STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 83635 (Completion Date 09/11/2026) and 81109 (Completion Date 07/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/11/2026 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-2700-1-a, WAC 388-78A-2700-1-f-iii, WAC 388-78A-2700-1-f-i, WAC 388-78A-2700-1-f-ii, WAC 388-78A-2700-3-f

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Holly George, Nursing Consultant Institutional

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

Sincerely,

Jim Sherman

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

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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

The department completed data collection for an unannounced on-site follow-up on 07/27/2026 of:

Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

This document references the following SOD dated: 07/28/2026

The following sample was selected for review during the unannounced on-site visit: 10 of 88 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

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.

Jamie Singer For Jim Sherman
Residential Care Services

08/07/2026
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.

M. Vulgamore
Administrator (or Representative)

9/18/2026
Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

(f) Make sure first-aid supplies are appropriate for.

(i) The size of the assisted living facility;

(ii) The services provided;

(iii) The residents served; and

(3) The assisted living facility's emergency preparedness plan must include procedures for.

(f) Provision of essential resident needs and supplies, including water, food, medications, and personal care items; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure that 1 of 1 maintenance room and 1 of 2 medications rooms were secured. This placed 88 residents at risk of harm.

Findings included...

Review of the facility's undated Characteristics Roster showed that 88 residents resided and received assisted living services at the facility. The characteristics roster identified ten residents with mental health issues and eleven residents with cognitive impairment.

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

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-2700 Emergency and disaster preparedness.

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(a) Maintain the premises free of hazards;

(f) Make sure first-aid supplies are appropriate for:

(i) The size of the assisted living facility;

(ii) The services provided;

(iii) The residents served; and

(3) The assisted living facility's emergency preparedness plan must include procedures for:

(f) Provision of essential resident needs and supplies, including water, food, medications, and personal care items; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure that 1 of 1 maintenance room and 1 of 2 medications rooms were secured. This placed 88 residents at risk of harm.

Findings included…

Review of the facility's undated Characteristics Roster showed that 88 residents resided and received assisted living services at the facility. The characteristics roster identified ten residents with mental health issues and eleven residents with cognitive impairment.

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Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/04/2026 for unlocked medication and maintenance room. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 07/19/2026.

Review of sampled residents' service plans showed that Resident 13's plan included a diagnosis of [redacted] and [redacted]. Resident 6's service plan showed a diagnosis of [redacted]. Resident 3's service plan showed a diagnosis of [redacted]. Resident 9's service plan showed a diagnosis of [redacted] and [redacted]. Resident 11's service plan showed a diagnosis of [redacted]. Resident 15's service plan showed a diagnosis of [redacted].

UNSECURED ROOMS

Observation on 07/27/2026 at 9:10 AM, showed the second-floor medication room located at the center of where the three hallways intersected was found to be unlocked. No facility staff were observed in the vicinity. Observation showed an unsecured refrigerator filled with prescription and over the counter medications inside the medication room. Observation showed the refrigerator contained injectable insulin pens and eyedrops along with other medications. Observations showed several unidentified assisted living residents ambulating back and forth past the unlocked medication room.

Observation and interview on 07/27/2026 at 9:15 AM, Staff O, Director of Operations-West, turned the doorknob to the second floor medication room and opened the door without a key. Staff O stated that the door should always be locked when a staff member is not present.

During an interview on 07/27/2026 at 1:27 PM Staff N, Senior Executive Director, stated that the the Health Care staff were in-serviced on the importance of ensuring that all medication rooms remained locked when not in use.

Observation and interview on 07/27/2026 at 9:15 AM, showed the door to the maintenance, electrical room, and storage room located on the third floor adjacent to resident apartments was unlocked. Observation showed maintenance room consisted of three large rooms without doors that contained large electrical panels with switches mounted to the wall, paint, chemicals, multiple hardware supplies, and multiple tools. Observation showed residents walked down the hallway to access their apartments. Staff P, Maintenance Director, stated they just unlocked the door when they arrived at work. The room also provided access to the facility roof. Observation showed an extension ladder that led to an open roof hatch which allowed for unrestricted access to the roof. Staff P stated that they opened the roof hatch to allow for fresh air and to cool off the room. Staff P stated that they unlocked the door in the morning when they arrived and locked the door when they left the community. Staff P stated that they go

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back and forth to the maintenance room all day, so they left door unlocked. Staff P stated that none of the residents ever go into the maintenance room. Staff P acknowledged that the facility resident population consisted of residents with mental health issues.

During an interview at the exit conference on 09/27/2026 at 1:27 PM, Staff O stated that the facility did not dispute the Department findings.

This is an uncorrected deficiency previously cited on 07/19/2025, WAC 388-78A-2700 subsections (1)(a).

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) 9/7/2026.

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

M. Vulgamore
Administrator (or Representative)

8/18/2026
Date

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back and forth to the maintenance room all day, so they left door unlocked. Staff P stated that none of the residents ever go into the maintenance room. Staff P acknowledged that the facility resident population consisted of residents with mental health issues.

During an interview at the exit conference on 09/27/2026 at 1:27 PM, Staff O stated that the facility did not dispute the Department findings.

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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

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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

The department completed data collection for the unannounced on-site full inspection on 05/18/2026 and 05/21/2026 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 77 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jane Hermano, NCI
Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

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 — 06/15/2026 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) — 6/18/26 Date

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 1 of 3 sampled care staff (Staff C) maintained a valid Cardiopulmonary Resuscitation (CPR) and first-aid card or certificate when they provided care and services to the assisted living residents. This failure placed 77 residents at risk of receiving improper care from untrained care staff persons.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 77 residents received Assisted Living services.

Review of the facility's undated employee roster showed that the facility hired Staff C,

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

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

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(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 1 of 3 sampled care staff (Staff C) maintained a valid Cardiopulmonary Resuscitation (CPR) and first-aid card or certificate when they provided care and services to the assisted living residents. This failure placed 77 residents at risk of receiving improper care from untrained care staff persons.

Findings included…

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 77 residents received Assisted Living services.

Review of the facility's undated employee roster showed that the facility hired Staff C,

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Resident Care Coordinator, on 03/31/2025. Review of Staff C's employee records showed that Staff C's previous CPR certification expired on 02/11/2026. The records showed the previous CPR certification did not include first-aid training. The records showed that on 05/18/2026, Staff C completed the current CPR and first-aid training.

Review of the undated employee schedule showed Staff C provided care and services to the assisted living residents between 05/03/2026 and 05/17/2026, without a valid CPR and first-aid card or certificate.

Observation between 05/18/2026 and 05/21/2026 showed that Staff C provided care and services to the Assisted Living residents.

During an interview on 05/19/2026 at 1:40 PM, Staff A, Executive Director, stated that Staff C's CPR card expired in February 2026. Staff A stated that Staff C completed their CPR and first-aid training on 05/18/2026. Staff A stated that Staff C provided care and services to the assisted living residents between February 2026 and May 2026 without valid CPR and first-aid training.

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) 7/19/26.

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

Administrator (or Representative) — Date 6/18/26

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess the resident's ability to safely use medical devices for 2 of 4 residents (Resident 11 and Resident 12). This failure placed Resident 11 and Resident 12 at risk for possible unmet care needs and injury.

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Resident Care Coordinator, on 03/31/2025. Review of Staff C's employee records showed that Staff C's previous CPR certification expired on 02/11/2026. The records showed the previous CPR certification did not include first-aid training. The records showed that on 05/18/2026, Staff C completed the current CPR and first-aid training.

Review of the undated employee schedule showed Staff C provided care and services to the assisted living residents between 05/03/2026 and 05/17/2026, without a valid CPR and first-aid card or certificate.

Observation between 05/18/2026 and 05/21/2026 showed that Staff C provided care and services to the Assisted Living residents.

During an interview on 05/19/2026 at 1:40 PM, Staff A, Executive Director, stated that Staff C's CPR card expired in February 2026. Staff A stated that Staff C completed their CPR and first-aid training on 05/18/2026. Staff A stated that Staff C provided care and services to the assisted living residents between February 2026 and May 2026 without valid CPR and first-aid training.

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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(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess the resident's ability to safely use medical devices for 2 of 4 residents (Resident 11 and Resident 12). This failure placed Resident 11 and Resident 12 at risk for possible unmet care needs and injury.

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Findings included…

Review of the facility's undated policy document titled "Supportive Devices" showed that the facility allowed "supportive devices" including side rails to be used as mobility aides and not an intervention to minimize the frequency of falls. The document showed that before a supportive device was placed into use, the Administrator and/or Health Services Director were responsible for discussing the risks and benefits of the device to the resident and evaluate the use for only mobility purposes. The document showed that prior to implementing any supportive device, a licensed nurse was responsible for completing an assessment and documenting the failure of the alternate methods. The document showed that a physician's order must be obtained and the use of a supportive device must be documented on the resident's Service Plan. The document showed the facility's staff were responsible for routinely monitoring residents utilizing side rails for continued safety and appropriateness.

