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

FC Kent Senior Living, LLC
Cogir of Kent
25035 104th Ave SE
Kent, WA 98030

RE: Cogir of Kent License # 2620

Dear Administrator:

This letter addresses Compliance Determination(s) 44021 (Completion Date 07/11/2024) and 40844 (Completion Date 05/14/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/11/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2474-2-e, WAC 388-112A-0611-1-a-i, WAC 388-112A-0611-1-a-ii, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-2, WAC 388-78A-2480-1, WAC 388-78A-2485-2, WAC 388-78A-2485-3, WAC 388-78A-2620-1-b, WAC 388-78A-2620-2-b, WAC 388-78A-2950-6, WAC 388-78A-3030-2-e, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-e, WAC 388-78A-2140-2-a, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1

The Department staff who did the on-site verification:
Kathy Young, Licensor
Michelle Yip, ALF Licensor

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

Sincerely,

Laurie Anderson

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

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

Statement of Deficiencies	Licensee #: 2620	Compliance Determination #40844
Plan of Correction	Cogir of Kent	Completion Date
Page 1 of 18	Licensee: FC Kent Senior Living, LLC	05/14/2024

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

The department completed data collection for the unannounced on-site full inspection on 05/08/2024, 05/09/2024, 05/09/2024 and 05/09/2024 at:
Cogir of Kent
25035 104th Ave SE
Kent, WA 98030

The following sample was selected for review during the unannounced on-site visit: 7 of 41 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Young, Licensor
Michelle Yip, ALF Licensor

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

05/17/2024 — Date

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

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 the unannounced on-site full inspection on 05/06/2024, 05/06/2024, 05/09/2024 and 05/09/2024 of:

Cogir of Kent
25035 104th Ave SE
Kent, WA 98030

The following sample was selected for review during the unannounced on-site visit: 7 of 41 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Young, Licensor
Michelle Yip, ALF Licensor

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

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

Residential Care Services _____ Date _____

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

Statement of Deficiencies	License #: 2620	Compliance Determination # 48844
Plan of Correction	Cogir of Kent	Completion Date
Page 2 of 18	Licensee: FC Kent Senior Living, LLC	05/14/2024

Administrator (or Representative)

5/20/24
Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

(i) A certified home care aide;

(ii) A long-term care worker who is exempt from the seventy-hour long-term care worker basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 staff (Staff A, Staff B, and Staff D) met all their training requirements needed to provide resident care. This failure placed all residents at risk of receiving inadequate care from untrained staff.

Findings included...

Review of the facility's Care Partner and Medication Care Partner job descriptions, revised 12/11/2017 and 12/03/2020 respectively, showed care staff were directly responsible for all resident care.

STAFF A
Review of the facility's staff roster showed the facility hired Staff A as a Medication Care Partner on 02/10/2023.

Administrator (or Representative) Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

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(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 staff (Staff A, Staff B, and Staff D) met all their training requirements needed to provide resident care. This failure placed all residents at risk of receiving inadequate care from untrained staff.

Findings included…

Review of the facility's Care Partner and Medication Care Partner job descriptions, revised 12/11/2017 and 12/03/2020 respectively, showed care staff were directly responsible for all resident care.

STAFF A
Review of the facility's staff roster showed the facility hired Staff A as a Medication Care Partner on 02/10/2023.

Review of Staff A's employee file showed Staff A completed six of 12 hours of required continuing education from their January 2023 birthday to their January 2024 birthday. Review of the facility's Medication Care Partner staff schedule from February 2024 through April 2024, showed Staff A typically worked one shift per week.

STAFF B
Review of the facility's staff roster showed the facility hired Staff B as a Care Partner on 04/07/2023.

Review of Staff B's employee file showed Staff B completed four of 12 hours of required of continuing education from their March 2023 birthday to their March 2024 birthday. Review of the facility's Care Partner staff schedule from February 2024 through May 2024 showed Staff B routinely worked five shifts per week.

