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

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

RE: Renton Assisted Living License # 2614

Dear Administrator:

This letter addresses Compliance Determination(s) 34373 (Completion Date 12/27/2023) and 28074 (Completion Date 09/15/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/27/2023 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2930-1-a-ii, WAC 388-78A-2930-1-a-iii, WAC 388-78A-2930-1-a-i, WAC 388-78A-2930-1-a, WAC 388-78A-2930-1-b, WAC 388-78A-2930-1-b-i, WAC 388-78A-2930-1-b-ii

The Department staff who did the on-site verification:
Harrison Udoye, Community Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Renton Assisted Living
Provider Type: Assisted Living Facility
License/Cert.#: 2614
Compliance Determination #: 28074
Intake ID: 93255
Investigator: Harrison Udoye
Region/Unit #: RCS Region 2 / Unit D
Investigation Date(s): 08/15/2023 through 09/15/2023
Complainant Contact Date(s): 09/06/2023

Allegation(s):

1) Provision of calling system (pendant)
2) House Keeping

Investigation Methods:

Sample:
Total residents: 115
Resident sample size: 3
Closed records sample size: 1

Observations:
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Kitchen

Interviews:
Identified staff
Nursing staff
Residents
Family members
Maintenance staff
Housekeeping staff
Staff development coordinator

Record Reviews:
Medical records
Incident investigation
Facility policies
Staff training records
Staff patterns
Maintenance logs
State reporting log

Investigation Summary:

1) Report of facility not providing Named Resident with communication system in the Assisted Living Facility (ALF).
Interview showed that facility staff failed to provide Resident a communication system (pendant) to call for assistance when needed upon admission on [redacted]/2023. Facility staff did not provide pendant to the Resident after the first fall on 08/03/2023. Resident also had another fall on 08/06/2023, hospitalized and passed on [redacted]/2023. Failed practice identified. Citation issued.

2) Housekeeping in the ALF.
Observation and interview showed that the room was not properly prepped for a new Resident to move in. The ceiling paint was unevenly matched, the window seal had duct tape all over it. Facility staff stated that maintenance person was let go from employment before completion of the room project and admission of the Named Resident. Failed practice identified. The facility was previously cited. No new citation issued since facility was still in their plan of correction period.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Renton Assisted Living
Provider Type: Assisted Living Facility
License/Cert.#: 2614
Compliance Determination #: 28074
Intake ID: 93207
Investigator: Harrison Udoye
Region/Unit #: RCS Region 2 / Unit D
Investigation Date(s): 08/15/2023 through 09/15/2023
Complainant Contact Date(s): 09/06/2023

Allegation(s):

1) Provision of calling system (pendant)
2) House Keeping

Investigation Methods:

Sample:
Total residents: 115
Resident sample size: 3
Closed records sample size: 1

Observations:
Residents
Activities
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Identified staff
Nursing staff
Family members
Residents
Housekeeping staff
Maintenance staff
Staff development coordinator

Record Reviews:
Medical records
State reporting log
Incident investigation
Facility policies
Personnel files
Staff training records

Investigation Summary:

1) Facility did not provide Named Resident with communication system in the Assisted Living Facility (ALF).
Interview showed that facility staff failed to provide Resident a communication system (pendant) to call for assistance when needed upon admission on [redacted]/2023. Facility

staff did not provide pendant to the Resident after the first fall on 08/03/2023. Resident also had another fall on 08/06/2023, hospitalized and passed on [redacted]/2023. Failed practice identified. Citation issued.

2) Housekeeping in the ALF.
Observation and interview showed that the room was not properly prepped for a new Resident to move in. The ceiling paint was unevenly matched, the window seal had duct tape all over it. Facility staff stated that maintenance person was let go from employment before completion of the room project and admission of the Named Resident. Failed practice identified. The facility was previously cited. No new citation issued since facility was still in their plan of correction period.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site complaint investigation on 08/15/2023, 08/15/2023 and 08/15/2023 of:

Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

This document references the following complaint number(s): 93255, 93207

The following sample was selected for review during the unannounced on-site visit: 3 of 115 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Harrison Udoye, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Laurie Anderson — Residential Care Services

09/21/2023 — 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: 10/12/2023

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to investigate an incident for 1 of 2 sampled residents (Resident 1) after an unwitnessed, injury fall. This failure placed Resident 1 at risk of harm, bodily injury, and possible death.

Findings included...