Note: Washington Administrative Code (WAC) 388-78A-2090, Full assessment topics.
The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

RESIDENT 11
Observation on 05/21/2026 at 9:01 AM showed that Resident 11 laid in a hospital bed. Observation showed two metal framed side rails attached from the head of the bed and extended to the mid-way of the bed, one side rail on each side of the bed. During the observation, Resident 11 said that "Is the side rail on the left side on the floor? Can you help put it up?" Observation showed both side rails were in a raised position. Observation showed that the side rail on the left side was attached sturdily to the bed. Observation showed that the side rail on the right side of the bed was loosened and wobbly, and the side rail was easily pulled over 4 inches away from the mattress in the mid-way of the bed without an effort. During an interview at this time, Staff I, Licensed Practical Nurse/Senior Health Services Director, stated that the side rail on the right-side was loosened. Staff I stated that they were unsure who the staff were responsible for routinely checking and maintaining the side rails for the resident. Staff I stated that they would notify the maintenance staff about the loosened side rail."

Review of Resident 11's records showed that the facility admitted Resident 11 in [redacted] 2022. The records showed a provider's order of the use of "bedside rails" dated 06/03/2025. The records showed that on 11/17/2025, the facility completed an assessment for Resident 11. The assessment showed Resident 11 required assistance with transfer and positioning. The assessment showed that Resident 11 required assistance with using assistive device. There was no documentation that showed the facility assessed Resident 11's ability to safely use side rails. There was no documentation that showed the facility documented the failure of alternate methods.

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

During an interview on 05/21/2026 at 12:02 PM, Staff I stated that they were unable to locate the documentation of the side rails assessment for Resident 11. Staff I stated that their former nurse did not assess Resident 11's ability to safely use the side rails.

RESIDENT 12
Observation on 05/21/2026 at 8:51 AM showed that Resident 12 laid in the hospital bed. Observation showed two metal framed side rails attached from the head of the bed and extended to the mid-way of the bed, one side rail on each side of the bed. Observation showed both side rails were in a raised position, and each side rail was sturdily attached to the bed with less than 2 inches gap between the rail and the mattress. The left side rail was close to the wall. During the observation, Resident 12 said that they used the side rails to position themselves in bed.

Review of Resident 12's records showed that the facility admitted Resident 12 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 09/06/2025, the facility completed an assessment for Resident 12. The assessment showed Resident 12 required hands-on assistance with transfer and positioning. There was no documentation that showed the facility assessed Resident 12's ability to safely use side rails.

During an interview on 05/21/2026 at 12:02 PM, Staff I stated that they were unable to locate the provider's order for the side rails use. Staff I stated that they were unable to locate the documentation of the side rails assessment for Resident 12. Staff I stated that their former nurse did not assess Resident 12's ability to safely use the side rails.

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) 7/19/24.

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

Administrator (or Representative) — Date 6/18/24

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:

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During an interview on 05/21/2026 at 12:02 PM, Staff I stated that they were unable to locate the documentation of the side rails assessment for Resident 11. Staff I stated that their former nurse did not assess Resident 11's ability to safely use the side rails.

RESIDENT 12
Observation on 05/21/2026 at 8:51 AM showed that Resident 12 laid in the hospital bed. Observation showed two metal framed side rails attached from the head of the bed and extended to the mid-way of the bed, one side rail on each side of the bed. Observation showed both side rails were in a raised position, and each side rail was sturdily attached to the bed with less than 2 inches gap between the rail and the mattress. The left side rail was close to the wall. During the observation, Resident 12 said that they used the side rails to position themselves in bed.

Review of Resident 12's records showed that the facility admitted Resident 12 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 09/06/2025, the facility completed an assessment for Resident 12. The assessment showed Resident 12 required hands-on assistance with transfer and positioning. There was no documentation that showed the facility assessed Resident 12's ability to safely use side rails.

During an interview on 05/21/2026 at 12:02 PM, Staff I stated that they were unable to locate the provider's order for the side rails use. Staff I stated that they were unable to locate the documentation of the side rails assessment for Resident 12. Staff I stated that their former nurse did not assess Resident 12's ability to safely use the side rails.

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 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:

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(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 the Washington state name and date of birth (WNDOB) background inquiry (BGI) for 2 of 5 sampled staff (Staff D and Staff G) within one business day after their start date. This failure placed 77 residents at risk for abuse and neglect from caregivers and staff persons with unknown backgrounds.

Findings included…

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 77 residents received assisted living services.

STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Caregiver, on 08/01/2025. Review of the undated employee schedule showed Staff D provided care and services in May 2026. Review of Staff D's employee records showed that Staff D's start date was 08/06/2025. The employee records showed that the facility submitted the background check authorization form for Staff D on 08/12/2025, six days after their start date. The employee records showed that Staff D's WNDOB BGI was completed on 08/12/2025.

During an interview on 05/19/2026 at 11:45 AM, Staff A, Executive Director, stated that the former business office manager completed the WNDOB BGI for Staff D when they were hired. Staff A stated that they were unaware Staff D's WNDOB BGI was done late.

STAFF G
Review of the facility's email titled "Renton Management Emails", dated 05/18/2026, showed that the facility rehired Staff G, Floating Maintenance Director, on 03/16/2026. Review of Staff G's employee records showed that Staff G's previous WNDOB BGI expired on 07/14/2025. The employee records showed that the facility submitted the background check authorization form for Staff G on 03/23/2026, seven days after they were rehired. The employee records showed that Staff G's WNDOB BGI was completed on 03/23/2026.

Observations on 05/18/2026 and 05/21/2026 showed that Staff G provided services to the assisted living residents in the facility.

During an interview on 05/19/2026 at 11:45 AM, Staff A stated that their corporate office rehired Staff G and completed the background check for Staff G. Staff A stated that Staff G worked in the facility as the Floating Maintenance Director. Staff A stated

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that they were unaware Staff G's WNDOB BGI was done late.

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) 7/19/26.

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

Administrator (or Representative) 6/18/26 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:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 sampled staff (Staff D and Staff E) complete their national fingerprint background check within one hundred and twenty-days of hire. This failure placed 77 residents at risk for potential abuse and neglect from care staff with an unknown background.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 77 residents received assisted living services.

STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Caregiver, on 08/01/2025. Review of Staff D's employee records showed that Staff D's start date was 08/06/2025. Staff D's employee records showed a final fingerprint background check was completed on 05/02/2026, 269 days after their start date.

STAFF E
Review of the facility's undated employee roster showed that the facility hired Staff E, Medication Technician, on 07/30/2025. Review of Staff E's employee records showed

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that they were unaware Staff G's WNDOB BGI was done late.

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.

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Administrator (or Representative) Date

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(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 sampled staff (Staff D and Staff E) complete their national fingerprint background check within one hundred and twenty-days of hire. This failure placed 77 residents at risk for potential abuse and neglect from care staff with an unknown background.

Findings included…

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 77 residents received assisted living services.

STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Caregiver, on 08/01/2025. Review of Staff D's employee records showed that Staff D's start date was 08/06/2025. Staff D's employee records showed a final fingerprint background check was completed on 05/02/2026, 269 days after their start date.

STAFF E
Review of the facility's undated employee roster showed that the facility hired Staff E, Medication Technician, on 07/30/2025. Review of Staff E's employee records showed

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that Staff E's start date was 08/01/2025. Staff E's employee records showed a final fingerprint background check was completed on 05/07/2026, 279 days after their start date.

During an interview on 05/19/2026 at 11:45 AM, Staff A, Executive Director, stated that their facility recently completed an internal audit on the employees' records. Statt A stated that they became aware that several care staff, including Staff D and Staff E, did not go to their fingerprint appointments and did not complete their national fingerprint background checks. Staff A stated that Staff D and Staff E completed their national fingerprint background checks late. Staff A stated that Staff D and Staff E provided direct care and services to the assisted living residents since they were hired and after their 120-days of provisional hire.

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) 7/19/26 .

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

Administrator (or Representative) 6/18/26 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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 sampled staff (Staff C, Staff D and Staff E) completed an initial test for Tuberculosis (TB), within three days of hire. This failure placed 77 Assisted Living residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings included...

Review of the facility's undated document titled, "Policy & Procedure: Tuberculosis (TB) Screening and Testing for Staff" showed that the facility followed the Washington Administrative Code (WAC) for TB screening, testing, documentation, and reporting.

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

that Staff E's start date was 08/01/2025. Staff E's employee records showed a final fingerprint background check was completed on 05/07/2026, 279 days after their start date.

During an interview on 05/19/2026 at 11:45 AM, Staff A, Executive Director, stated that their facility recently completed an internal audit on the employees' records. Statt A stated that they became aware that several care staff, including Staff D and Staff E, did not go to their fingerprint appointments and did not complete their national fingerprint background checks. Staff A stated that Staff D and Staff E completed their national fingerprint background checks late. Staff A stated that Staff D and Staff E provided direct care and services to the assisted living residents since they were hired and after their 120-days of provisional hire.

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.

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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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 sampled staff (Staff C, Staff D and Staff E) completed an initial test for Tuberculosis (TB), within three days of hire. This failure placed 77 Assisted Living residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings included…

Review of the facility's undated document titled, "Policy & Procedure: Tuberculosis (TB) Screening and Testing for Staff" showed that the facility followed the Washington Administrative Code (WAC) for TB screening, testing, documentation, and reporting.

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Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 77 residents received assisted living services.

STAFF C
Review of the facility's undated employee roster showed that the facility hired Staff C, Resident Care Coordinator, on 03/31/2025. Review of Staff C's employee records showed that Staff C completed two-step TB tests with negative results. Staff C's employee records showed that the initial TB test was administered on 05/14/2025, 44 days after they were hired.

STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Caregiver, on 08/01/2025. Review of Staff D's employee records showed that Staff D's start date was 08/06/2025. Staff D's employee records showed the documentation of one TB skin test, dated 01/04/2024, with a negative result of nine millimeters (MM) induration. Staff D's employee records showed a chest x-ray report, dated 01/15/2025, with no signs of TB. Staff D's employee records showed no documentation that as of 05/18/2026, the facility completed any TB skin test or TB blood test for Staff D.

STAFF E
Review of the facility's undated employee roster showed that the facility hired Staff E, Medication Technician, on 07/30/2025. Review of Staff E's employee records showed that Staff E's start date was 08/01/2025. Staff E's employee records showed that Staff E completed a Quantiferon(R)-TB Gold Plus test (a blood test for TB) with a negative result on 12/09/2025, 130 days after their start date.

During an interview on 05/19/2026 at 11:45 AM, Staff A, Executive Director, stated that the facility's licensed nurse was responsible for TB screening and testing for all new employees.

During an interview on 05/20/2026 at 1:00 PM, Staff I, Licensed Practical Nurse/Senior Health Services Director, stated that they were responsible for TB screening and testing for all employees. Staff I stated that they reviewed the TB testing for the employees. Staff I stated that they identified several new staff, including Staff C, Staff D, and Staff E, did not complete their TB testing properly as required. Staff I stated that Staff C and Staff E completed their initial TB test late. Staff I further stated that they were unfamiliar with the Washington state requirements for TB. Staff I stated that they misinterpreted the TB skin test result previously completed by Staff D. Staff I stated that they did not know a nine-millimeters induration of the TB skin test was considered a negative result. Staff I stated that Staff D's chest x-ray showed a negative result of TB. Staff I stated that they were unaware that Staff D required a TB test at hire. Staff stated that they did not complete TB testing for Staff D after they were hired.

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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) [signature] Date 6/18/26

WAC 246-217-025 Issuance of food worker cards -- Fees.

(5) The food worker card examination will be uniform statewide and will be prepared by and/or approved by the department; except that jurisdictional health departments may include additional questions to address local health concerns. The examination will cover topics identified in subsection (4) of this section, as required instruction topics. An exam must be approved by the department prior to its use. To pass the examination the applicant must answer at least eighty percent of the questions correctly.

(9) All food worker cards shall be issued and signed by the local health officer. The local health officer may contract with persons to provide the required training or testing within his/her jurisdiction. The contracts shall include test security provisions so that test questions, scoring keys, and other examination data are exempt from public disclosure to the same extent as records maintained by state or local government agencies.

WAC 246-217-035 Validity and form of food worker cards.

(5) The card shall be approximately three inches by five inches in size and contain the following information:

(b) The identity of the jurisdictional health department issuing the card;

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 1 of 8 food service workers (Staff H) obtained a food handler card through the Washington state Local Health Department. This failure placed 77 residents at risk for receiving food from an unqualified food service worker.

Findings included...

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

Plan/Attestation Statement

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Based on observation, interview and record review, the facility failed to ensure 1 of 8 food service workers (Staff H) obtained a food handler card through the Washington state Local Health Department. This failure placed 77 residents at risk for receiving food from an unqualified food service worker.

Findings included…

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

Review of the facility's undated Characteristics Roster showed 77 residents resided at the facility and received Assisted Living Services.

Review of Staff H's employee records showed the facility hired Staff H on 07/07/2022 as a Dietary Aide. Staff H's records showed they completed a food handler card, dated 07/29/2025 and expired on 07/29/2028, online through an outside company. There was no documentation that showed Staff H completed any food handler training through the Washington state Public County Health department.

Observation on 05/19/2026 at 11:00 AM and on 05/20/2026 at 2:30 PM, showed Staff H, Food Worker, working in the facility's main kitchen and dining room.

During an interview on 05/20/2026 at 2:30 PM, Staff M, Food Service Director, stated they did not know that all food worker cards were required to be obtained through a Washington state Public County Health department. Staff M stated they were not aware Staff H completed their food worker card through an outside company other than a Washington state Public County Health department.

Plan/Attestation Statement

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Administrator (or Representative) 6/18/26 Date

RCW 70.129.080 Mail and telephone -- Privacy in communications. The resident has the right to privacy in communications, including the right to:

(3) Have reasonable access to the use of a telephone where calls can be made without being overheard.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide resident access to a telephone that allowed for privacy for 77 Assisted Living Residents. This failure violated the 77 residents' rights to place calls without being overheard by staff and others.

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

Review of the facility's undated Characteristics Roster showed 77 residents resided at the facility and received Assisted Living Services.

Review of Staff H's employee records showed the facility hired Staff H on 07/07/2022 as a Dietary Aide. Staff H's records showed they completed a food handler card, dated 07/29/2025 and expired on 07/29/2028, online through an outside company. There was no documentation that showed Staff H completed any food handler training through the Washington state Public County Health department.

Observation on 05/19/2026 at 11:00 AM and on 05/20/2026 at 2:30 PM, showed Staff H, Food Worker, working in the facility's main kitchen and dining room.

During an interview on 05/20/2026 at 2:30 PM, Staff M, Food Service Director, stated they did not know that all food worker cards were required to be obtained through a Washington state Public County Health department. Staff M stated they were not aware Staff H completed their food worker card through an outside company other than a Washington state Public County Health department.

Plan/Attestation Statement

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Based on observation and interview, the facility failed to provide resident access to a telephone that allowed for privacy for 77 Assisted Living Residents. This failure violated the 77 residents' rights to place calls without being overheard by staff and others.

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Statement of Deficiencies	License #: 2614	Compliance Determination # 77542
Plan of Correction	Renton Assisted Living	Completion Date
Page 12 of 37	Licensee: Greenlake Management Renton, LLC	06/04/2026

Findings Included...

Review of the facility's undated Characteristics Roster showed 77 residents resided at the facility and received Assisted Living Services.

Observation on 05/18/2026 at 9:15 AM showed that the business offices located on the second floor next to the main facility entrance were closed and locked.

During an interview on 05/18/2026 at 9:15 AM, an unidentified facility staff member stated that the front offices were locked. The unidentified staff member stated that the front office staff, which included Staff J, Business Office Manager, and Staff A, Executive Director, were not in the facility and were expected to arrive shortly,

Observation on 05/18/2026 between 12:01 PM and 1:00 PM, and on 05/20/2026 at 2:15 PM, showed that there were five public phones located in the hallways of the facility, two phones fastened to the wall on the third floor, one phone on the second floor and two phones on the first floor. Observation showed that when each phone was used to dial out none of the five phones functioned. During the observation an unidentified resident in a wheelchair observed the Department's Representative attempt to use the phone on the second floor. The unidentified Resident yelled out that the phones did not work. The unidentified resident stated that none of the hallway phones worked.

During an interview on 05/18/2026 between 12:01 PM and 1:00 PM, Staff A stated that the hallway phones were for resident use. Staff A, Staff I, Senior Health Services Director, and Staff G, Floating Maintenance Director, all stated they were unaware that none of the hallway phones did not work. Staff A stated that Staff G would look at the phones to see was needed to repair them. Staff I stated that the residents were allowed to use the front office phones to make private calls when staff were available.

During an interview on 05/20/2026 at 2:39 PM, Staff A stated that not all 77 Assisted Living Residents owned a cell phone. Staff A stated that the residents upon request were allowed access to the office phones on the second floor. Staff A said that the phones were only accessible during office hours and when staff were available to assist.

Plan/Attestation Statement

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Review of the facility's undated Characteristics Roster showed 77 residents resided at the facility and received Assisted Living Services.

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Observation on 05/18/2026 between 12:01 PM and 1:00 PM, and on 05/20/2026 at 2:15 PM, showed that there were five public phones located in the hallways of the facility, two phones fastened to the wall on the third floor, one phone on the second floor and two phones on the first floor. Observation showed that when each phone was used to dial out none of the five phones functioned. During the observation an unidentified resident in a wheelchair observed the Department's Representative attempt to use the phone on the second floor. The unidentified Resident yelled out that the phones did not work. The unidentified resident stated that none of the hallway phones worked.

During an interview on 05/18/2026 between 12:01 PM and 1:00 PM, Staff A stated that the hallway phones were for resident use. Staff A, Staff I, Senior Health Services Director, and Staff G, Floating Maintenance Director, all stated they were unaware that none of the hallway phones did not work. Staff A stated that Staff G would look at the phones to see was needed to repair them. Staff I stated that the residents were allowed to use the front office phones to make private calls when staff were available.

During an interview on 05/20/2026 at 2:39 PM, Staff A stated that not all 77 Assisted Living Residents owned a cell phone. Staff A stated that the residents upon request were allowed access to the office phones on the second floor. Staff A said that the phones were only accessible during office hours and when staff were available to assist.

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Administrator (or Representative) Date

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

WAC 388-78A-3030 Toilet rooms and bathrooms.

(2) The assisted living facility must provide each toilet room and bathroom with:

(e) Provide mechanical ventilation to the outside; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 4 of 12 air exchange ventilation systems (first floor common bathroom, third floor common bathroom, Resident 5 bathroom, Resident 7 and Resident 9's shared bathroom) vented to the exterior of the building. This failure placed residents at risk of communicable disease and Resident 7 and Resident 9 at risk for a diminished quality of life.