STAFF D
Review of the facility's staff roster showed the facility hired Staff D as the Resident Lifestyle Director on 04/01/2022.

Review of the facility's Resident Lifestyle Director job description showed the Director's responsibilities included pushing a wheelchair, helping residents walk and sit up, and lifting residents.

Review of Staff D's employee file showed Staff D held a Home Care Aid (HCA) certification. Review showed Staff D completed eight of 12 hours of the required continuing education from their January 2023 birthday to their January 2024 birthday. Review of the facility's Lifestyle staff schedule showed Staff D worked five shifts per week.

During an interview on 05/07/2024 at 9:20 AM, Staff F, Executive Director, stated that the facility used Staff D in the capacity as an HCA, to drive residents to appointments and to take the residents on outings. Staff F stated that Staff D was available to provide resident care during outings if needed. Staff F stated that Staff D provided residents with assistance in activities of daily living, such walking up and down the stairs of the van.

During an interview on 05/07/2024 at 1:18 PM, Staff A stated that they were aware all staff had not completed their continuing education from birthday to birthday.

Plan/Attestation Statement

Review of Staff A's employee file showed Staff A completed six of 12 hours of required continuing education from their January 2023 birthday to their January 2024 birthday. Review of the facility's Medication Care Partner staff schedule from February 2024 through April 2024, showed Staff A typically worked one shift per week.

STAFF B
Review of the facility's staff roster showed the facility hired Staff B as a Care Partner on 04/07/2023.

Review of Staff B's employee file showed Staff B completed four of 12 hours of required of continuing education from their March 2023 birthday to their March 2024 birthday. Review of the facility's Care Partner staff schedule from February 2024 through May 2024 showed Staff B routinely worked five shifts per week.

STAFF D
Review of the facility's staff roster showed the facility hired Staff D as the Resident Lifestyle Director on 04/01/2022.

Review of the facility's Resident Lifestyle Director job description showed the Director's responsibilities included pushing a wheelchair, helping residents walk and sit up, and lifting residents.

Review of Staff D's employee file showed Staff D held a Home Care Aid (HCA) certification. Review showed Staff D completed eight of 12 hours of the required continuing education from their January 2023 birthday to their January 2024 birthday. Review of the facility's Lifestyle staff schedule showed Staff D worked five shifts per week.

During an interview on 05/07/2024 at 9:20 AM, Staff F, Executive Director, stated that the facility used Staff D in the capacity as an HCA, to drive residents to appointments and to take the residents on outings. Staff F stated that Staff D was available to provide resident care during outings if needed. Staff F stated that Staff D provided residents with assistance in activities of daily living, such walking up and down the stairs of the van.

During an interview on 05/07/2024 at 1:18 PM, Staff A stated that they were aware all staff had not completed their continuing education from birthday to birthday.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2620	Compliance Determination # 40844
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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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 06/27/24

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

Administrator (or Representative) — Date: 5/20/24

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 failed to ensure 1 of 3 care staff (Staff A) was screened for tuberculosis (TB) within three days of hire. This failure placed residents at risk for contracting tuberculosis, a contagious illness.

Findings included...

Review of the facility's Medication Care Partner job description, revised 12/11/2017, showed care staff were directly responsible for all resident care.

Review of the facility's staff roster showed the facility hired Staff A as a Medication Care Partner on 02/13/2023.

Review of the facility's Medication Care Partner staff schedule from February 2024 through April 2024, showed Staff A typically worked one shift per week.

Review of Staff A's employee file showed Staff A was administered a TB test on 3/28/23, 47 days after date of hire.

During an interview on 05/08/2024 at 1:20 PM, Staff F, Executive Director, stated that they were aware Staff A's TB test was administered late.

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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(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 failed to ensure 1 of 3 care staff (Staff A) was screened for tuberculosis (TB) within three days of hire. This failure placed residents at risk for contracting tuberculosis, a contagious illness.

Findings included…

Review of the facility's Medication Care Partner job description, revised 12/11/2017, showed care staff were directly responsible for all resident care.