Review of the facility's undated document titled "Internal Incident Report" showed that on 08/03/2023 at 8:00 AM, Resident 1 fell in the common bathroom, on the first floor of the facility. The document showed Resident 1 sustained multiple abrasions and a cut to their forehead. The document showed facility staff immediately assisted Resident 1. Staff called 911 for medical treatment. Emergency Medical Services (EMS) transported Resident 1 to the hospital for further evaluation. The document also showed that facility staff did not administer first aid to Resident 1 while they waited for EMS to arrive.

Review of facility's document titled "Charting Notes", dated 08/29/2023, showed that on 08/03/2023 at 12:20 PM, Staff H, Medication Tech, documented Resident 1's fall with description of the condition of the of Resident 1. Staff H documented that Resident 1 was bleeding from a cut on the forehead. Staff H documented that 911 was called. Further review of the notes showed that on 08/04/2023 at 4:38 PM, Staff B, Former Health Service Director, made a "late entry". The late entry documented that on 08/03/2023 at 6:40 PM, Resident 1 returned to the facility with four to five stitches on the right side of the forehead. Additional review of the notes showed that on 08/06/2023 at 4:04 AM, Staff E, Medication Tech, documented that Resident 1 fell out of bed, hit their right hip and knee. Staff E documented that they called emergency services 911. Staff E documented they left a voice message for the family. Staff E documented that at the time of the incident, Resident 1 had no Primary Care Provider (PCP) listed on file.

Review of facility's undated resident records identified Resident 1 with a history of falls.

There was no documentation in the records after the initial fall on 08/03/2023 that showed the facility completed an assessment to determine possible cause for the fall or determine if there were any changes in Resident 1's condition. There was no documentation the facility implemented any measures to prevent possible recurrence.

During an interview on 08/15/2023 at 12:02 PM, Staff A, Former Executive Director, stated that they were unaware of the incident. Staff A stated that they were out of the facility at the time of the incident. Staff A stated that they recalled speaking with Resident 1's representative. Staff A was unable to recall specifically what the conversation was about.

During an interview on 08/15/2023 at 1:01 PM, Staff C, Former Nurse Specialist Director, stated that they were unaware of the incident. Staff C stated that they were unsure why facility staff did not complete an incident report with a plan of care addendum after the initial fall on 08/03/2023.

During an interview on 09/06/2023 at 12:11 PM Staff D, Former Resident Care Coordinator (RCC), stated that they were instructed to write an incident report for Resident 1's fall on 08/06/2023. Staff D stated that since they were not present when the incident happened, they did not write the report.

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) 10/30/2023

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

Sherry Su-Tomm — Administrator (or Representative)

10/17/2023 — Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(ii) Resident living rooms and resident sleeping rooms; and

(iii) Corridors, as well as common and outdoor areas accessible to residents.

(b) Provide the resident with personal wireless communication devices, such as pendants or

wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

(ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to provide 1 out of 3 sampled residents (Resident 1) with a means to summon for staff assistance. This failure placed Resident 1 at risk of harm, injury, and unmet care needs.

Findings included...

On 08/15/2023 at 2:20 PM, observation of three sampled residents showed that two out of the three residents, Resident 2 and Resident 3, wore a call pendent. Resident 1 passed on [redacted]/2023 so unable verify if Resident 1 wore a call pendant.

During an interview on 08/15/2023 at 12:02 PM, Staff A, Former Executive Director, stated that upon admission, all residents should receive a pendant to able to call facility staff for help. Staff A stated that they were unaware that Resident 1 did not receive a pendant when Resident 1 admitted to the facility on [redacted]/2023.

During an interview on 08/15/2023 at 1:01 PM, Staff C, Former Nurse Specialist/Delegator, stated that per report received, Staff B, Former Director of Nursing, requested Staff D, Former Resident Care Coordinator, provide Resident 1 with a pendant after the initial fall on 08/03/2023. The report noted that Staff D stated they were too busy when Resident 1 admitted to the facility, and when Resident 1 experienced their first fall, to give Resident 1 a pendant.

During an interview on 09/06/2023 at 12:11 PM Staff D, Former Resident Care Coordinator (RCC), stated that the facility was out of pendants. Staff D stated that they emailed Staff F, Marketing Director, to send the names of residents that needed a new pendant or a replacement pendant. Staff D stated they never received any reply. Staff D denied that they stated they were too busy to provide Resident 1 a pendant. Staff D acknowledged that they were short staffed which delayed the completion of some tasks and provision of the pendant to Resident 1.

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) 10/30/2023

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

Administrator (or Representative)

10/17/2023
Date