Findings included…

COMMON BATHROOMS

Review of the facility's Exhaust Vents log dated 04/15/2026 showed that all exhaust fans in the facility were found to be functioning.

Observation on 05/18/2026 at 12:01 PM, showed a non-functioning outflow ventilation system in the third-floor common bathroom.

Observation on 05/18/2026 at 12:13 PM, showed the exhaust air vent in the first-floor common bathroom when tested with a tissue paper failed to draw the tissue paper towards the exhaust air vent.

During an interview on 05/18/2026 at 12:13 PM, Staff G, Floating Maintenance Director, stated that they were unaware that the exhaust air vent of the common bathroom on the first floor did not function. Staff G stated that the exhaust air vents were routinely checked every month. Staff G stated they did not remember when the exhaust systems were last checked.

During an interview on 05/18/2026 between 12:01 and 12:30 PM, Staff A, Executive Director, stated that they were not aware the vents were not functional.

RESIDENT 5
Observation on 05/20/2026 at 3:30 PM showed that the exhaust air vent in Resident 5's bathroom did not function. Observation showed that when a single piece of toilet paper was placed against the exhaust fan grille the fan failed to draw the tissue towards the grille.

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During an interview on 05/20/2026 at 3:30 PM Resident 5 stated that they were unaware the bathroom exhaust fan vent was not working.

RESIDENT 7 and RESIDENT 9
Observation on 05/20/2026 at 2:54 PM, showed that the shared bathroom exhaust fan failed to consistently draw and hold a single sheet of tissue paper towards the exhaust fan.

During an interview on 05/20/2026 at 2:54 PM, Resident 7 stated that the failed exhaust fan did not bother them as long as the bathroom did not smell.

Plan/Attestation Statement

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Administrator (or Representative) 6/18/26 Date

WAC 388-78A-2970 Garbage and refuse disposal. The assisted living facility must:

(3) Provide for safe and sanitary collection and disposal of:

(a) Garbage and refuse;

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure adequate garbage containers and kept the area clear of clutter and hazards for 1 of 1 garbage refuse station (Garbage refuse area 1). This placed 77 residents at risk of exposure to hazards and unsafe sanitary conditions.

Findings included...

Review of the facility's undated Characteristics Roster showed that 77 residents resided and received assisted living services at the facility.

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During an interview on 05/20/2026 at 3:30 PM Resident 5 stated that they were unaware the bathroom exhaust fan vent was not working.

RESIDENT 7 and RESIDENT 9
Observation on 05/20/2026 at 2:54 PM, showed that the shared bathroom exhaust fan failed to consistently draw and hold a single sheet of tissue paper towards the exhaust fan.

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure adequate garbage containers and kept the area clear of clutter and hazards for 1 of 1 garbage refuse station (Garbage refuse area 1). This placed 77 residents at risk of exposure to hazards and unsafe sanitary conditions.

Findings included…

Review of the facility's undated Characteristics Roster showed that 77 residents resided and received assisted living services at the facility.

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

Observation during the facility environmental tour on 05/18/2026 at 12:37 PM, showed two large open metal dumpsters unsecured located in the back parking lot. Observation showed that the back parking lot also provided a designated covered area for residents to smoke. Multiple unidentified residents were observed smoking in the back parking lot. Observation showed medication cups, latex gloves, plastic spoons, papers towels on the ground around the garbage containers. Observation showed the back wall area behind the dumpsters was cluttered with broken chairs, wheelchairs, walkers, bath benches, two mattresses, and a couch lined up against the retaining wall.

During an interview on 05/18/2026, Staff G, Floating Maintenance Director, and Staff A, Executive Director, both stated that the disposed items needed to be haul away and disposed of at the local dump.

Observation on 05/20/2026 at 1:30 PM, showed the multiple broken equipment and furniture remained lined up behind the dumpsters against the back retaining wall. Observation showed the area was easily accessible to residents. Observation showed several unidentified Assisted Living Residents utilized the smoking area.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 6/18/26

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must

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Observation during the facility environmental tour on 05/18/2026 at 12:37 PM, showed two large open metal dumpsters unsecured located in the back parking lot. Observation showed that the back parking lot also provided a designated covered area for residents to smoke. Multiple unidentified residents were observed smoking in the back parking lot. Observation showed medication cups, latex gloves, plastic spoons, papers towels on the ground around the garbage containers. Observation showed the back wall area behind the dumpsters was cluttered with broken chairs, wheelchairs, walkers, bath benches, two mattresses, and a couch lined up against the retaining wall.

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Observation on 05/20/2026 at 1:30 PM, showed the multiple broken equipment and furniture remained lined up behind the dumpsters against the back retaining wall. Observation showed the area was easily accessible to residents. Observation showed several unidentified Assisted Living Residents utilized the smoking area.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must

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specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to develop and document monitoring plan and care instructions in the resident's Service Plan for the use of blood thinner for 3 of 4 sampled residents (Resident 1, Resident 4 and Resident 13), the use of injectable medication for 2 of 2 sampled staff (Resident 4 and Resident 6), the use of urinary catheter for 1 of 1 sampled residents (Resident 4), the use of supplemental oxygen for 1 of 1 sampled resident (Resident 8), and the use of medical device for 1 of 2 sampled residents (Resident 13). These failures placed Resident 1, Resident 4, Resident 6, Resident 8, and Resident 13 at risk for unmet care needs.

Findings included…

Review of the facility's undated policy document titled "Supportive Devices" showed that the facility allowed "supportive devices" including side rails to be used as mobility aides and not an intervention to minimize the frequency of falls. The document showed that the use of a supportive device must be documented on the resident's Service Plan (SP). The document showed the facility's staff were responsible for routinely monitoring residents utilizing side rails for continued safety and appropriateness.

Review of the facility's undated documents titled "Care Plan Binders" showed the facility kept the residents' care plans and general caregivers' instructions for some topics that included the use of blood thinning medication and the signs and symptoms of high/low blood sugar.

RESIDENT 13
Observation inside Resident 13's apartment on 05/21/2026 at 9:07 AM showed Resident 13 laid in a hospital bed. Observation showed two metal framed side rails attached from the head of the bed and extended to the mid-way length of the bed, one side rail on each side of the bed. Observation showed the side rail on the left side was in a raised position and close to the wall. Observation showed that the side rail on the right side of the bed was in a raised position, and it was sturdily attached to the bed with less than 2 inches gap between the rail and the mattress. Observation showed a metallic transfer pole (an assisted device for mobility) was mounted to the floor and ceiling, 1.5 foot away from the right side in mid-way of the bed. During the observation, Resident 13 said that they used the side rails to position themselves in bed and they used the transfer pole to transfer in and out of bed every day.

Review of Resident 13's records showed that the facility admitted Resident 13 in [redacted] 2022 with medical diagnoses of [redacted]

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

[redacted]. The records showed that on 10/30/2025, the facility completed an assessment for Resident 13. The assessment showed that Resident 13 used side rails and transfer pole for transferring. The assessment showed that Resident 13 required hands-on assistance with transfers and change in position. The records showed that Resident 13 used Aspirin (a blood thinning medication) once daily.

Review of Resident 13's SP, dated 10/31/2025, showed no documentation that Resident 13 used side rails and transfer pole. There was no documentation that showed who were responsible for assisting Resident 13 with using the side rails and transfer pole daily, and when Resident 13 became unable to use the assisted device independently. There were no instructions provided for the staff on how to maintain and check the safety of the side rails and transfer pole. The SP showed no documentation of the possible side effects from the use of blood thinning medication. There was no documentation on the SP that instructed the care staff to look up the information in the Care Plan Binder.

During an interview on 05/21/2026 at 12:02 PM, Staff I, Licensed Practical Nurse (LPN)/Senior Health Services Director, stated that they completed an assessment of the side rails and transfer pole for Resident 13. Staff I stated that they were unable to locate the care instructions for the side rails and transfer pole on the SP. Staff I stated that they were unsure who were responsible for routinely monitoring the assisted device for continued safety and appropriateness.

RESIDENT 1
Review of Resident 1's records showed that the facility admitted Resident 1 in [redacted] 2022 with a medical diagnosis of [redacted].

Review of the Resident 1's electronic Medication Administration Record (eMAR), dated May 2026, showed that Resident 1 received enteric coated Aspirin 81 milligrams (mg) by mouth once a day for "Blood clot". The eMAR did not provide Medication Technicians (unlicensed staff who dispensed medications) and caregivers with the adverse side effects that they should be aware of for the resident who received routine Aspirin for blood clotting issues.

Review of Resident 1's SP, dated 10/31/2025, showed a diagnosis of [redacted] and [redacted]. The SP was not individualized and did not show information that informed the Medications Technicians and Caregivers of the potential side effects from taking Aspirin daily.

RESIDENT 4
Review of Resident 4's records showed that the facility admitted Resident 4 in [redacted] 2025 with medical diagnoses of [redacted] and [redacted]. The records showed that on 01/02/2026, the facility completed an assessment for Resident 4. The assessment showed that Resident 4 used

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an indwelling urinary catheter (a tube inserted into the bladder to drain urine) and Resident 4 was independent with toileting. The assessment showed Resident 4 required assistance with medication management.