Review of the facility's staff roster showed the facility hired Staff A as a Medication Care Partner on 02/10/2023.

Review of the facility's Medication Care Partner staff schedule from February 2024 through April 2024, showed Staff A typically worked one shift per week.

Review of Staff A's employee file showed Staff A was administered a TB test on 3/29/23, 47 days after date of hire.

During an interview on 05/08/2024 at 1:20 PM, Staff F, Executive Director, stated that they were aware Staff A's TB test was administered late.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2620	Compliance Determination # 48844
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 5/20/24 Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis, and

(3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure failed to ensure 2 of 2 staff (Staff A and Staff B) with positive tuberculosis (TB) results, were evaluated for signs and symptoms of TB and obtained and followed the recommendation of their health care provider. This failure placed residents at risk for contracting a contagious illness.

Findings included...

Review of the facility's Care Partner and Medication Care Partner job descriptions, revised 12/11/2017 and 12/03/2020 respectively, showed care staff were directly responsible for all resident care.

STAFF A
Review of the facility's staff roster showed the facility hired Staff A as a Medication Care Partner on 02/10/2023.

Review of Staff A's employee file showed Staff A tested positive for TB. There was no record that showed Staff A was evaluated for signs and symptoms of TB. There was no record that showed Staff A obtained and followed the recommendation of their health care provider.

Review of the facility's Medication Care Partner staff schedule from February 2024 through April 2024, showed Staff A typically worked one shift per week.

STAFF B

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date)_____ .

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Administrator (or Representative) Date

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Based on interview and record review, the facility failed to ensure failed to ensure 2 of 2 staff (Staff A and Staff B) with positive tuberculosis (TB) results, were evaluated for signs and symptoms of TB and obtained and followed the recommendation of their health care provider. This failure placed residents at risk for contracting a contagious illness.

Findings included…

Review of the facility's Care Partner and Medication Care Partner job descriptions, revised 12/11/2017 and 12/03/2020 respectively, showed care staff were directly responsible for all resident care.

STAFF A
Review of the facility's staff roster showed the facility hired Staff A as a Medication Care Partner on 02/10/2023.

Review of Staff A's employee file showed Staff A tested positive for TB. There was no record that showed Staff A was evaluated for signs and symptoms of TB. There was no record that showed Staff A obtained and followed the recommendation of their health care provider.

Review of the facility's Medication Care Partner staff schedule from February 2024 through April 2024, showed Staff A typically worked one shift per week.

STAFF B

Review of the facility's staff roster showed the facility hired Staff B as a Care Partner on 04/07/2023.

Review of Staff B's employee file showed Staff B tested positive for TB. There was no record that showed Staff B was evaluated for signs and symptoms of TB. There was no record that showed Staff B obtained and followed the recommendation of their health care provider.

Review of the facility's Care Partner staff schedule from February 2024 through May 2024 showed Staff B routinely worked five shifts per week.

During an interview on 05/07/2024 at 1:18 PM, Staff F, Executive Director, stated that they were unaware of the regulation that required staff with a positive TB test result be evaluated for signs and symptoms of TB and follow the recommendation of their health care provider.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/27/24

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

Administrator (or Representative) 5/20/24 Date

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

(1) Develop, implement and disclose to potential and current residents, policies regarding:

(b) The conditions under which pets may be in the assisted living facility.

(2) Ensure animals living on the assisted living facility premises:

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure it implemented its pet policy and ensure 5 of 5 sampled pets (Pet 1, Pet 2, Pet 3, Pet 4, and Pet 5) were veterinarian certified to be free of diseases transmittable to humans. These failures placed residents at risk of contracting illnesses spread by pets and possible injury.

Review of the facility's staff roster showed the facility hired Staff B as a Care Partner on 04/07/2023.

Review of Staff B's employee file showed Staff B tested positive for TB. There was no record that showed Staff B was evaluated for signs and symptoms of TB. There was no record that showed Staff B obtained and followed the recommendation of their health care provider.

