staff E stated that it had been a week since Resident 4's last dose of Oxycodone. Staff E stated they were unaware Resident 4 had medicated themselves with Tylenol to manage their pain.

RESIDENT 5

Review of Residents 5's Home Community and Services (HCS) Assessment, dated 08/25/2022, showed that Resident 5's diagnoses included [REDACTED] and [REDACTED]. The HCS assessment showed that the facility provided medication assistance.

Review of Resident 5's March 2023 eMAR showed an order for subcutaneous (under the skin) (SQ) insulin injections based on a sliding scale (insulin dose administered according to blood glucose level result) order. The order showed Resident 5 received a base dose of Humalog (fast acting insulin) SQ, 10 units before dinner and an additional dose based on the physician established sliding scale. Resident 5's sliding scale was written for additional units to be added to the base dose when blood sugar test results were 200-249=2 units; 250-299=3 units; 300-349=4 units; 350-400 =5 units; 401-500=6 units.

Review of Resident 5's March 2023 eMAR showed Resident 5's blood glucose reading on 03/16/2023 at 4:59 PM was 228. Review of the eMAR showed that a non-delegated HCA signed the eMAR for the administration of 10 units of Humalog insulin. Per the physician's order, based on the blood glucose level of 228, Resident 5 needed an additional two units. During an interview on 3/17/2022 at 12:22 PM, Staff E confirmed that Resident 5 used an insulin sliding scale to determine the proper dosage to be administered. Staff E stated that they found no other documentation that Resident 5 received a wrong dose of insulin. Staff E stated that they were unaware of medication error on 03/16/2023.

RESIDENT 21

Review of Resident 21's March 2023 eMAR showed an order for Icy Hot 7.5% (pain relief patch applied on the skin), one patch applied topically every day, left on for 12 hours, then removed for 12 hours. The March 2023 eMAR "exception" page showed between 03/01/2023 and 03/22/2023, Resident 21 did not receive the Icy Hot patch. Further review of the March 2023 eMAR showed staff documented several entries that stated the Icy Hot patch was "not covered", "not on hand", "not covered medication", and four entries that the "resident refused".

RESIDENT 22

Review of the facility's undated document "Resident Characteristics Roster" showed Resident 22 was diagnosed with [REDACTED].

Review of Resident 22's February 2023 eMAR showed an order for Humalog (fast acting insulin), 12 units to be injected subcutaneously, three times daily with meals. The order showed the dosage was adjusted to the sliding scale, based on blood sugar test results. The order showed Resident 22 was allowed up to 63 units of insulin per day. The order showed the sliding scale as: blood sugar of 100-200= 12 units, 201-250=14 units, 251-300= 16 units, 301-350=18, 351-400=20 units, 401-1000=21 units. The order documented that the primary care provider was to be notified when blood sugar was less than 70 or more than 400. Further review of the February 2023 eMAR showed that on 02/03/2023 at noon, Resident 22's blood glucose was 289. Resident 22 received 18 units of insulin, two units more than written in the sliding scale order. On 02/11/2023 at noon, the eMAR showed Resident 22's blood glucose was 209. Resident 22 received 12 units of insulin, two less than written in the sliding scale order.

RESIDENT 23

Review of Resident 23's March 2023 eMAR showed an order dated 03/16/2023 for cephalexin (antibiotic) 500 milligrams (mg), one capsule to be given three times a day for seven days. The March 2023 eMAR showed resident 23 received the first dose on 03/16/2023 at 5:00 PM. Further review showed Resident 23 received three doses each day on 03/17/2023, 03/18/2023, 03/19/2023, 03/20/2023, 03/21/2023. On 03/22/2023, Resident 23 received only one dose at 8:00 AM. Resident 23 only received 17 of the 21 prescribed doses of the antibiotic. The March 2023 eMAR documentation showed that Resident 23 missed four doses of the antibiotic.

RESIDENT 24

Review of Resident 24's March 2023 eMAR showed an order for Famotidine (medication used to treat heartburn and indigestion), one 20 mg tablet by mouth at bedtime. The March 2023 eMAR "exception" page showed between 03/02/2023 and 03/11/2023, Resident 24 did not receive the Famotidine. Further review of the March 2023 eMAR showed staff documented several entries that stated the Famotidine was "not on hand", "refill needed", "waiting for refill", and "needs refill". The eMAR also showed an order for Levetiracetam (medication to treat epilepsy, a type of seizure), one 500 mg tablet to be given by mouth, twice a day. Further review of the eMAR showed that between 03/19/2023 and 03/21/2023, staff documentation stated that the Levetiracetam was not available or was "waiting for a refill".

RESIDENT 27

Review of Resident 27's March 2023 eMAR showed an order for Aspercreme with lidocaine, 4% patch to be applied topically to the back of the neck every day for pain. The order showed the patch was applied for 12 hours and then removed. Review of the March 2023 eMAR showed the Aspercreme pain patch was not applied from 03/15/2023 through 03/17/2023. Further review of the eMAR "exception" page showed staff documented "Waiting for refill". On 03/18/2023, staff documented "pharmacy bill not paid" as reason medication was unavailable. The March 2023 eMAR showed an order for Metamucil (stool softener), one cap to be given every day for constipation. Review of the March 2023 eMAR showed Resident 27 did not receive the Metamucil between 03/18/2023 and 03/20/2023. Further review of the March 2023 eMAR "exception" page showed staff documented the "medication requires refill authorization from Primary Care Provider and has been requested by pharmacy/community".

During an interview on 03/16/2023 at 9:50 AM, Resident 27 stated, "my neck hurts, I am having pain". Resident 27 stated the staff had not applied their pain patch for two days.

During an interview on 03/16/2023 at 11:13 AM, Staff R stated that they applied the Aspercreme patches between Resident 27's shoulder blades. Staff R stated that the pharmacy bill for the Aspercreme needed to be paid for the order to be filled. Staff R stated they were waiting for the pharmacy to refill the order.

During an interview on 03/17/2023 at 1:30 PM, Staff E stated that they were unaware that Resident 27's pain patch was unavailable.

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, Renton Assisted Living 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-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to obtain and verify physician orders for 4 of 4 sampled residents (Resident 3, Resident 4, Resident 6, and Resident 25). This failure placed the residents at risk for compromised health.

Findings included...

Review of the facility's document titled "Medication Policies", dated 08/10/2021, defined a medication error when staff did not correctly process a physician's order. The policy showed that the staff would follow a consistent workflow to ensure medication orders and electronic Medication Administration Record (eMAR) were up to date and medications were received in a timely manner.

Review of the facility's undated document titled "Assisted Living Resident Characteristics Roster" showed that the facility admitted Resident 3 in [REDACTED] 2016 with multiple diagnoses which included [REDACTED]. The facility admitted Resident 4 in [REDACTED] 2021 with diagnosis of [REDACTED]. The facility admitted Resident 6 in [REDACTED] 2015 with diagnosis of [REDACTED]. The facility admitted Resident 24 in [REDACTED] 2022 with diagnosis of [REDACTED]. The facility admitted Resident 25 in [REDACTED] 2022 with diagnosis of [REDACTED].