Review of Resident 4's February 2026, March 2026, April 2026, and May 2026 eMAR showed that Resident 4 used Aspirin once daily and insulin (a medication that lowers blood sugar level) injections four times daily.

Observation on 05/20/2026 at 1:40 PM showed a urine drainage bag was fastened to Resident 4's left lower leg. During an interview at this time, Resident 4 stated that they used a urinary catheter every day. Resident 4 stated that they visited the external provider for catheter care every 2 weeks, and the external provider changed the urinary catheter for them.

Review of Resident 4's SP, dated 01/02/2026, showed that the facility's staff was responsible to "observe for signs of complications and notify Home Health or the physician as needed". There was no documentation that showed what the signs of complication were for the care staff to monitor. The SP did not provide any staff instructions for whom to notify and what actions to take in responses to abnormal signs of the urinary catheter. Further review of the SP showed no documentation of the possible side effects from the blood thinning medication and insulin. There were no instructions for care staff about what actions were needed if Resident 4 experienced any side effects. There was no documentation on the SP that instructed the care staff to look up the information in the Care Plan Binder.

During an interview on 05/21/2026 at 12:02 PM, Staff I stated that Resident 4 independently managed their urinary catheter. Staff I stated that the former nurse assessed the resident and completed the SP. Staff I stated that they did not develop a care plan on what to do when the urinary catheter went wrong. During the same interview, Staff I stated that they provided the staff with general care instructions for the blood thinning medications and high and low blood sugar and maintained the care instructions in a "Care Plan Binder". Staff I stated that they did not specify the use of blood thinning medications and diabetic medications for each individual resident.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 08/22/2025, the facility completed an assessment for Resident 6. The assessment showed that Resident 6 did not require assistance with medication administration.

Review of Resident 6's February 2026, March 2026, April 2026, and May 2026 eMARs showed the physician orders of medication included Victoza (a medication that regulates blood sugar) injection subcutaneously (under the skin) every day.

Review of Resident 6's SP, dated 08/22/2025, showed no documentation of the possible

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side effects from the medication for diabetes. There were no instructions for care staff about what actions were needed if Resident 6 experienced any side effects.

RESIDENT 8
Observation and interview on 05/21/2026 at 3:00 PM, showed Resident 8 seated on their recliner chair receiving an oxygen supplement from an oxygen concentrator (a respiratory equipment that supply oxygen) through a nasal cannula (oxygen tubing with two prongs inserted in the nose). Observation showed the oxygen flow rate was set at 3.5 liters per minute. A portable nebulizer machine (a small machine that turns liquid medicine into a mist for which a person can inhale) sat on the floor.

During an interview, Resident 8 stated that they sleep comfortably on a recliner chair. Resident 8 stated that they independently managed their oxygen and nebulizer. Resident 8 stated that they used 3.5 liters per minute of oxygen since they started their oxygen treatment. Resident 8 did not remember seeing staff regularly perform equipment safety checks. Resident 8 stated that they lost oxygen support for a few minutes when the power went off last April. Resident 8 stated that they had no idea what service the facility would do if they were unable to manage their oxygen or during a power outage.

Review of Resident 8's March 2026, April 2026, and May 2026 eMARs showed Resident 8 was diagnosed with [redacted]. The eMARs showed no documentation of a physician's order for oxygen.

Review of Resident 8's records showed a pulmonary outpatient consult summary on 03/19/2025. The summary showed Resident 8's COPD was not "well-controlled; currently smoking contributing". Review of the summary showed Resident 8 experienced an increase in shortness of breath during their lung function test. Resident 8's treatment regimen included supplementary oxygen at two liters per minute. The treatment plan did not show when the oxygen flow rate (the number dialed on the oxygen machine's flow meter) should be adjusted.

Review of Resident 8's "Full Assessment" and "Service Plan", dated 04/30/2026, showed that Resident 8 received oxygen. The SP showed no documentation of the staff's responsibility for management and monitoring of the oxygen equipment, or any guidelines for staff to follow in the event Resident 8 demonstrated signs and symptoms of shortness of breath.

During an interview on 05/20/2026 at 9:01 AM, Staff I stated that Resident 8 was able to report any change of their health condition to the staff. Staff I stated that they were unaware that Resident 8's SP did not document any safety plan and potential complications associated with COPD and long-term use of oxygen therapy.

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Statement of Deficiencies	License #: 2614	Compliance Determination # 77542
Plan of Correction	Renton Assisted Living	Completion Date
Page 20 of 37	Licensee: Greenlake Management Renton, LLC	06/04/2026

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) 7/19/26 .

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

Administrator (or Representative) Susie Dailey Date 6/18/26

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.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure care staff performed hand hygiene when the care staff administered medications for 4 of 4 sampled residents (Resident 3, Resident 5, Resident 9, and Resident 10). The facility failed to dispose contaminated sharps safely for 1 of 1 sampled resident (Resident 6). These failures placed Resident 3, Resident 5, Resident 6, Resident 9, and Resident 10 at risk of contracting infectious illnesses.

Findings included...

Review of the facility's policy document titled "Medication Management", dated 10/22/2025, showed that the facility required their staff to wash hands thoroughly or sanitize hands with alcohol gel when the staff administered medications.

Review of the facility's policy document titled "Policy: Handwashing Procedures", dated 11/11/2024, showed that "all employees must wash their hands before starting work or entering any resident care or medication handling area". The policy document showed that "all employees must wash their hands after removing gloves especially when handling soiled materials". The policy document showed that "all employees must wash their hands after handling or administering medications, although staff are permitted to

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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 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.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure care staff performed hand hygiene when the care staff administered medications for 4 of 4 sampled residents (Resident 3, Resident 5, Resident 9, and Resident 10). The facility failed to dispose contaminated sharps safely for 1 of 1 sampled resident (Resident 6). These failures placed Resident 3, Resident 5, Resident 6, Resident 9, and Resident 10 at risk of contracting infectious illnesses.

Findings included…

Review of the facility's policy document titled "Medication Management", dated 10/22/2025, showed that the facility required their staff to wash hands thoroughly or sanitize hands with alcohol gel when the staff administered medications.

Review of the facility's policy document titled "Policy: Handwashing Procedures", dated 11/11/2024, showed that "all employees must wash their hands before starting work or entering any resident care or medication handling area". The policy document showed that "all employees must wash their hands after removing gloves especially when handling soiled materials". The policy document showed that "all employees must wash their hands after handling or administering medications, although staff are permitted to

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use hand sanitizer in between passing resident medications if not near a hand-washing station, but will do so at their earliest opportunity". The policy document showed that handwashing was required before putting on gloves and after removing gloves, and gloves did not replace the need for hand hygiene.

Review of the facility's policy document titled "Infection Control: Use and Disposal of Sharps", dated 02/15/2024, showed that the facility required all contaminated sharps to be discarded in containers that were closable, puncture resistant, leak proof on sides and bottom, labeled with a biohazard label, and red in color. The document showed that sharps containers should be replaced routinely and not be allowed to overfill.

Review of the Centers for Disease Control and Prevention (CDC) website, titled "Clinical Safety: Hand Hygiene for Healthcare Workers ", (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html), dated 06/02/2026, showed that hand hygiene included handwashing with water and soap and antiseptic hand rub with alcohol-based foam or gel hand sanitizer. The website showed that CDC recommended healthcare personnel to clean hands immediately before touching a patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal.

HAND SANITATION
RESIDENT 3
Observation on 05/21/2025 at 7:48 AM showed Staff K, Licensed Practical Nurse (LPN)/Medication Technician, administered medication for Resident 3 in front of the second floor Medication Room. Observation showed Staff K put on single-use gloves and administered an injection for Resident 3. Observation showed that after Staff K administered the injection for Resident 3, Staff K discarded the injection needle, put away the injection equipment into the medication cart, removed the single-use gloves, and pushed the medication cart to the next resident's apartment. Observation showed Staff K did not wash their hands in a handwashing sink and did not sanitize hands with alcohol gel when they changed gloves, and before and after they administered medication for Resident 3.

RESIDENT 10
Observation on 05/21/2025 at 7:59 AM showed Staff K pushed the medication cart from the second floor Medication Room to the front of Resident 10's apartment. Observation at this time showed Staff C, Resident Care Coordinator, was present at the medication cart and provided guidance on medication administration to Staff K. Observation showed Staff K put on single-use gloves and entered Resident 10's apartment with Staff C. Observation showed that while Staff K was inside Resident 10's apartment, Staff K administered two eye-drop medications and applied topical medication to the lower legs for Resident 10. Observation showed that after Staff K administered the eye-drop and topical medications for Resident 10, Staff K left Resident 10's apartment, put away the containers of medications into the medication cart, removed the single-use gloves, and pushed the medication cart to the next resident's apartment. Observation showed Staff K did not wash their hands in a handwashing sink and did not sanitize hands with alcohol gel when they changed gloves, and before and after they administered medication for Resident 10.