Review of the facility's Care Partner staff schedule from February 2024 through May 2024 showed Staff B routinely worked five shifts per week.

During an interview on 05/07/2024 at 1:18 PM, Staff F, Executive Director, stated that they were unaware of the regulation that required staff with a positive TB test result be evaluated for signs and symptoms of TB and follow the recommendation of their health care provider.

Plan/Attestation Statement

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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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Statement of Deficiencies	License #: 2620	Compliance Determination # 43844
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Page 7 of 18	Licensee: FC Kent Senior Living, LLC	05/14/2024

Findings included...

Review of the facility's Pet Policy, revised 01/18/2022, showed that pets were only allowed in common areas when entering and exiting the buildings. Pets must be in a pet carrier or leashed when they were moved through the common areas. The policy showed pets must not exceed 20 pounds. The policy omitted the regulation that required pets be veterinarian certified to be free of diseases transmittable to humans.

PET 1, PET 2, and PET 3
Review of the facility's veterinary records showed no documentation that Pet 1, Pet 2, and Pet 3 were veterinarian certified to be free of diseases transmittable to humans.

PET 4
Observation on 05/08/2024 at 12:10 PM, showed Pet 4 walked around, unleashed, on the first floor of the facility. Residents were present in the area and the dining room. Observation showed Pet 4 exceeded the 20-pound facility pet weight limit.

During an interview on 05/08/2024 at 12:10 PM, Staff F, Executive Director, stated Pet 4 was a facility dog owned by a staff member. Staff F stated that the residents preferred Pet 4 be allowed to walk unleashed, freely around the facility. Staff F stated that Pet 4 was overdue for a veterinarian visit. Staff F stated that an appointment was scheduled for Pet 4 to see the veterinarian.

PET 5
Observation on 05/08/2024 at 12:50 PM, showed Pet 5 in Resident 4's apartment, along with pet care items. During an interview at that time, Resident 4 stated that they moved into the facility with their pet.

During an interview on 05/08/2024 at 1:18 PM, Staff F stated that they were unaware that Resident 4 moved into the facility with Pet 5. Staff F stated that this was the first time they had observed Pet 5 in the facility.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/27/24

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Administrator (or Representative) Date 5/20/24

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During an interview on 05/09/2024 at 1:18 PM, Staff F stated that they were unaware that Resident 4 moved into the facility with Pet 5. Staff F stated that this was the first time they had observed Pet 5 in the facility.

Plan/Attestation Statement

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Administrator (or Representative) Date

Statement of Deficiencies	License #: 2620	Compliance Determination # 40844
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WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the water temperature in 3 of 6 common area sinks (first-floor common bathroom, Resident Laundry Room sink, and third-floor common bathroom) measured between 105 degrees Fahrenheit (F) and 120 degrees F. This failure placed all the residents at risk of burns from scalding water and a diminished quality of life.

Findings included...

Review of the facility's water temperature logbook for 2024, showed the facility checked the water temperature in five random apartments once a week. The logbook showed no documentation that common area water temperatures were checked in 2024

Observations on 05/06/2024 between 9:45 AM and 12:45 PM, showed the hot water temperature in the first-floor common bathroom measured 123.8 degrees F; the hot water temperature in the Resident Laundry Room measured 128.1 degrees F; and the hot water temperature in the third-floor common bathroom measured 122.3 degrees F.

During an interview on 05/06/2024 at Staff H, Maintenance Director, stated that the temperature should not be above 120 degrees F.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/27/24

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

Administrator (or Representative) — Date 5/20/24

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

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

(a) Provide mechanical ventilation to the outside; and

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the water temperature in 3 of 6 common area sinks (first-floor common bathroom, Resident Laundry Room sink, and third-floor common bathroom) measured between 105 degrees Fahrenheit (F) and 120 degrees F. This failure placed all the residents at risk of burns from scalding water and a diminished quality of life.