RESIDENT 3

Review of Resident's 3 Personal Service Plan (PSP), dated 4/08/2022, showed that the facility assisted Resident 3 with medication administration, which included coordination of medications between health care providers and pharmacy. Further review of Resident 3's PSP showed a history of dermatitis (a condition marked with skin irritation, itch, and rash) and redness under skin folds. The PSP also showed that staff were responsible to observe and report to nurses any skin redness or open areas.

Review of Resident 3's December 2022, and January 2023, February 2023 and March 2023 eMAR, showed a physician's order, dated 10/12/2022, for Clotrimazole 1% cream (topical medication to treat itch and fungal skin infections). The order directed that the medication be applied to rash under the breasts and groin creases two times daily for 14 days. Further review of the eMAR showed a follow-up order, dated 11/15/2022, that requested the facility fax the physician a copy of the eMAR weekly for four weeks. The order also requested an update on Resident 3's condition that showed how well the skin treatment with the Clotrimazole worked. Further review of Resident 3's records showed there was no documentation the facility followed-up with Resident 3's physician.

During an interview on 3/15/2023 at 2:40 PM, Staff E, Health Services Director and Staff R, Medication Technician, stated that they were not aware that Resident 3's skin treatment was only for 14 days. Staff E confirmed that they did not complete a skin assessment. Staff E also stated that they did not fax the eMAR and skin update to the physician as directed in the physician order.

RESIDENT 4

Observation on 03/16/2023 at 1:32 PM, showed Resident 4 lying in a hospital bed with a nasal cannula (oxygen tubing with two prongs inserted in the nose to provide supplemental oxygen) attached to the oxygen concentrator. Further observation showed the air flow regulator was set at 4 liters per minute. Observation at 3:10 PM, showed Resident 4 used a walker and portable oxygen tanks while at the resident mailboxes.

Review of Resident 4's medical records contained an order titled "Medication Changes", dated 12/13/2023, which showed the oxygen flow rate was not to exceed 4 liters of oxygen per minute. The order did not show if Resident 4 was to use an oxygen mask or nasal canula. The order did not show a specific flow rate to set at the regulator. The order did not show if Resident 4's oxygen saturation should be monitored, and the order did not provide any parameters for Resident 4's oxygen saturation level to show when the rate should be adjusted. Review of Resident 4's March 2023 electronic Medication Administration Record (eMAR) did not show any orders for oxygen. Further review of the March 2023 eMAR provided no documentation about who monitored and managed Resident 4's oxygen.

During an interview on 03/16/2023 at 1:32 PM, Resident 4 stated that they used oxygen continuously. Resident 4 stated that they switched over to the portable tanks when they moved about the facility.

During an interview on 03/20/2023 at 11:00 AM, Staff E, Licensed Practical Nurse, Health Services Director, confirmed that the facility did not obtain a specific oxygen order which provided instructions about Resident 4's oxygen use.

RESIDENT 6

Review of Resident 6's "Current Annual assessment", dated 10/31/2022, showed Resident 6 received oxygen at 2 liters per minute via a nasal cannula for shortness of breath.

Review of Resident 6's medical records contained an Emergency Department summary visit dated 01/17/2022. The summary showed Resident 6 was evaluated for "acute hypoxic respiratory failure due to acute exacerbation of COPD with wheezing and shortness of breath" (an abnormally low level of oxygen in the blood). The summary visit showed that Resident received oxygen "at home" intermittently.

Observation on 03/14/2023 at 11:18 AM, showed an oxygen concentrator in Resident 6's apartment, next to their bed. Further observation showed no tubing or humidifier attached to the oxygen concentrator.

During an interview on 03/14/2023 at 11:18 AM, Resident 6 stated that they used oxygen at night and as needed. Resident 6 stated that for approximately the last two months, they were unable to use their oxygen because there was no oxygen tubing available.

During an interview on 03/17/2023 at 12:30 PM, Staff PP, Resident Care Coordinator, stated that they did not believe Resident 6 currently used oxygen. Staff PP stated that they looked through Resident 6's old records and found a handwritten paper, dated 2017, inserted in a page protector. The handwritten paper showed the name of the oxygen company who previously provided Resident 6 oxygen supplies in the past. Staff PP stated that they were unable to locate any current oxygen order for Resident 6.

RESIDENT 24

Review of Resident 24's eMAR dated March 2023 showed an order for Insulin Lispro (fast acting insulin) to be administered Subcutaneously [under the skin (SQ)] based on a sliding scale (Number of insulin units administered according to blood glucose level result in accordance with the sliding scale. The order showed that Resident 24's blood sugar was to be rechecked after two hours and if Resident 24's blood sugar was greater than 400 another round of sliding scale insulin was to be administered. The order further showed that Resident 24's blood sugar was to be rechecked two hours after the second round of sliding scale insulin was given and if Resident 24's blood sugar was still greater than 400 the Primary Care Provider was to be notified.

Review of Resident 24's eMAR for February 2023 and March 2023, showed no documentation that Resident 24's blood sugar was checked two hours after the initial sliding scale insulin was administered.

During an interview on 04/03/2023 at 10:36 AM, Staff PP, stated that Resident 24 checked their own blood sugar levels and notified the Med Techs or Licensed nurse of the results. Staff PP stated that Resident 24 was vision impaired and required the Med Techs to dial the insulin pen to the correct number of units of insulin based on Resident 24 blood sugar results and in accordance to the physician's order. Staff PP stated the Med Techs handed the insulin pen to Resident 24 who then injected themselves. Staff PP stated that Resident 24 insisted on management of their insulin and blood sugar levels. Staff PP stated that Resident 24 refused to allow the Med Techs to check their blood sugar levels. Staff PP stated confirmation that the facility should have notified Resident 24's doctor and asked for clarification and further instruction.

RESIDENT 25

Observation on 03/15/2023 at 7:30 AM, showed Staff CC, Medication Technician (Med Tech), checked Resident 25's blood glucose (BG) prior to insulin administration. Further observation showed Staff CC document the BG results in a separate note page of the eMAR, not directly on the eMAR.

Review of Resident 25's March 2023 eMAR showed no orders for Resident 25's blood glucose to be checked before insulin was administered.

During an interview on 03/15/2023 at 7:30 AM, Staff CC confirmed there was no order to check Resident 25's blood glucose. Staff CC stated that Resident 25 had a history of low BG level. Staff CC stated that due to the history of low blood sugars, Staff CC checked Resident 25's BG to confirm it was not low. Staff CC stated that when Resident 25's BG level was low, they gave Resident 25 some juice, then rechecked the blood sugar before they administered any insulin.

During an interview on 03/16/2023 at 3:41 PM, Collateral Contact 2 (CC2), facility contracted Registered Nurse Delegator, stated that staff were delegated to administer insulin for Resident 25. CC2 stated that there was no physician's order for blood glucose

checks. CC2 stated that without the physician's order, no staff were allowed to be delegated to conduct blood glucose checks for Resident 25.

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, Renton Assisted Living 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:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(c) Initial and on-going assessments of the nursing needs of each resident;

(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:

(a) Chapter 18.79 RCW, Nursing care;

(b) Chapter 18.88A RCW, Nursing assistants;

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

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

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to monitor nurse delegation services for 19 of 19 sampled residents (Resident 4, Resident 10, Resident 11, Resident 22, Resident 23, Resident 24, Resident 25, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, and Resident 40). The facility also failed to implement nurse delegation services for 1 of 1 residents (Resident 4) after admission. This failure placed all

20 residents at risk of harm and compromised health from potential medication errors from undelegated staff.