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RESIDENT 5
Observation on 05/21/2025 at 8:05 AM showed Staff K pushed the medication cart from Resident 10's apartment to the front of Resident 5's apartment. Observation showed Resident 5 came out of their room to the hallway. Observation showed Staff K put on single-use gloves and dispensed the oral medication to Resident 5. Observation showed that after Resident 5 took the oral medication, Staff K changed gloves, gathered the blood sugar testing equipment, pricked the resident's finger, collected a blood drop, and performed the blood sugar test for Resident 5. Observation showed that after Staff K administered the blood sugar test, Staff K placed an unused needle on an injection pen, dialed the injection units on the injection pen, and administered the injection for Resident 5. Further observation showed Staff K put away the injection equipment into the medication cart, removed the single-use gloves, and pushed the medication cart to the next resident's apartment. Observation showed Staff K did not wash their hands in a handwashing sink and did not sanitize hands with alcohol gel when they changed gloves, and before and after they administered medication for Resident 5.

During an interview on 05/21/2025 at 8:35 AM, Staff K stated that they were familiar with the procedures for medication administration and hand sanitation. Staff K stated that they did not wash hands and sanitize hands when they administered medication to the residents. Staff K stated that they did not follow the required medication administration and hand sanitation procedures.

RESIDENT 9
Observation on 05/21/2026 at 8:14 AM, showed Staff L, Medication Technician/Caregiver wore single-used gloves and gathered Resident 9's blood sugar testing equipment. Staff L pricked Resident 9's finger and had an error message on the glucometer (a device that measures and shows the amount of sugar in a blood sample). After three failed attempts at correct readings, Staff L was able to get Resident 9's blood sugar test results. With the same gloved hands, Staff L dialed the base dose units of fast acting insulin (injectable medication) on the injection pen and an additional dose as ordered on the physician established sliding scale. Staff L administered the insulin injection for Resident 9. Observation showed Staff L discarded the used needle from the injection pen and with the same gloves dispensed oral medications for Resident 9. Staff L did not sanitize or wash their hands between tasks.

Observations on 05/21/2026 between 8:20 AM and 8:59 AM showed Staff L tested blood sugar level and administered an insulin injection to one unidentified resident. Observation showed Staff L wore different gloves to prepare and dispense medication for the next unidentified resident. Observation showed Staff L did not sanitize or wash their hands when they changed gloves.

During an interview on 05/21/2026 at 9:04 AM, Staff L stated that they were trained on proper hand hygiene practices. Staff L stated that they were aware to sanitize or wash their hands each time they provided medication services. Staff L stated they forgot to wash their hands after they removed their gloves.

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DISPOSAL of CONTAMINATED SHARPS
RESIDENT 6
Observation inside Resident 6's apartment on 05/21/2026 at 10:55 AM showed no sharps container, labeled with a biohazard label, present anywhere in the apartment. During an interview at this time, Resident 6 stated that they independently used needles to self-administer injections every day. Resident 6 stated that the facility did not provide them with a sharps container. Resident 6 stated that they discarded their used needles into a glass container. Resident 6 stated that their glass container was small and easily overfilled. Resident 6 stated that when they turned in the glass container filled up with used needles to the facility, the facility refused to dispose of the sharps for them. Resident 6 stated that they needed a sharps container.

During an interview on 05/21/2026 at 12:02 PM, Staff I, LPN/Senior Health Services Director, stated that they were aware of the infection prevention requirements for sharps disposal. Staff I stated that they were unaware Resident 6 was not provided with a sharps container.

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) [signature] Date 6/18/26

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

(f) Make sure first-aid supplies are appropriate for:

(i) The size of the assisted living facility;

(ii) The services provided;

(iii) The residents served; and

(3) The assisted living facility's emergency preparedness plan must include procedures for:

(f) Provision of essential resident needs and supplies, including water, food, medications, and personal care items; and

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DISPOSAL of CONTAMINATED SHARPS
RESIDENT 6
Observation inside Resident 6's apartment on 05/21/2026 at 10:55 AM showed no sharps container, labeled with a biohazard label, present anywhere in the apartment. During an interview at this time, Resident 6 stated that they independently used needles to self-administer injections every day. Resident 6 stated that the facility did not provide them with a sharps container. Resident 6 stated that they discarded their used needles into a glass container. Resident 6 stated that their glass container was small and easily overfilled. Resident 6 stated that when they turned in the glass container filled up with used needles to the facility, the facility refused to dispose of the sharps for them. Resident 6 stated that they needed a sharps container.

During an interview on 05/21/2026 at 12:02 PM, Staff I, LPN/Senior Health Services Director, stated that they were aware of the infection prevention requirements for sharps disposal. Staff I stated that they were unaware Resident 6 was not provided with a sharps container.

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Administrator (or Representative) Date

WAC 388-78A-2700 Emergency and disaster preparedness.

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(a) Maintain the premises free of hazards;

(f) Make sure first-aid supplies are appropriate for:

(i) The size of the assisted living facility;

(ii) The services provided;

(iii) The residents served; and

(3) The assisted living facility's emergency preparedness plan must include procedures for:

(f) Provision of essential resident needs and supplies, including water, food, medications, and personal care items; and

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This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have a system in place to ensure that 4 of 4 emergency water tanks (Tank 1, Tank 2, Tank 3, and Tank 4) were readily accessible for residents in an emergency. The facility failed to ensure that 1 of 1 Maintenance room, housekeeping room, and 1 of 3 medications rooms were secured. The facility failed to ensure first aid kits were readily available for use. This placed 77 residents at risk of harm.

Findings included…

Review of the facility's undated Emergency/Disaster manual did not show instructions for emergency water.

Review of the facility's undated Characteristics Roster showed that 77 residents resided and received assisted living services at the facility. The characteristics roster identified ten residents with mental health issues and eight residents with cognitive impairment.

EMERGENCY WATER
Observation and interview on 05/20/2026 at 2:30 PM, showed Staff G, Floating Maintenance Director and Staff A, Executive Director, attempted to access the facility's emergency hot water located on the first floor behind a locked door marked boiler room. Observation showed that Staff G and Staff A did not have a key to access the room. Staff A stated they would go to the front office to get the key. Observation showed Staff A returned without a key and stated they did not know where the key was. Observation showed Staff G popped open the door lock with a flathead screwdriver to gain access to the room. Observation showed four 100-gallon hot water tanks with valves at the bottom of each tank. There were no instructions provided for staff on how to access the water from the tank. There were no hoses or containers to collect the water. Staff G stated that there should be hoses and buckets to collect the water if needed.

During an interview on 05/20/2026 at 2:20 PM, Staff M, Food Service Director, stated that they did not keep emergency water or bottled water in the kitchen.

During an interview on 05/20/2026 at 2:35 PM, Staff A stated that Staff N, Senior Executive Director, said residents would use individual toilet tank reservoirs for emergency drinking water.

Observation 05/20/2026 at 3:50 PM, showed the toilet reservoir tanks in apartment 306 contained water with black floating particles that resembled mold.

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During an interview on 05/20/2026 at 3:50 PM, Resident 12 and Resident 14 both stated that they would only drink the water from the toilet tank reservoir if they boiled the water first in the microwave. Resident 12 and Resident 14 both said they would only drink the water from the toilet tank reservoir in a case of emergency after the water was boiled in the microwave. Resident 12 and Resident 14 both said that if the electrical power was out, they would not drink the water from the toilet unless there was some way to boil it.

UNSECURED ROOMS
MAINTENANCE ROOM
Observation and interview during the facility environment tour on 05/18/2026 between 11:45 AM and 2:00 PM, showed the door to the third-floor maintenance, electrical room, and storage room was unlocked. Observation showed three large rooms without doors that contained large electrical panels with switches mounted to the wall, paint, chemicals, multiple hardware supplies, and multiple tools. Staff G stated they just exited the room to conduct the facility tour. Staff G stated the door was normally locked. The room also provided access to the facility roof fire escape hatch. Observation showed a ladder located in the unlocked maintenance room that led to the roof access door which was observed to be wide open which allowed for unrestricted access to the roof.

During an interview on 05/18/2026 at 11:45 AM, Staff G stated that the maintenance door was to always remain locked to prevent unauthorized access to the room and the roof.

MEDICATION ROOM
Observation on 05/18/2026 at12:05 PM, showed the second-floor medication room located at the center of where three hallways intersected was unlocked. No facility staff were observed in the vicinity. Observation showed an unsecured refrigerator filled with prescription and over the counter medications inside of the medication room. Observation showed the refrigerator contained injectables and eyedrops along with other medications. Observation showed multiple unidentified Assisted Living residents ambulating about the hallway in front of the medication room. Observation at 3:15 PM showed the second-floor medication room was propped wide open. No staff were present. Unidentified Assisted Living Residents were observed walking back and forth past the open medication room. Observation showed that at 3:11 PM, Staff I, Senior Health Services Director, walked down the hallway past the opened medication room and entered the stairwell. At the Department Representative’s request Staff I turned and secured the medication room.

RECORDS AND OXYGEN ROOM
Observation on 05/18/2026 at 12:14 PM, showed that a third-floor storage room located next to the main laundry and common bathroom was unlocked. The first room was filled with boxes of facility records. A second room was observed inside of the first room labeled Oxygen room. The door was closed with a key attached to a chain that was fastened to the entry door and was inserted in the lock. The oxygen room contained multiple oxygen tanks.

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HOUSEKEEPING ROOM
Observation on 05/18/2026 at 12:09 PM, showed a third-floor housekeeping room was unlocked. Observation showed multiple chemicals in the room which included glass cleaner, Surface cleaner, and other cleaning products.

During an interview on 05/18/2026 at 12:09, Staff A and Staff N, Senior Executive Director, stated that the doors to the records storage room, oxygen room and housekeeping room should be locked.