Findings included…

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Plan/Attestation Statement

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Administrator (or Representative) Date

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Statement of Deficiencies	License #: 2620	Compliance Determination # 43844
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This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the mechanical ventilation functioned to exchange air between the inside and outside of the facility in 3 of 4 common bathrooms (first-floor common bathroom 1, first-floor common bathroom 2, and second-floor common bathroom). This failure placed residents at risk of respiratory distress and a diminished quality of life.

Findings include...

Observations on 05/06/2024 between 9:45 AM -- 12:45 PM, showed non-functioning ventilation systems in the two common bathrooms on the first floor and the second-floor common bathroom.

During an interview on 05/06/2024 at that time, Staff H, Maintenance Director, acknowledged the nonfunctioning air exchange vents. Staff H stated that the vents were checked monthly. Staff H stated that there was no log of the monthly vent checks.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/27/24

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

Administrator (or Representative) — Date 5/20/24

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;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the mechanical ventilation functioned to exchange air between the inside and outside of the facility in 3 of 4 common bathrooms (first-floor common bathroom 1, first-floor common bathroom 2, and second-floor common bathroom). This failure placed residents at risk of respiratory distress and a diminished quality of life.

Findings included…

Observations on 05/06/2024 between 9:45 AM – 12:45 PM, showed non-functioning ventilation systems in the two common bathrooms on the first floor and the second-floor common bathroom.

During an interview on 05/06/2024 at that time, Staff H, Maintenance Director, acknowledged the nonfunctioning air exchange vents. Staff H stated that the vents were checked monthly. Staff H stated that there was no log of the monthly vent checks.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2100 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;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

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Based on observation, interview, and record review, the facility failed to complete the required full assessment for 3 of 7 sampled residents (Resident 4, Resident 6, and Resident 7) at admission and with a change of condition. This failure placed Resident 4, Resident 6, and Resident 7 at risk of unmet care needs and a decreased quality of life.

Findings included...

RESIDENT 4
Observation in Resident 4's apartment on 05/08/2024 at 12:50 PM showed a Bi-Level Positive Airway Pressure (BiPAP, a machine that helps breathing) machine at the right side of the head of the bed. Observation showed the BiPAP machine was plugged into the electric outlet on the wall, and connected to an air tube and a facial mask. Observation showed bottles of medications were kept in the lockable cabinet. Observation showed a red-colored sharp disposal container on the table. Observation showed a cat walked inside the apartment. Observation showed there was a cat bed, a food dish, and a litter box inside the apartment.

During an interview on 05/08/2024 at 12:50 PM, Resident 4 stated that they used the BiPAP machine for the past five years. Resident 4 stated that they used the BiPAP machine for breathing when they sleep in the afternoon and every night. Resident 4 stated that they operated the BiPAP machine independently. Resident 4 stated they independently managed their medications that included ordering and obtaining the medications. Resident 4 stated that their family helped obtain and deliver the over-the-counter medications, as needed. Resident 4 stated that they owned the cat, and they moved into the apartment with the cat. Resident 4 stated that their family helped clean the litter box when they visited every week.

During an interview on 05/14/2024 at 1:51 PM, Resident 4 stated that since October 2023, they had a cardiac pacemaker (a battery-powered medical device that regulates heart beats) implanted inside their chest. Resident 4 stated that they had a pacemaker monitor device installed in the apartment. Resident 4 stated that their pacemaker required ongoing monitoring for any major heart event from the clinic. Resident 4 stated that the facility did not assess the pacemaker and the related care needs.

Review of Resident 4's records showed that the facility admitted Resident 4 in [redacted] 2023 with medical diagnoses of obstructive [redacted] and [redacted]. The records showed that on 02/08/2024, Staff G, Resident Services Director, completed an assessment for Resident 4. The assessment showed no documentation of Resident 4's BiPAP usage. The assessment showed no documentation of the cardiac pacemaker and the related care needs. The assessment showed no documentation of Resident 4's pharmacy, the ways in which Resident 4 obtained prescribed medications and over-the-counter medications. The assessment showed no documentation of the cat and the related pet care.