Findings included...

Nurse Delegation Monitoring

Review of the facility's Registered Nurse Delegation binder on 03/20/2023, showed several Department of Social and Health Services (DSHS) "Nurse Delegation: Nursing Visit" forms for Resident 10, Resident 11, Resident 22, Resident 23, Resident 24, Resident 25, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, and Resident 40. Review of the "Nurse Delegation: Nursing Visit" forms showed the last Registered Nurse Delegator visit was on 12/12/2022. The next visit was due on or before 03/12/2023.

Additional review of the facility's Nurse Delegation binder showed that the nurse delegation nursing visit forms for Resident 10, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, and Resident 40 were eight days past due. The nurse delegation visit forms for Resident 22 and Resident 25 were updated on 03/15/2023, during the licensing inspection. Further review of the binder showed Resident 11, Resident 23, Resident 24, and Resident 25 received nurse delegation for assistance with the administration of insulin. Review of these nurse delegation forms showed no documentation or other forms of verification by the facility contracted RND (Collateral Contact 2, CC 2), that showed the staff delegated to administer insulin were supervised, and their performance evaluated weekly for the first four weeks after the initial delegation, as required per WAC 246-840-930.

Review of Washington Administrative Code 388-78A-2020 Definitions showed that the definition of documentation as "document means to record, with signature, title, date, and time: information about medication administration, medication assistance or nursing care procedure, and processes that are required by law, rule, or policy".

During an interview on 03/16/2023 at 3:41 PM, CC 2 stated that they did weekly visits for the first four weeks for staff who were delegated for the first time to administer insulin for a particular resident. CC 2 stated that they did not document the weekly evaluation and performance reviews and did not have any other type of verification to show the evaluations and reviews occurred.

RESIDENT 4

Review of the facility's undated document titled "Assisted Living Resident Characteristics Roster" showed that the facility admitted Resident 4 in [REDACTED] of 2021. Review of Resident 4's care records showed Resident 4 was diagnosed with [REDACTED].

Review of Resident 4's March 2023 electronic Medication Administration Record (eMAR) showed that Resident 4 received Lantus Solostar insulin (long-acting insulin) twice a day.

Resident 4 also received Lispro (short acting insulin), administered subcutaneously (under the skin [SQ]) based on a sliding scale (insulin dose administered according to blood glucose level result) order. Resident 4 received the Lispro four times a day, before meals and at bedtime.

Review of Resident 4's nursing visit document showed that Medication Technicians (Med Techs) were delegated to administer topical and inhaled medications and check Resident 4's blood sugar levels. Review of the facility's copy of a second DSHS "Nurse Delegation: Instructions for Nursing Task" form, dated 01/08/2023, showed that Med Techs were delegated to administer topical medications as ordered, administer inhaled medications as ordered, and check Resident 4's blood sugar levels as ordered. Further review of Resident 4's records showed there was no documentation to show the facility Med Techs were delegated to administer insulin based on the insulin sliding scale order.

Observation on 03/17/2023 at 11:15 AM, showed Staff R, Medication Technician, check Resident 4's blood sugar. The blood sugar result showed 109. Based on Resident 4's sliding scale order, Staff R did not administer insulin. During an interview at this time, Staff R confirmed Resident 4 was an insulin dependent diabetic. Staff R stated that they administered insulin to Resident 4 when required based, on Resident 4's blood sugar test results.

During an interview on 03/15/2023 at 12:00 PM, Staff T, Licensed Practical Nurse, Director of Corporate Compliance, stated that the facility contracted with an outside Registered Nurse Delegator, Collateral Contact 2 (CC2). Staff T stated that CC2 provided nurse delegation services for the facility residents, which included residents whose care was funded by the Department or the Health Care Authority. During a follow-up interview on 03/15/2023 at 2:00 PM, Staff T stated that they spoke with the facility's contracted Registered Nurse Delegator (RND) and the RND was aware the nurse delegation nursing visit forms needed to be reviewed and update.

During an interview on 03/16/2023 at 1:32 PM, Resident 4 confirmed they received insulin. Resident 4 stated that the facility Med Techs checked their blood sugar and administered their insulin.

During an interview on 03/16/2023 at 3:41 PM, Collateral Contact (CC2), facility contracted Registered Nurse Delegator, stated that "I know I am overdue for a nurse delegation visit". CC2 stated that the facility did not inform them that Resident 4 was an insulin dependent diabetic and required insulin to be administered by the Med Techs. CC2 stated that the facility Med Techs were not delegated to administer routine and sliding scale insulin for Resident 4.

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, Renton Assisted Living 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-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.

(8) Medical and nursing services provided by the assisted living facility for a resident, including:

(a) A record of providing medication assistance and medication administration, which contains:

(iii) The signature or initials of the person providing any medication assistance or administration; and

(b) A record of any nursing treatments, including the signature or initials of the person providing them.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to accurately document in the medication administration record the medication assistance and administration provided to 9 of 9 sampled residents (Resident 1, Resident 2, Resident 4, Resident 6, Resident 8, Resident 11, Resident 20, Resident 22, and Resident 24). This failure placed Resident 1, Resident 2, Resident 4, Resident 6, Resident 8, Resident 11, Resident 20, Resident 22, and Resident 24 at risk of increased health issues from improper medication assistance and potential medication errors.

Findings included...

Review of the facility's document titled "Medication Services", dated 08/10/2021, showed the facility staff were responsible to follow the medication services procedure to ensure "all medications that staff members handle, store, and assist with will be documented on the Medication Assistance Record (MAR) and in accordance with state regulations".

Review of the facility's undated document titled "Assisted Living Resident Characteristics Roster" showed the facility admitted Resident 1 in [REDACTED] 2019; Resident 2 in [REDACTED]; Resident 4 in [REDACTED] 2021; Resident 6 in [REDACTED] 2015; Resident 8 in [REDACTED] 2018; Resident 11 in [REDACTED] 2022; Resident 20 in [REDACTED] 2002; Resident 22 in [REDACTED] 2017; and Resident 24 in [REDACTED] 2022.

RESIDENT 1

Review of Resident 1's medication records showed a physician's order, dated 10/12/2022, for Tremfya (medication used to skin to treat psoriasis, a skin disease with red, itchy, scaly patches). The order stated inject one milliliter every eight weeks. Further review of the December 2022, January 2023, February 2023, and March 2023 electronic medication administration records (eMAR) showed that between 12/01/2022 and 03/13/2023, the facility did not administer the Tremfya injection. The December 2022 showed documentation entered by Staff CC, Medication Technician, that documented the medication was not administered as Staff CC was not allowed to administer the injection. Further documentation showed Staff CC notified Staff PP, Resident Care Coordinator, that the injection was not given. Review of the February 2023 eMAR showed that on 02/01/2023, Staff CC, documented the Tremfya injection was not given, and administration of the Tremfya injection was "out of scope of practice" for Medication Technicians. There was no documentation in any of Resident 1's eMAR that showed Medication Technicians were not allowed to administer the injection, a nurse delegated task. Further review of all eMARs showed no documentation that a licensed nurse followed up with Resident 1 to administer the injection.