FIRST AID KITS
Observation on 05/18/2026 at 12:48 PM during the facility environmental tour showed no first aid kits were readily available for use.

During an interview on 05/18/2026 at 12:48 PM, Staff A stated that there was a first aid kit locked up in each medication cart, in the medication rooms, and in the business office. Staff A stated that there were no first aid kits readily available in an unlocked area.

Plan/Attestation Statement

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Administrator (or Representative) 6/18/26 Date

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

(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:

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HOUSEKEEPING ROOM
Observation on 05/18/2026 at 12:09 PM, showed a third-floor housekeeping room was unlocked. Observation showed multiple chemicals in the room which included glass cleaner, Surface cleaner, and other cleaning products.

During an interview on 05/18/2026 at 12:09, Staff A and Staff N, Senior Executive Director, stated that the doors to the records storage room, oxygen room and housekeeping room should be locked.

FIRST AID KITS
Observation on 05/18/2026 at 12:48 PM during the facility environmental tour showed no first aid kits were readily available for use.

During an interview on 05/18/2026 at 12:48 PM, Staff A stated that there was a first aid kit locked up in each medication cart, in the medication rooms, and in the business office. Staff A stated that there were no first aid kits readily available in an unlocked area.

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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:

(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:

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

Based on observation, interview, and record review, the facility failed to ensure that 4 of 4 sampled pets (Pet 1, Pet 2, Pet 3, and Pet 4) remained current with their required examinations and certified to be free of diseases transmittable to humans. These failures placed 77 residents at risk of infectious diseases.

Findings included…

Review of the facility's policy titled "Pet Policy," dated 12/15/2024, showed that the facility followed the Washington Administrative Code (WAC). The policy showed that the resident was required to provide an initial and annual examination and a written veterinarian certification that the pet was free from diseases transmittable to humans. The policy showed that the resident was responsible for maintaining their pets or arranging for alternate care as needed.

Review of the facility's Disclosure of Services showed that the facility permitted pets to live on the premises with the conditions stated in their pet policy.

Review of the facility's undated Resident Characteristic Roster showed that the facility provided care and services to 77 residents.

PET 1
Review of the records showed no documentation that Pet 1 (dog) had received a regular examination of health in 2024 and 2025. Pet 1 records showed no initial or current veterinarian certificate that verified they were free of diseases transmittable to humans.

PET 2
Review of Pet 2 (service dog) records showed no initial or current veterinarian certificate that verified they were free of diseases transmittable to humans.

PET 3
Review of the records showed no documentation that Pet 3 (cat) had received a regular examination of health in 2024 and 2025. Pet 3 records showed free of disease certification in 2021. Pet 3 records showed no current veterinarian certificate that verified they were free of diseases transmittable to humans.

PET 4
Review of the records showed no documentation that Pet 4 (dog) had received a regular examination of health in 2025 and 2026. Pet 4 records showed no current veterinarian certificate that verified they were free of diseases transmittable to humans.

Observation on 05/20/2026 at 2:56 PM showed animal feces on the floor, in front of the television. During an interview at this time, Resident 8 stated they were responsible for

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Pet 4. Resident 8 stated they will take care of Pet 4's waste later.

During an interview on 05/21/2026 at 11:10 AM, Staff A, Executive Director, stated that they were temporarily responsible for maintaining the pet records. Staff A stated that one pet was scheduled for a health examination. Staff A stated they were unable to thoroughly review the records.

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) 6/18/26 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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to integrate the resident's care needs for medication management assessed by the Department's case manager for 1 of 8 sampled residents (Resident 6). This failure placed Resident 6 at risk for unmet care needs.

Findings included...

Review of Resident 6's records showed that the facility admitted Resident 6 in

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Pet 4. Resident 8 stated they will take care of Pet 4's waste later.

During an interview on 05/21/2026 at 11:10 AM, Staff A, Executive Director, stated that they were temporarily responsible for maintaining the pet records. Staff A stated that one pet was scheduled for a health examination. Staff A stated they were unable to thoroughly review the records.

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 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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to integrate the resident's care needs for medication management assessed by the Department's case manager for 1 of 8 sampled residents (Resident 6). This failure placed Resident 6 at risk for unmet care needs.

Findings included…

Review of Resident 6's records showed that the facility admitted Resident 6 in

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[redacted] 2024. The records showed Resident 6's medical diagnoses included [redacted], and [redacted] The records showed that Resident 6 received prescriptions of oral medication, nasal spray, and injections. The records showed that on 08/22/2025, the facility completed an assessment for Resident 6. The assessment showed that Resident 6 self-administered all medications, and Resident 6 did not require assistance with medication administration.

Review of the Department of Social and Health Services' (DSHS) "Assessment Details-Initial" dated 12/20/2024, "Assessment Details-Interim" dated 09/12/2025, "Assessment Details-Interim" dated 04/17/2025, and "Assessment Details-Annual" dated 11/30/2025, showed that the Department's case manager completed four assessments for Resident 6 since they were admitted to the facility. The documents showed that when the facility admitted Resident 6 in [redacted] 2024, the Department's case manager completed an initial assessment for Resident 6. The Department's initial assessment showed that Resident 6 required assistance with medication administration. The document showed that Resident 6 forgot to take medications and Resident 6's ability of self-administration of medication fluctuated. The Department's Interim and Annual assessments showed that Resident 6 required medication assistance with medication administration.

During an interview on 05/21/2026 at 10:55 AM, Resident 6 stated that they experienced blackouts infrequently. Resident 6 stated that they sometimes forgot to take their medication. Resident 6 stated that they required reminder assistance with medication administration.

Review of Resident 6's Service Plan (SP), dated 08/22/2025, showed that Resident 6 self-administered all medications. The SP showed that the facility's staff was responsible for reordering the medications, and the facility's nurse was responsible for "overseeing Resident 6's self-medication". The SP did not show any staff instructions for what assistance the care staff provide in support of self-medication administration. The SP did not show any staff instructions for what assistance the care staff provide to address resident care needs for medication administration.

During an interview on 05/21/2026 at 12:02 PM, Staff I, Licensed Practical Nurse (LPN)/Senior Health Services Director, stated that the former nurse completed the last SP for Resident 6. Staff I stated that they were unaware of Resident 6's medication administration needs assessed by the DSHS' case manager. Staff I stated that they were unable to locate additional care instructions in the SP regarding Resident 6's medication management.

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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) 7/19/26 .

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

Administrator (or Representative) [signature] Date 6/18/26

WAC 388-78A-2170 Required assisted living facility services.

(2) The assisted living facility must provide each resident with the following basic services, consistent with the resident's assessed needs and negotiated service agreement:

(b) Housekeeping - Providing a safe, clean and comfortable environment for each resident, including personal living quarters and all other resident accessible areas of the building;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide 1 of 1 sampled resident (Resident 8) with a clean, comfortable living environment in their personal apartment. This failure placed the resident at risk for diminished quality of life by living in unsanitary condition.

Findings included...

Review of the facility's Disclosure of Services showed that the facility provided light housekeeping services once a week, unless indicated in the resident's negotiated service agreement.

Review of Resident 8's WA Health and Service Evaluation Results, equivalent to an assessment dated 04/30/2026, included environmental safety issues related to dog urine and feces. Resident 8 was assessed and needed staff assistance with all housekeeping tasks.

Review of Resident 8's Negotiated Service Agreement, known as Service Plan Detail (SP), dated 04/30/2026, showed that Resident 8 was independent with toileting. Review of the SP showed Resident 8 required total assistance with housekeeping from care staff. The SP showed that Resident 8 refused housekeeping staff to do housekeeping

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide 1 of 1 sampled resident (Resident 8) with a clean, comfortable living environment in their personal apartment. This failure placed the resident at risk for diminished quality of life by living in unsanitary condition.

Findings included…

Review of the facility's Disclosure of Services showed that the facility provided light housekeeping services once a week, unless indicated in the resident's negotiated service agreement.

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tasks due to "trust issues." The SP showed Resident 8 had a pet, and care staff assisted with pet care as needed.

Observation on 05/20/2026 at 2:50 PM showed an unidentified housekeeper came out from another resident's apartment across from Resident 8's apartment. The housekeeper asked if they could go inside Resident 8's apartment with the Department staff. The housekeeper stated that Resident 8 sometimes refused their apartment cleaned. Observation showed Resident 8 seated on a recliner chair in front of a television, covered in a blanket. The odor inside Resident 8's apartment was pungent and intensely strong. Observation showed formed fecal waste near Resident 8's recliner, as well as food crumbs and wrappers on the floor. Observation showed dark fecal waste marks on the toilet seat and feces on the bathroom floor. Observation showed Resident 8 allowed the housekeeper cleaned their apartment. During an interview at this time, Resident 8 stated that there was dog fecal waste on the floor. Resident 8 stated that they were unable to get to the bathroom on time that morning, and their feces ended up on the floor. Resident 8 was unaware of the fecal smear they left on the toilet seat. Resident 8 stated they called for clean-up and no staff came. Resident 8 stated that it was hard for the facility to maintain good housekeepers.

Observation on 05/21/2026 at 9:20 AM showed Staff K, Licensed Practical Nurse knocked on the open door of Resident 8's apartment and announced Resident 8's medication for the morning. Staff C, Resident Care Coordinator, accompanied Staff K inside Resident 8's apartment. Resident 8 sat on the recliner chair. Observation showed fecal waste on the floor near where the resident sat. Observation showed traces of feces on the toilet seat.