During an interview on 05/08/2024 at 1:30 PM, Staff G stated that they were unaware Resident 4 used a BiPAP. Staff G was unaware Resident 4 owned and kept a cat in the apartment. Staff G stated that in February 2024 when they completed an assessment for

Based on observation, interview, and record review, the facility failed to complete the required full assessment for 3 of 7 sampled residents (Resident 4, Resident 6, and Resident 7) at admission and with a change of condition. This failure placed Resident 4, Resident 6, and Resident 7 at risk of unmet care needs and a decreased quality of life.

Findings included…

RESIDENT 4
Observation in Resident 4's apartment on 05/08/2024 at 12:50 PM showed a Bi-Level Positive Airway Pressure (BiPAP, a machine that helps breathing) machine at the right side of the head of the bed. Observation showed the BiPAP machine was plugged into the electric outlet on the wall, and connected to an air tube and a facial mask. Observation showed bottles of medications were kept in the lockable cabinet. Observation showed a red-colored sharp disposal container on the table. Observation showed a cat walked inside the apartment. Observation showed there was a cat bed, a food dish, and a litter box inside the apartment.

During an interview on 05/08/2024 at 12:50 PM, Resident 4 stated that they used the BiPAP machine for the past five years. Resident 4 stated that they used the BiPAP machine for breathing when they sleep in the afternoon and every night. Resident 4 stated that they operated the BiPAP machine independently. Resident 4 stated they independently managed their medications that included ordering and obtaining the medications. Resident 4 stated that their family helped obtain and deliver the over-the-counter medications, as needed. Resident 4 stated that they owned the cat, and they moved into the apartment with the cat. Resident 4 stated that their family helped clean the litter box when they visited every week.

During an interview on 05/14/2024 at 1:51 PM, Resident 4 stated that since October 2023, they had a cardiac pacemaker (a battery-powered medical device that regulates heart beats) implanted inside their chest. Resident 4 stated that they had a pacemaker monitor device installed in the apartment. Resident 4 stated that their pacemaker required ongoing monitoring for any major heart event from the clinic. Resident 4 stated that the facility did not assess the pacemaker and the related care needs.

Review of Resident 4's records showed that the facility admitted Resident 4 in [redacted] 2023 with medical diagnoses of obstructive [redacted] ([redacted]) and [redacted] ([redacted]). The records showed that on 02/08/2024, Staff G, Resident Services Director, completed an assessment for Resident 4. The assessment showed no documentation of Resident 4's BiPAP usage. The assessment showed no documentation of the cardiac pacemaker and the related care needs. The assessment showed no documentation of Resident 4's pharmacy, the ways in which Resident 4 obtained prescribed medications and over-the-counter medications. The assessment showed no documentation of the cat and the related pet care.

During an interview on 05/08/2024 at 1:30 PM, Staff G stated that they were unaware Resident 4 used a BiPAP. Staff G was unaware Resident 4 owned and kept a cat in the apartment. Staff G stated that in February 2024 when they completed an assessment for

Resident 4, they did not assess Resident 4's care capabilities, care needs, preference for the BiPAP usage and pet care. Staff G stated that Resident 4 was independent with medication management. Staff G stated that they did not assess Resident 4's ability to obtain and use prescribed medications and over-the-counter medications. Staff G stated that they were unaware of which pharmacy Resident 4 used.

During an interview on 05/14/2024 at 3:55 PM, Staff G stated that they did not know Resident 4 had a cardiac pacemaker. Staff G stated that they did not assess Resident 4's cardiac pacemaker and the related care needs.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2023. The records showed that on 04/09/2024, Staff G completed an assessment for Resident 6. The assessment showed that Resident 6 independently managed their medications. The records showed the name of the pharmacy used by Resident 6. The assessment showed no documentation of the ways in which Resident 6 obtained prescribed medications and over-the-counter medications.