During an interview on 03/16/2023 at 2:40 PM, Resident 1 stated that the facility did not administer the Tremfya injection. Resident 1 stated that they received the injection at the out-patient clinic every 2 months.

During an interview on 03/17/2023 at 7:15 AM, Staff PP reported that the facility did not administer Resident 1's Tremfya injection. Staff PP stated that the facility received an updated physician order in March 2022 that changed the administration of the medication to the out-patient clinic every two months. Staff PP stated that they were unaware Resident 1's eMAR was not updated with the updated physician's order.

RESIDENT 2

Review of Resident 2's medication records showed an order for Oxycodone (a narcotic addictive opioid pain reliever), 10 milligram (mg), one tablet by mouth every eight hours, as needed. Review of the March 2023 eMAR showed that Resident 2 received the Oxycodone every day between 03/01/2023 and 03/13/2023. Further review of the eMAR showed that on 03/01/2023, 03/02/2023, 03/03/2023, 03/07/2023, 03/08/2023, 03/09/2023, and 03/10/2023, there were no staff initials to indicate who provided the medication to Resident 2, as required. The eMAR only showed a number and a letter, 2X, that was used to indicate how many times the medication was given to Resident 2.

RESIDENT 4: Pain medication and insulin

Review of Resident 4's medication records showed an order for Oxycodone 5 mg tab, 1.5 tablet (7.5 milligrams) to be given by mouth every six hours as needed. Review of the March 2023 eMAR showed that Oxycodone was given several times a day between 03/01/2023 and 03/13/2023. Further review of the eMAR showed that there were no staff initials to indicate who provided the medication to Resident 4, as required. The eMAR only showed numbers and letters (2X, 3X, and 4X) that were used to indicate how many times the medication was given to Resident 4.

Review of Resident 4's medication records showed an order, dated 01/12/2023, for Lispro insulin (short acting), administered subcutaneously [under the skin (SQ)], based on a sliding scale (Insulin dose administered according to blood glucose level test results). The order showed the insulin was administered four times a day, before meals and at bedtime. The March 2023 eMAR showed a box for each day of the month for staff to document the number of units given. The eMAR showed that Resident 4 received insulin on eight different days, 03/03/2023, 03/04/2023, 03/05/2023, 03/06/2023, 03/07/2023, and 03/08/2023. Review of the March 2023 eMAR showed no documentation of how many units of insulin were administered on each of these days.

RESIDENT 6

Review of Resident 6's eMAR dated March 2023 showed an order dated 11/02/2022 for double antibiotic ointment to be applied to "affected areas topically every day". Review of eMARs dated December 2022, January 2023, and February 2023, showed that the antibiotic ointment was applied every day as ordered. The March 2023 eMAR showed that it was signed as given every day from 03/01/2023 through 03/13/2023.

During an interview on 03/17/2023 at 11:00 AM, Resident 6 stated that a double antibiotic ointment was used to treat a rash on their buttocks. Resident 6 stated that the rash cleared up "years ago" and the double antibiotic ointment was no longer applied. Resident 6 stated that the Med Techs (Medication Technicians, non-licensed staff who dispense and administer medications) had not provided the antibiotic ointment for months.

During an interview on 03/17/2023 at 11:10 AM, Staff DD, Med Tech, confirmed that they signed the eMAR to show they applied the double antibiotic ointment to Resident 6's affected area. Staff DD stated they did not know where to apply the double antibiotic ointment. Staff DD admitted that they did not physically apply the double antibiotic ointment to Resident 6. Staff DD stated that they put the ointment in a plastic cup, handed the cup to Resident 6 who applied the ointment themselves. Staff DD admitted they signed the eMAR without actually administering the double antibiotic ointment.

RESIDENT 8: Insulin

Review of Resident 8's medication records showed an order, dated 10/01/2022, for Lantus insulin (long-acting insulin), 54 units to be given at 4:00 PM daily. Review of the December 2022, January 2023, February 2023, and March 2023 eMARs showed that between 12/01/2022 and 03/13/2023, the injection site was not documented which allowed for the same site to be used without rotation.

During an interview on 03/15/2023 at 2:30 PM, Staff PP, Resident Care Coordinator, stated that the facility relied on the pharmacy to enter the prescription orders into the Quick eMAR system for all the residents, which included boxes on the eMAR for documentation of the injection site. Staff PP stated that they were aware the insulin prescription orders did not provide boxes for staff to document the injection site. Staff PP stated that only the facility's licensed nurses were authorized to add the boxes when omitted by the pharmacy. Staff PP stated that they did not follow up with the corporate nurse for additional assistance when facility's nurse was unavailable.

RESIDENT 11

Review of Resident 11's medication records showed an order, dated 02/09/2023, for Novolog insulin (rapid acting insulin) to be given three times a day, per the physician ordered sliding scale. Review of the March 2023 eMAR showed that from 03/01/2023 through 03/13/2023, Resident 11 received insulin 46 times. Further review of the March 2023 eMAR showed the number of units given was not documented 33 times.

RESIDENT 20

Review of Resident 20 March 2023 eMAR showed an order, dated 10/28/2022, for Basaglar insulin (long-acting insulin), 21 units to be given nightly. The March 2023 eMAR showed a box for each day of the month where the injection site was to be documented. Review of the eMAR showed that between March 01, 2023, through March 20, 2023, the injection site was not documented which allowed for the same site to be used without rotation.

Review of Resident 20 eMAR dated February 2023 showed there were no injection sites documented for the Basaglar insulin to ensure the same site was not used repeatedly.

RESIDENT 22

Review of Resident 22 March 2023 eMAR showed an order for Humalog (fast acting insulin) "inject 12 units subcutaneously three times daily with meals, adjust based on blood sugar and sliding scale up to 63 units daily". Review of the March 2023 eMAR showed a sliding scale order for Humalog: "inject subcutaneously [under the skin] 3 times daily before meals per sliding scale; hold if 99 or less, 100-200=12 units, 201-250=14 units, 251-300=16 units, 301-350=18 units, 351-400=20 units, 401-1000=21 units. Notify PCP if less than 70 or more than 400. Not to exceed 63 units/day".

Review of Resident 22 eMAR dated February 2023 showed that on 03/01/2023, 03/03/2023, 03/04/2023, 03/08/2023, 03/10/2023, 03/14/2023, 03/15/2023, and 03/25/2023 the units of insulin administered were not documented.

RESIDENT 24

Review of Resident 24's medication records showed an order for Lantus Solostar insulin (long-acting insulin) to be given subcutaneously every morning. The medication records also showed an order for Lispro to be given four times a day per sliding scale based on Resident 24's blood glucose readings.

Review of Resident 24's February 2023 and March 2023 eMARs showed boxes to document the amount of insulin administered. Review of Resident 24 February 2023 eMAR showed the number of units of Lantus Solostar insulin was not documented. Further review of the March 2023 eMAR showed that from 03/01/2023 through 03/16/2023, insulin was administered 42 times. The March 2023 eMAR showed insulin the number of units administered were not documented.

