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) 60898 (Completion Date 06/10/2025) and 57515 (Completion Date 04/25/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/10/2025 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-2660-7, WAC 388-78A-2660-2

The Department staff who did the on-site verification:
Karri Hernandez, Community Complaint Investigator

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

Sincerely,

Laurie Anderson

Laurie Anderson, Community 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 #: 57515
Investigator: Harrison Udoye
Investigation Date(s): 03/25/2025 through 04/25/2025
Complainant Contact Date(s):

Intake ID: 174028
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):
Neglect: lack of care that resulted in injury

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 2 Closed records sample size: 0
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Social services staff
Record Reviews:	Medical records Hospital records Hospital records State reporting log Incident investigation

Investigation Summary:
Reviewed intake, interviewed relevant parties, reviewed documents, made relevant observations. Failed practice identified and facility was cited. See CD 57515 dated 04/29/2025.

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 #: 57515
Investigator: Harrison Udoye
Investigation Date(s): 03/25/2025 through 04/25/2025
Complainant Contact Date(s):

Intake ID: 172794
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):
Neglect: lack of care that resulted in injury

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Resident rooms
Interviews:	Identified resident Identified staff Nursing staff
Record Reviews:	Medical records Hospital records Incident investigation State reporting log

Investigation Summary:
Reviewed intake, interviewed relevant parties, reviewed documents, made relevant observations. Failed practice identified and facility was cited. See CD 57515 dated 04/29/2025.

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 #: 57515
Investigator: Harrison Udoye
Investigation Date(s): 03/25/2025 through 04/25/2025
Complainant Contact Date(s):

Intake ID: 172721
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):
Neglect: lack of care that resulted in injury

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Identified resident Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Administrator Residents
Record Reviews:	Medical records Hospital records State reporting log Incident investigation

Investigation Summary:
Reviewed intake, interviewed relevant parties, reviewed documents, made relevant observations. Failed practice identified and facility was cited. See CD 57515 dated 04/29/2025.

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 03/25/2025, 04/03/2025, 04/22/2025 and 04/08/2025 of:

Renton Assisted Living
71 SW VICTORIA ST
RENTON, WA 98057

This document references the following complaint number(s): 174028, 172794, 172721

The following sample was selected for review during the unannounced on-site visit: 2 of 90 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Harrison Udoye, Community Complaint Investigator
Karri Hernandez, 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

04/30/2025
Date

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

Paulette Stahl
District Administrator
Western Portfolio
Administrator (or Representative)

5/2/25
Date

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess and provide care and services for 2 of 2 sampled residents (Resident 1 and Resident 2)'s with necessary medical treatment. This failure placed Resident 1 and Resident 2 at risk of compromised health conditions, and possible death.

Findings included...

RESIDENT 1
Review of Resident 1's face sheet, dated 04/07/2025, showed the facility admitted Resident 1 on [redacted]/2024. The face sheet from admission showed Resident 1 required medications and wound care to their right heel on Mondays, Wednesdays, and Fridays. The document showed Resident 1 start date for wound care on 01/30/2025.

Observation on 04/07/2025 at 12:30 PM showed Resident 1 had a wound on the inner portion of their right ankle. The wound was the size of a fifty-cent piece. Observation showed Resident 1 had a quarter sized wound on their right heel. During an interview at this time, Resident 1 stated that they had so much pain in their right foot that they called Emergency Medical Services (EMS) to the facility to help with wound care. Resident 1 stated that EMS referred Resident 1 to the Emergency Room for wound care. Resident 1 stated that they were released from the hospital with continuation of

previous wound care orders and new antibiotic medication. Resident 1 stated that the facility staff had not attempted, or completed, any wound care since they admitted to the facility.

Review of Resident 1's WA Health and Services Evaluation Results and Services Plan (also known as the Facility Care Plan), dated 03/26/2025, showed Resident 1 had an active wound on their left foot/heel, which decreased Resident 1's ability to walk due to pain. Based on observation of the wound, the facility's care plan incorrectly documented the location of the wound.

Review of Resident 1's March 2025 Medication Administration Record (MAR) showed an active order for wound care and wound care supplies. The MAR showed no documentation that any wound care was completed on Mondays, Wednesdays, or Fridays, as ordered.

Review of Resident 1's progress notes showed no documentation that staff provided any wound care. There was no documentation that showed Resident 1 refused assistance with wound care. There was no documentation that showed staff completed any skin assessment check.

During an interview on 04/07/2025 at 11:30 AM, Staff A, (Administrator), stated that they were unaware that Resident 1 required wound care assistance. Staff A stated that any wound care needed would be the responsibility of a Home Health wound care provider. Staff B, (Licensed Practical Nurse), stated that they were a new employee to the facility, and they were unaware Resident 1 needed any wound care. Staff A and Staff B stated that they were unaware if Resident 1 had any Home Health orders for wound care.

During an interview on 04/24/2025 at 12:53 PM, Collateral Contact 1 (CC1- Washington State Department of Social and Health Services Clinical Nurse Investigator), stated that when they were in the facility, they spoke with Resident 1. CC1 stated that Resident 1 reported to them that facility staff had not completed, or attempted to complete, any wound care since Resident 1 moved into the facility.

RESIDENT 2
Review of Resident 2's face sheet, dated 03/19/2025, showed the facility admitted Resident 2 on [redacted]/2024.

Review of Resident 2's Home and Community Services Assessment, dated 12/27/2024 showed that Resident 2 had two diabetic wounds, one on each foot. The assessment showed Resident 2 had surgical wounds related to diabetic foot issues. The assessment showed that facility staff were to provide diabetic foot care. The assessment provided Diabetic Foot Care instructions for the facility staff. The instructions stated that Resident 2 needed daily foot inspections, and if any changes were noted, staff were to notify the

appropriate health care provider.

Review of Resident 2's hospital record, dated 04/24/2025, showed Resident 2 admitted to the hospital on [redacted]/2025 with multiple diagnoses which included: [redacted]. The record showed Resident 2 was hospitalized from [redacted]/2025 to [redacted]/20025. The record showed that on [redacted]/2025, Resident 2 received a surgical debridement (medical procedure to remove dead or damaged tissue from a wound) of the wet gangrene wound on their right foot. The record showed Resident 2 required emergency dialysis (life-sustaining treatment for individuals with kidney failure to filter waste and excess fluid from the blood). The record showed Resident 2 received a hemodialysis catheter (a tube inserted into a blood vessel to provide access for dialysis treatment [a treatment used for people with kidney failure]). The record showed Resident 2 discharged from hospital on [redacted]/2025 to an Adult Family Home.

During an interview on 03/25/2025 at 12:00pm, Staff A stated that Resident 2 had a potentially life-threatening wound. Staff A stated that facility staff called EMS to transport Resident 2 to the hospital for wound care. Staff A stated that when EMS arrived, Resident 2 refused transport to the hospital. Staff A stated that Law Enforcement (LE) was called to assist with Resident 2's transport and admission to the hospital. Staff A stated that Resident 2 repeatedly refused wound care assistance, bathing assistance, and housekeeping assistance from staff since their admit to the facility.

The facility was unable to provide any documentation that showed Resident 2 refused staff assistance with personal care, skin and foot checks, and wound care treatment.

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) 5/22/25 .

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

Paulette Stahl
District Administrator
Western Portfolio
Administrator (or Representative)

5/2/25
Date