During an interview on 05/21/2026 at 1:24 PM, Staff A, Executive Director, stated that they supervised the housekeepers. Staff O, Director of Operations-West, stated that if Resident 8 were unable to independently manage their dog, Resident 8 may arrange for alternative pet care.

Plan/Attestation Statement

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Jessie Dowd — Administrator (or Representative)

6/18/26 — Date

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Observation on 05/21/2026 at 9:20 AM showed Staff K, Licensed Practical Nurse knocked on the open door of Resident 8’s apartment and announced Resident 8’s medication for the morning. Staff C, Resident Care Coordinator, accompanied Staff K inside Resident 8’s apartment. Resident 8 sat on the recliner chair. Observation showed fecal waste on the floor near where the resident sat. Observation showed traces of feces on the toilet seat.

During an interview on 05/21/2026 at 1:24 PM, Staff A, Executive Director, stated that they supervised the housekeepers. Staff O, Director of Operations-West, stated that if Resident 8 were unable to independently manage their dog, Resident 8 may arrange for alternative pet care.

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Administrator (or Representative) Date

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WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 sampled staff (Staff A) completed a Washington State Name and Date of Birth Background Inquiry every two years. This failure placed 77 residents at risk for potential abuse, neglect, or exploitation from a staff person with an unknown background check.

Findings included…

Review of the facility's undated Resident Characteristic Roster showed the facility provided care and services to 77 residents.

Review of the facility's undated employee list, showed that the facility hired Staff A, Executive Director, on 07/31/2023 in a different role.

Review of Staff A's facility personnel records showed that Staff A started their role as Executive Director on 01/09/2026. Review of the records showed a previous Washington State Name and Date of Birth (WNDOB) background inquiry (BGI) was completed on 07/31/2023. The initial WNDOB BGI expired on 07/31/2025. The records showed that the facility completed Staff A's WNDOB BGI on 09/19/2025, 50 calendar days after the initial BGI expired.

During an interview on 05/19/2026 at 12:54 PM, Staff A stated that their two-year WNDOB BGI was submitted late.

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Administrator (or Representative) Jessie Davis Date 6/18/26

WAC 388-78A-2210 Medication services.

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure safe medication systems were implemented when controlled medications were not accounted for in 4 of 4 (First floor Controlled Drug Administration Log 1 and 2 and Second floor Controlled Drug Administration Log 1 and 2) Controlled Drug Administration binders for residents with prescribed controlled medications. The facility failed to ensure medications were properly stored for 1 of 1 unidentified resident. The facility failed to follow and discontinue a medication order as prescribed by the physician for 1 of 1 resident (Resident 14). These failures placed residents on prescribed controlled medications at risk of financial exploitation and residents receiving medication management services at risk for harm and medication errors.

Findings included...

Review of the facility's policy titled "Medication Management," revised 10/22/2025, showed that the facility maintained an effective and safe medication and treatment administration system. The policy showed that any change of a resident's medication regimen required communication between the resident or responsible party and the community staff. The policy showed that medications were dispensed according to the prescribed physician orders.

Review of the facility's policy titled, "Managing Controlled Medications," revised

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Administrator (or Representative) Date

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Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure safe medication systems were implemented when controlled medications were not accounted for in 4 of 4 (First floor Controlled Drug Administration Log 1 and 2 and Second floor Controlled Drug Administration Log 1 and 2) Controlled Drug Administration binders for residents with prescribed controlled medications. The facility failed to ensure medications were properly stored for 1 of 1 unidentified resident. The facility failed to follow and discontinue a medication order as prescribed by the physician for 1 of 1 resident (Resident 14). These failures placed residents on prescribed controlled medications at risk of financial exploitation and residents receiving medication management services at risk for harm and medication errors.

Findings included…

Review of the facility’s policy titled "Medication Management," revised 10/22/2025, showed that the facility maintained an effective and safe medication and treatment administration system. The policy showed that any change of a resident's medication regimen required communication between the resident or responsible party and the community staff. The policy showed that medications were dispensed according to the prescribed physician orders.

Review of the facility’s policy titled, “Managing Controlled Medications," revised

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02/15/2024, showed that the facility accounted for and handled controlled medications in accordance with federal and state regulations and its accepted standards of practice. The policy showed two staff, a shift supervisor or medication technician (MT), counted, verified, and signed controlled medications at the beginning and end of each shift daily.

MISSING SIGNATURES IN CONTROLLED DRUG ADMINISTRATION LOG

Observation on 05/19/2026 between 10:54 AM and 11:20 AM, showed the facility had three floors, and each floor was designated with two mobile medication carts. Each medication cart had its own controlled drug (drugs or any other substance that is tightly controlled by the government because of the risk of misuse and dependence) administration log, kept in the lock box of the cart. Observation showed the controlled medication lock boxes contained multiple single-dose/blister-pack medication cards (a card that packages doses of medications within small, clear-resistant plastic bubbles) and bottles for different residents.

Review of the facility's March 2026, April 2026, and May 2026 controlled drug daily count records showed there were three shifts for each day of the month. Review of the logs showed there were 77 missing signatures for outgoing shifts and 58 missing signatures for the incoming shifts.

During an interview at the time of the observation, Staff L, Medication Technician/Caregiver (MT, nurse delegated staff to deliver, assist, or administer medications), stated that they signed the controlled daily count record in every shift they worked. Staff L stated that maybe some of the missing signatures had come from MTs who worked two (double) shifts on the same day and did not call another staff to count or that staff simply forgot to sign.

During an interview on 05/19/2026 at 12:01 PM, Staff I, Senior Health Services Director stated that the missing signatures may have been from MTs who worked double shifts on the same day.

MEDICATIONS NOT PROPERLY STORED

Observation on 05/19/2026 at 11:56 AM showed that one of the first floor medication cart drawers contained one medication cup filled with six oral medications. The medication cup was not labeled with any resident's name, medication names and dose. Staff L was unable to identify who the medications were for or what medications were in the cup.

During an interview at the time of the observation, Staff L stated that they were responsible for the medication services for residents on the first floor. Staff L stated that they were unaware about the prepared medications inside the medication cup.

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MEDICATION ORDER CHANGE

Observation on 05/21/2026 at 9:30 AM, showed Staff K, Licensed Practical Nurse (LPN)/Medication Technician), dispensed and delivered medications to Resident 15's room. Resident 15 asked if their blood pressure medications were in the cup. Resident 15 refused to take their medications unless Staff K removed the medicine for blood pressure. Resident 15 stated that they came back from the hospital late last night. Resident 15 stated that one of the blood pressure medications was discontinued at the hospital and gave the after visit summary to the facility nursing staff. Resident 15 stated that the blood pressure medication made their mouth swollen. Observation showed Staff K and Staff C, Resident Care Coordinator checked Resident 15's electronic Medication Administration Record (eMAR). The eMAR showed that the medication was not discontinued.

Review of the hospital discharge visit summary, dated [redacted]/2026, showed a medication instruction. The new order showed that Resident 15 should not restart the angiotensin converting enzyme inhibitor (medication that lowers blood pressure) due to an allergic reaction. The instruction included that the primary physician ordered a different type of blood pressure medication.

During an interview on 05/21/2026 at 10:20 AM, Staff I, stated that they were unable to check any visit summary received from last night. Observation showed Staff I found Resident 15's visit summary from the stack of papers and went over the summary. Staff I stated that the medication change was not made.

This is a recurring deficiency previously cited on 09/08/2025, 07/17/2025, and 10/11/2024.

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WAC 388-78A-2540 Administrator requirements. The licensee must ensure the assisted living facility administrator:

(1) Meets the training requirements under chapter 388-112A WAC; and

(3) Meets the administrator qualification requirements referenced in WAC 388-78A-2520 through 388-78A-2527 .

This requirement was not met as evidenced by:

Based on interview and record review, the Licensee failed to ensure 1 of 1 sampled staff (Staff A, Executive Director) met the Washington State qualifications and requirements to be an assisted living facility (ALF) administrator. This failure placed 77 residents at risk for unmet care needs by an untrained and unqualified staff.

Findings included…

NOTE: RCW 74.39A.009 Definitions. (12) “Direct care worker” means a paid caregiver who provides direct, hands-on personal care services to persons with disabilities or the elderly requiring long-term care.

Review of the facility’s undated Resident Characteristic Roster showed that the facility provided care and services to 77 residents.

Review of the facility’s staff records showed that Staff A was hired on 07/31/2023. The records showed that Staff A completed the Washington Home Care Aide (HCA) Core Basic Curriculum. Review of the records showed Staff A did not obtain their HCA credentials and had less than three years of paid experience providing direct care or managing persons who provided direct care to vulnerable adults.

During an interview on 05/19/2026 at 12:51 PM, Staff A stated that they became the facility’s administrator on 01/09/2026. Staff A stated that they did not have any HCA certification or credentials. Staff A stated that they were unaware that they did not meet the qualifications for the administrator upon hire.

During an interview on 05/19/2026 at 12:56 PM, Staff N, Senior Executive Director, stated that they hired Staff A based on their cumulative experience managing staff who cared for vulnerable adults, either directly or indirectly.

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