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, Renton Assisted Living 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-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

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

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 4

sampled staff (Staff B, Staff C, Staff D, and Staff F) completed facility orientation as required. These failures placed all the residents at risk of abuse, neglect, and receiving care and services from staff without the required qualifications and training.

Findings included...

Record review of the facility's undated "Staff Roster" showed that the facility hired Staff B, Caregiver, on 05/25/2022; Staff C, Housekeeper, on 06/01/2022; Staff D, Caregiver, on 01/05/2023; and Staff F, Caregiver, on 12/05/2022.

Review the facility's undated document titled "New Employee Orientation" showed that new employee orientation included training on the care setting, resident care, safety, communication skills, infection control, and resident rights. Further review of the document showed that the facility required all new employee orientation be completed and signed and dated by the employee and their manager.

Review of the facility's undated document titled "Caregiver Orientation Skills Checklist" showed that the caregiver orientation included additional training on health service policy and procedures, infection control, and incident management. Further review of the document showed that the facility required all new caregivers be oriented to skills, show competency, and be signed and dated by the employee, their preceptor (trainer), and the Health Services Director.

Review of the facility's personnel files showed that the facility maintained the orientation documentation for all staff. Further review of the personnel files for Staff B, Staff C, Staff D, and Staff F showed no documentation that indicated the staff completed the "New Employee Orientation". Additionally, the personnel files for Staff B, Staff D, and Staff F showed no documentation that indicated the care staff completed the "Caregiver Orientation".

During an interview on 03/15/2023 at 9:00 AM, Staff A, Executive Director, stated that they were aware the facility provided a facility orientation checklist for all new employees and an additional orientation checklist for new caregivers. Staff A further stated that they were unaware Staff B, Staff C, Staff D, and Staff F failed to complete the required facility training when hired.

During an interview on 03/20/2023 at 11:40 AM, Staff C stated that they did not receive facility orientation. Staff C stated that they were unfamiliar with the training for new employees.

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, Renton Assisted Living 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-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation, record review, and interview. The facility failed to ensure it provided a well-maintained environment for residents. This failure placed the residents at risk of a diminished quality of life.

Findings included...

Record review of the facility's undated document titled, "Program Overview" showed, "The coordination of the department's efforts in maintaining resident living units, common areas, and office space is most important in providing maximum resident satisfaction and a safe living environment."

Hallways

During an environmental tour, on 03/13/2023 from 10:58 AM – 12:30 PM, observation showed the facility had three floors with each floor connected by three hallways. The common hallways showed doors and door jams of the medication room, common restrooms, and resident apartments had peeling and scraped paint revealing previous paint shades and colors. All of the wooden handrails in each of the hallways had a worn stain and lacquer finish. The wooden door to the center staircase from the second to the main floor had a 1.5-inch by 12-inch tapered gouge on the bottom of the door. Ceiling tiles were water-stained and cracked with wires poking through holes along the hallways throughout the facility. The wallpaper in (location) had seams pulled loose. The first-floor center hallway showed a wheelchair and hand truck/dolly next to the elevator. The first-floor hallway smelled of cigarette smoke.

Observations, on 3/13/2023 at 11:00 AM, 03/16/2023 at 10:00 AM and 03/17/2023 at 1:00 PM, showed the smell of cigarette smoke in the third-floor hallway. Further observation on 03/15/2023 at 9:58 AM, showed the smell of cigarette smoke on the third floor at the intersection of all three hallways and the TV/Activity Room. The smell of cigarette smoke at that time, smelled the strongest near an apartment at the end of the hall. Observation on 03/15/2023 at 9:00 AM, showed the smell of cannabis smoke in the second-floor hallway.

During an interview, on 03/14/2023 from 10:58 AM , Staff G, Maintenance Supervisor, acknowledged that doors needed to be painted and ceiling tiles needed to be replaced. Staff G was unable to state what caused the stains on the ceiling tiles in the hallways. Staff G stated that the wires sticking out of the hallway ceilings were unused internet wiring and needed to be pushed back in. Staff G stated that the maintenance to the building had been done incorrectly with wallpaper painted over. Staff G stated that they needed to glue down the wallpaper's seams. Staff G stated that they always kept the hand truck and wheelchair in the hall. Staff G stated the smell of cigarette smoke was coming from the area of a first-floor apartment in which the resident rolled their own cigarettes.

During the resident group meeting, on 03/14/2023 from 1:00 PM – 2:00 PM, the participating residents complained that smoking rules were not followed and cigarette and sometimes cannabis smoke went under apartment doors into the hallways. The participating residents identifying as living on the second and third floors, complained it was difficult to breathe while walking in the hallways. The participating residents stated concerns that the indoor smoking could cause a fire. The participating residents stated that the hallways sometimes smelled of urine. The participating residents stated the floors was not cleaned and mopped enough. The participating residents stated there were periods of time where the hallways throughout the facility were littered with unattended debris such as soiled briefs and cigarette butts.

Common Restrooms

Observations, on 03/13/2023 from 10:58 AM – 12:30 PM, showed the facility had four common restrooms available to residents. The paper towel dispensers in the bathrooms were removed from the walls. In the areas where the paper towel dispensers had been, the walls remained unpainted or with peeling wallpaper. Loose paper towels and paper towel rolls designed for dispensers had been placed on the counters. One of two common restrooms on the main or second floor had a not sanded, spackled unpainted area on the wall.

During an interview, on 03/14/2023 from 10:58 AM – 12:30 PM, Staff G, stated that the paper towels dispensers were rented and returned to the rental company. Staff G stated that he knew of no plan to replace the dispensers.

During an interview, on 03/14/2023 at 2:20 PM, Resident 9 stated that the facility's common bathrooms did not have toilet paper and paper towels. Resident 9 further stated that the facility put the paper products in the bathroom when the Department Representatives were onsite.

TV/Activities Rooms

Observations, on 03/13/2023 from 10:58 AM – 12:30 PM, showed the facility had three common TV/Activities Rooms – one on each floor. Each of the TV/Activities Rooms had a kitchenette with a sink and cabinets with worn stain and no paper towel dispensers.

During an interview, on 03/14/2023 from 10:58 AM – 12:30 PM, Staff G, acknowledged the worn condition of cabinets in the TV/Activities Rooms.

During an interview on 03/13/2023 at 1:50 PM, Staff A, Executive Director, stated that she was not very satisfied with the condition of the building. Staff A stated that maintenance of the building had been absent.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 246-215-02120 Food worker cards.

(1) The permit holder and person in charge of the food establishment shall ensure that all food employees are in compliance with the provisions of chapter 69.06 RCW and chapter 246-217 WAC for obtaining and renewing valid foodworker cards.

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14).
food employees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(1) After touching bare human body parts other than clean hands and clean, exposed portions of arms;

(2) After using the toilet room;

(3) After caring for or handling service animals or aquatic animals as specified under WAC 246-215-02415 (2);

(4) Except as specified under WAC 246-215-02400 (2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;

(5) After handling soiled equipment or utensils;

(6) During food preparation, as often as necessary to remove soil and contamination and to

prevent cross contamination when changing tasks;

(7) When switching between working with raw food and working with ready-to-eat food;

(8) Before donning gloves for working with ready-to-eat food unless a glove change is not the result of contamination; and

(9) After engaging in other activities that contaminate the hands or gloves.

WAC 246-215-03525 Temperature and time control Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16).

(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530 , and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:

(b) At 41 F (5 C) or less.

WAC 246-215-04250 Functionality Warewashing machines, data plate operating specifications (FDA Food Code 4-204.113). A warewashing machine must be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operation specifications including the:

(1) Temperatures required for washing, rinsing, and sanitizing;

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(d) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC Food service;

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(3) The assisted living facility may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

(a) Modified or therapeutic diets;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that dishes and utensils were washed and sanitized properly; all staff handling food maintained valid food worker cards; all staff practiced handwashing between tasks; potentially hazardous foods were stored and served at a safe temperature; and to prepare and provide

therapeutic diets to 29 residents. These failures placed the residents of the facility at risk for foodborne illness and not having their dietary needs met.

Findings included...

Dishwasher Sanitization

Record review of the facility's undated document titled, "Dining Services Guidelines" showed the facility's dishwasher temperature log contained boxes for staff to document a daily AM and PM commercial dishwasher temperature and initial when done. The document showed that if the temperatures did not meet the standard were documented, staff were to circle the temperature and follow-up to resolve the temperature being out of range.

Record review of the facility's dishwasher temperature log from 02/01/2023 – 03/13/2023, showed staff logged wash temperature three times daily. The dishwasher temperature log showed staff logged all the temperatures taken at 115 degrees Fahrenheit (F). The dishwasher temperature log showed there were no circled temperatures.

Observation, on 03/13/2023 at 2:49 PM, of the commercial dishwasher showed a manufacturer's guideline on the temperature gauge. The temperature gauge showed the dishwasher needed to be operating at minimum of 120 degrees F.

During an interview, on 03/13/2023 at 2:49 PM, Staff I, Dining Services Director, acknowledged the dishwasher's temperature gauge specified the wash temperature was to be at 120 degrees F. Staff I then was that 115 degrees F was acceptable.

During an interview, on 03/14/2023 at 9:04 AM, Staff A, Executive Director, stated that Staff I needed to ensure the dishes were washed at the proper sanitizing temperature.

Food Worker Cards

Record review of the facility's undated document titled, "Dining Services Guidelines," showed no requirement for staff involved with food services to residents were to maintain valid food worker cards.

Record review of the facility's document titled, "Position: Dining Services Director," dated April 2020, showed that the facility's Dining Services Director was to ensure that employees practice safe food-handling techniques and comply with relevant regulations. The Dining Services Director was to ensure that all staff had required licenses.

Record review showed that three of the dining services staff (Staff M, N, and O) did not have a valid food worker card. Staff M's, title, food worker card expired on 03/06/2023. Staff N's, title, food worker card expired on 08/27/2022. Staff O's, Dishwasher, food worker card expired on 09/12/2022.

During an interview, on 03/13/2023 at 2:27 PM, Staff N stated that they knew they were responsible for maintaining a valid food worker card.

During an interview, on 03/13/2023 at 2:35 PM, Staff I stated that she was aware staff were working with invalid food worker cards. Staff I stated that staff began renewing their cards on the first day of the full inspection. Staff I stated that she previously asked the staff to renew the cards, but that did not occur because they were busy. Staff I stated that staff with expired food worker cards were not supposed to come into work but continued to work.

Record review of the facility's position descriptions for Personal Care Assistant (Caregiver) and Medication Technician/Assistant, dated April 2020, showed that Personal Care Assistants and Medication Technicians/Assistants were expected to assist with the preparation, handling, delivery, and other dining related responsibilities.

Record review of care staff personnel files showed that Staff E, Health Services Director, and Staff F, Medication Technician, did not have a food worker card on file. Review showed Staff B's, Caregiver, food worker card to expired on 12/30/2021.

During an interview, on 03/15/2023 at 9:00 AM, Staff A stated that she was unaware Staff E and Staff F failed to obtain food worker cards. Staff A stated that she was unaware that Staff B's food worker card expired. Staff A stated that they did not have a system in place to keep track of the valid status of food worker cards for their staff. Staff A stated that they required all care staff to handle food which included delivering food trays to the residents in their rooms and assisting in the dining room. Staff A stated that the facility required all care staff maintained a valid food worker card and that requirement included the Health Services Director and the Executive Director.

Handwashing

Record review of the facility's undated document titled, "Dining Services Guidelines" showed that employees were to understand what and how to prevent cross-contamination (the transfer of harmful bacteria or other microorganisms from one substance or surface to another). Employees were expected to follow precautions to prevent cross-contamination and prevent foodborne illness through proper handwashing techniques.

Observation, on 03/14/2023 at 8:50 AM, of the dishwashing process following breakfast service, showed Staff L, Dietary Aide, wearing gloves while handling and washing dirty dishes and utensils and then emptying the dishwasher and putting clean dishes away. Staff L did not remove the gloves and wash their hands before switching tasks to empty the dishwasher. Observation showed that Staff I went from bare-handed contact with dirty dishes and cleaning a food services cart to emptying the dishwasher and putting clean dishes away without washing their hands between tasks.

During an interview, on 03/14/2023 at 9:04 AM, after reviewing the observations, Staff A

stated that the washed dishes had been contaminated by the lack of proper hand hygiene.

Cold Holding

Review of the Food and Drug Administration (FDA) website, on 03/27/2023, showed potentially hazardous food defined as, "as any perishable food which consists in whole or in part of milk or milk products, eggs, meat, poultry, rice, fish, shellfish."

Record review of the facility's undated document titled, "Dining Services Guidelines" showed, the facility was to ensure that residents did not suffer foodborne illnesses by adhering to proper precautions. Precautions included holding potentially hazardous food at 40 degrees F or below.

Observation of dining services, on 03/14/2023 at 7:30 AM, showed staff served milk, juice, and cold cereal from two carts to residents in the dining room. Further observation showed the carts were non-refrigerated and had two open shelves. Both carts contained a gallon of regular milk and a half-gallon of lactose-free milk (four containers of milk in total) with a handwritten date of 03/13/2023 on each container. Of the four containers of milk, only one was on a one-inch, single layer of ice in a container the size of the bottom of the gallon of milk.

Observation, on 03/14/2023 at 7:59 AM, showed Staff O poured regular milk from one cart into cereal and served a resident. At 8:07 AM, Staff O poured and served another resident a glass of regular milk from the container that was on ice.

During an interview, on 03/14/2023 at 8:00 AM, Staff L, Dietary Aide, confirmed that the milk served was previously served to the residents 03/13/2023 and using the observed non-refrigerated carts. Staff L stated that after 03/13/2023's breakfast service the milk containers were dated and placed back into the refrigerator. Upon request, Staff L located a thermometer and measured the temperature of the four containers of milk. Staff L reported that the regular milk tested at 52.5 degrees F and 46.8 degrees F, and the lactose-free milk tested at 50.6 and 49.6 degrees F. Staff L stated the safe cold food temperature was, "Maybe 52 degrees."

During an interview, on 03/14/2023 at 8:12 AM, Staff I stated that the cold holding temperature was, "maybe 35 degrees or 40 degrees." Staff I stated that they tested the temperature of the cold foods. When told about the milk temperatures, Staff I stated that she was not sure why the milk was 52 degrees F. Upon request, Staff I tested the remaining milk on both non-refrigerated carts. Staff I stated that the remaining regular milk container measured at 50.1 degrees F. Staff I stated this was the container resting on ice. Staff I stated that the lactose-free milk measured at 52.1 degrees F and 50.9 degrees F. Staff I left the milk on the carts and did not address the temperature of the milks.

During an interview, on 03/14/2023 at 8:09 AM, Staff J, Cook, was told the temperatures of the milk on both carts. Staff J stated that cold foods needed to be kept at 35 degrees F to be served. Staff J left the milk on the carts and did not address the temperature of the

milks.

Observation, on 03/14/2023 at 8:24 AM, showed Staff J poured a glass of regular milk and served it to a resident.

During an interview, on 03/14/2023 at 8:26 AM, Staff J confirmed that they knew they just served milk that was over 50 degrees F to a resident. Staff J stated that she told the other staff about this issue previously.

In an observation and interview, on 03/14/2023 at 8:47 AM, showed Staff J wheeled a cart of the remaining milk into the walk-in refrigerator. Staff J stated that they put the milk in the refrigerator for later use.

During an interview, on 03/14/2023 at 9:04 AM, Staff A stated that milk under those circumstances was not safe for resident consumption and needed to be immediately discarded instead of returning it to the refrigerator for future food service. Staff A stated that her interpretation of the events observed within dining services demonstrated that Staff I did not have the necessary knowledge of safe food handling techniques. Staff stated that as a result, Staff I could not and did not pass along the proper food safety techniques to the dining services staff.

Therapeutic Diets

Record review showed the facility did not have a dietitian-approved dietary manual.

Record review of the facility's undated document titled, "Dining Services Guidelines" showed the facility would try to accommodate therapeutic diets (diets prescribed by providers that are adjusted to accommodate individuals with different health needs).

Record review of the facility's undated document titled, "Diet Sheet" showed the facility identified 29 residents who required a therapeutic diet.

During the resident group meeting, on 03/14/2023 at 1:00 PM, three residents identified themselves as having diabetes mellitus (a condition where that affects how the body uses glucose or sugar). The three residents stated that the facility offered no diabetic-appropriate meal substitutions other than salad. The residents added that the only dessert substitution for diabetics was gelatin.

During an interview, on 03/15/2023 at 9:18 AM, Resident 2 stated that the facility served little food specific to their renal diet. Resident 2 further explained that when the facility served nothing they could eat, they ate food not provided by the facility.

During an interview, on 03/27/2023 at 11:08 AM, Resident 29 stated that their medical

diagnoses included [REDACTED]. Resident 29 stated that the facility provided the same meals for every resident regardless of whether they had different dietary needs. Resident 29 stated that the food provided by the facility did not follow the dietary recommendations. Resident 29 stated that the facility said they had a dietitian and agreed to arrange a dietitian to review their diet six months ago, when they moved in. Resident 29 further stated that over the past six months, they had not seen any dietitian provided by the facility. Resident 29 stated that since they moved in, their blood sugar levels increased from an average of 200 to averaging between 240-250.

During an interview, on 03/13/2023 at 2:25 PM, Staff K, Cook, stated that they were not aware of and were not using a dietary manual as part of food preparation.

During an interview, on 03/13/2023 at 2:35 PM, Staff I stated that they did not have a dietary manual for use during food preparation. Staff I showed the facility's menus were signed by a dietitian.

During an interview, on 03/14/2023 at 8:09 AM, Staff J that they were not aware of and were not using a dietary manual as part of food preparation.

During an interview, on 03/16/2023 at (Time), Staff J confirmed that the facility served food to over 20 residents with specific dietary needs.

During an interview, on 03/17/2023, Staff I stated that the facility did not serve food specifically for residents with diabetes mellitus.

During an interview on 03/16/2023 at 1:50 PM, Staff S, Executive Director, stated that they had an extensive background in food services. Staff S stated that the facility served a sizable population of residents with diabetes mellitus. Staff S added that the facility failed to concentrate on menus and snacks specialized for the nutritional needs of residents with diabetes mellitus

Plan/Attestation Statement

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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:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

ased on interview and record review, the facility failed to ensure all staff are trained related to reporting suspected abandonment, abuse, neglect, exploitation, and financial exploitation. This failure placed the residents at risk of abuse, neglect, and exploitation.

Findings included...

Record review of the facility's policy titled, "Elder Abuse, Neglect, and Exploitation," dated 12/15/2021, stated that showed that staff are to report any suspected or observed resident abuse, neglect, or misappropriation to the Department. The Policy stated that all the Personal Care Assistants would receive an in-service regarding reporting on annual basis.

During an interview, on 03/13/2023 at 1:08 PM, Staff P, Medication Technician, was unable to define mandatory reporting or state the immediate timeframe for making a mandatory report. Staff X, Caregiver, reported that they were not trained by the facility regarding mandatory reporting to the Department's toll-free telephone number for reporting resident abuse and neglect (Hotline). Staff X was unaware of their responsibilities related to abuse and neglect and of the facility's abuse and neglect policy.

During an interview, on 03/13/2023 at 1:31 PM, Staff Q, Caregiver, was unable to define mandatory reporting or state the immediate timeline for making a mandatory report. Staff Y, Medication Technician, reported that they were not trained by the facility regarding mandatory reporting the Hotline. Staff Y was unaware of their responsibilities related to abuse and neglect and were unaware of the facility's abuse and neglect policy.

During an interview, on 3/15/2023 at 10:45 AM, Staff G, Maintenance Supervisor, was unaware that they had to report abuse, neglect, and exploitation to the Hotline. Staff G further reported that they were unaware of where to locate the hotline number and were unaware of the facility's abuse and neglect policy.

During an interview, on 3/15/2023 at 11:20 AM, Staff R, Medication Technician, stated that they did not know where to locate within the facility the Hotline number to report abuse and neglect.

During an interview, on 03/14/2023 at 10:56 AM, Staff A, Executive Director, stated that it was no surprise that staff did not have a grasp of abuse, neglect, and mandated reporting.

Staff A stated that they would look for the abuse, neglect, and mandated reporting staff training.

During an interview, on 03/16/2023 at 8:41 AM, Staff A reported that the facility had no records that an abuse, neglect, and mandated reporting training occurred for any of the staff.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

- (1) Develop, implement and disclose to potential and current residents, policies regarding:
 - (b) The conditions under which pets may be in the assisted living facility.
- (2) Ensure animals living on the assisted living facility premises:
 - (a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;
 - (b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain pet records for all pets living in the facility including veterinarian certification that pets were free of disease transmittable to human, received regular examinations and vaccinations, and an assessment of the residents' ability to handle pet responsibilities. These failures placed the residents at risk for contracting illnesses and unmanaged pets living in the facility.

Findings included...

Record review of the facility's undated document titled "Disclosure of Services" showed the facility permitted pets. The Disclosure of Services stated that pets must have regular veterinary examinations and vaccinations and be free of diseases transmittable to humans.

Record review of the facility's undated pet policy showed pets must have current vaccination records on file with the Executive Director. The pet policy stated that a regular review of the residents' ability to handle pet responsibilities would be conducted by a designated member of the facility's management team.

During an interview, on 03/13/2023 at 10:00 AM, Staff A, Executive Director, and Staff E, Health Services Director, stated that they were aware of the four facility parakeets (Pets 1, 2, 3, and 4) and that two residents had cats (Pets 8 and 9). Staff A and Staff E stated that they were unsure of which resident owned the cats. They said they had no resident dogs residing in the facility.

Pets 1, 2, 3, and 4

Observation, on 03/13/2023 at 11:23 AM, showed a cage with four parakeets (Pets 1, 2, 3, and 4) in a common vending machine area and seating room located off the resident dining room.

During an interview, on 03/13/2023 at 11:23 AM, Staff G, Maintenance Supervisor, confirmed the facility owned the four parakeets.

Record review of a Washington State Department of Agriculture document titled, "Certificate of Veterinary Inspection," dated 03/29/2019, showed that initially six parakeets were certified to be free of diseases transmittable to human. The Certificate showed it was valid for 30 days from the date of inspection. There were no current veterinary certifications that the parakeets were free of diseases transmittable to humans and no record the facility obtained regular examinations and vaccinations for the four remaining parakeets.

Pets 5, 6, 8, and 12

Record review showed no documentation that Pet 5 was current with exams and vaccines and free of disease transmittable to humans.

Record review showed no documentation that Pet 6 was current with exams and vaccines and free of disease transmittable to humans.

Observation, on 03/15/23 at 9:18 AM, showed a sign on the door of Pet 8's owner instructing others not to let the kitty out. Inside the apartment showed cat food and Pet 8 living in the apartment.

Record review showed the facility failed to acquire veterinary records for Pet 8 showing Pet 8 was current with exams and vaccines and was free of diseases transmittable to humans.

Record review showed the facility failed to acquire veterinary records for Pet 12 showing

Pet 12 was current with exams and vaccines and free of disease transmittable to humans.

During an interview, on 3/16/23 at 9:30 AM, Staff E stated that after checking for pets within the facility, the facility had no records for four of residents' cats (Pet 5, 6, 8, and 12).

Pet 7

Record review of veterinary records showed no documentation that Pet 7 was certified by a veterinarian to be free of diseases transmittable to humans. Pet 7's veterinary records showed Pet 7's vaccinations and exam were due on 10/20/2020. The veterinary exam, dated 10/21/2019, showed that Pet 7's coat was in poor condition. The veterinary exam showed Pet 7 had a greasy coat, significant back scaling (dandruff or dead skin), and an occasional mat. Pet 7's veterinarian advised bathing.

There was no evidence the facility completed an assessment that the Resident for Pet 7 had the ability to handle pet responsibilities as in the facility's pet policy/lease agreement.

During an interview, on 3/16/23 at 9:30 AM, Staff E stated that they were not sure which staff was responsible for assessing the residents' ability to care for pets. Staff E stated that they were unable to locate any record of such an assessment for the Resident of Pet 7.

Pets 9, 10, and 11

Observation, on 03/13/2023 at 10:59 AM, showed Pet 9 running around unleashed on the main floor of the facility. Observation showed that the main floor was busy with resident traffic and the surrounding residents knew Pet 9's name.

Record review of veterinary records showed no documentation that Pet 9 was certified by a veterinarian to be free of diseases transmittable to humans. Pet 9's record showed Pet 9's annual exam and vaccinations were due on 08/05/2022. There was no other record that showed Pet 9 was up to date with examinations and vaccines.

Record review of veterinary records showed no documentation that Pet 10 was certified by a veterinarian to be free of diseases transmittable to humans. Review showed that Pet 10 was due for a vaccination on 04/27/2022. There was no record that Pet 10 received the vaccination.

Record review of veterinary records showed Pet 11 had its most recent exam on 02/15/2021. The exam stated Pet 11 had their last vaccinations on 08/31/2021. There was no record that Pet 11 was up to date with an exam and vaccines.

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, Renton Assisted Living 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-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a current disaster plan and a sufficient emergency food supply for the residents were on premises. This failure placed the residents at risk of harm in the event of an internal or external disaster and insufficient food supply in the event of an emergency.

Findings included...

Disaster Plan

Record review showed the facility did not develop or maintain a current disaster plan on the premises that described measures for staff to take in an emergency. The facility produced a disaster manual, dated May 2021, from the previous corporation that operated the facility. The facility did not establish their own plans for the communication, coordination, and alternative resident accommodation. Review showed the previous corporation's plan did not support the facility as it currently operated.

During an interview, on 03/13/2023 at 3:19 PM, Staff A, Executive Director, acknowledged that the facility did not have a current disaster manual. Staff A stated that she did not know who the First Responders were, what to coordinate, or where they would send residents in the event of an evacuation.

Emergency Food Provisions

Observation, on 03/14/2023 at 10:25 AM, showed the facility's emergency food supply for 100 residents located on one shelf of the dry food storage room accessible from the commercial kitchen. The facility set aside one quarter (1/4) of a box of snack-size cheese and peanut butter crackers; 1 unopened box and three opened, partially used boxes of crackers; an opened, partially used 20-count box of individual wrapped rice cereal based treats; one unopened box and two opened, partially used boxes of 10-count individual servings of instant oatmeal; two boxes with 20 ounces of cookies; and one opened, partially used box of instant food thickener.

During an interview, on 03/14/2023 at 10:25 AM, after reviewing the facility's emergency food supply, Staff I, Dining Services Director, confirmed that the food items was the only emergency food reserves for the facility. Staff I further reported that they used the supply when the kitchen was out of food.

During an interview, on 03/14/2023 at 10:45 AM, Staff A stated that she saw the facility's emergency food supply, and it was not enough to support their residents. Staff A stated that she believed that the facility should have a five-day emergency food supply. Staff A stated that she had spoken with Staff T, Corporate Director of Compliance, who stated that the facility needed to maintain a four-day emergency food supply. Staff A provided an undated document, obtained from their food vendor, titled, "96-hour sustainability menu using perishable items."

During an interview, on 03/14/2023 at 11:29 AM, Staff T, stated that the facility needed to maintain an emergency food supply for 72 hours. Staff T provided an undated document, obtained from their food vendor, titled, "72-hour sustainability menu using perishable items."

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, Renton Assisted Living 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



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

04/17/2023

CERTIFIED MAIL

9489 0090 0027 6382 8694 15

Greenlake Management Renton, LLC
Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

RE: Renton Assisted Living # 2614

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/03/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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

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

(2) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the assisted living facility.

The facility failed to complete a character, competence, and suitability (CCS) review for 1 of 6 sampled staff (Staff C, housekeeper) when the name and date of birth background check showed results that required a CCS review. The facility completed a CCS review on 03/15/2023 during the time of the full inspection.

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

The facility failed to notify the Department of the newly appointed facility administrator within 10 days of the effective date of change. On 03/01/2023, the facility appointed a new administrator. On 03/14/2023, during the inspection, the facility corrected the issue when they submitted the change of information form to the Department.

You Are Not:

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after

you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

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

Enclosure