During an interview on 05/08/2024 at 1:30 PM, Staff G confirmed that Resident 6 independently managed their medications. Staff G stated that Resident 6 used the "in-house pharmacy" and independently communicated to the pharmacy. Staff G stated that they were unsure how Resident 6 obtained their prescribed medications and over-the-counter medications.

RESIDENT 7
Observation of Resident 7's apartment on 05/08/2024 at 7:25 AM, showed a half-length bedrail without a mesh attached to the the head of the bed, on the left side. Observation showed the bedrail was securely fastened to the bed frame. Observation of the bedrail showed a 2-inch gap between the mattress and rail. During an interview, Collateral Contact 1 (CC1, Resident 7's representative) stated that they acquired and installed the bedrail. CC1 stated that since July 2023, Resident 7 used the bedrail for mobility and transfers. CC1 stated that the facility did not assess the bedrail and the facility did not explain the risks of bedrail use.

Review of the facility's policy titled "Bed Rails and Enablers", dated 08/11/2022, showed that the facility permitted the use of side-in enabler that attached to the bed frame. The policy showed the facility required a physician's order for the device to be used for mobility. The policy showed the facility required the completion of resident consent and documentation in the resident's service plan along with instructions for monitoring.

Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2023. The records showed that on 04/25/2024, Staff G completed Resident 7's assessment. The assessment showed no documentation that Resident 7 used a bedrail. There was no documentation of a physician's order for Resident 7 to use the bedrail. There was no documentation that the facility assessed Resident 7 for their ability to safety use the bedrail.

Resident 4, they did not assess Resident 4's care capabilities, care needs, preference for the BiPAP usage and pet care. Staff G stated that Resident 4 was independent with medication management. Staff G stated that they did not assess Resident 4's ability to obtain and use prescribed medications and over-the-counter medications. Staff G stated that they were unaware of which pharmacy Resident 4 used.

During an interview on 05/14/2024 at 3:55 PM, Staff G stated that they did not know Resident 4 had a cardiac pacemaker. Staff G stated that they did not assess Resident 4's cardiac pacemaker and the related care needs.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2023. The records showed that on 04/09/2024, Staff G completed an assessment for Resident 6. The assessment showed that Resident 6 independently managed their medications. The records showed the name of the pharmacy used by Resident 6. The assessment showed no documentation of the ways in which Resident 6 obtained prescribed medications and over-the-counter medications.

During an interview on 05/08/2024 at 1:30 PM, Staff G confirmed that Resident 6 independently managed their medications. Staff G stated that Resident 6 used the "in-house pharmacy" and independently communicated to the pharmacy. Staff G stated that they were unsure how Resident 6 obtained their prescribed medications and over-the-counter medications.

RESIDENT 7
Observation of Resident 7's apartment on 05/08/2024 at 7:25 AM, showed a half-length bedrail without a mesh attached to the the head of the bed, on the left side. Observation showed the bedrail was securely fastened to the bed frame. Observation of the bedrail showed a 2-inch gap between the mattress and rail. During an interview, Collateral Contact 1 (CC1, Resident 7's representative) stated that they acquired and installed the bedrail. CC1 stated that since July 2023, Resident 7 used the bedrail for mobility and transfers. CC1 stated that the facility did not assess the bedrail and the facility did not explain the risks of bedrail use.

Review of the facility's policy titled "Bed Rails and Enablers", dated 05/11/2022, showed that the facility permitted the use of slide-in enabler that attached to the bed frame. The policy showed the facility required a physician's order for the device to be used for mobility. The policy showed the facility required the completion of resident consent and documentation in the resident's service plan along with instructions for monitoring.

Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2023. The records showed that on 04/25/2024, Staff G completed Resident 7's assessment. The assessment showed no documentation that Resident 7 used a bedrail. There was no documentation of a physician's order for Resident 7 to use the bedrail. There was no documentation that the facility assessed Resident 7 for their ability to safety use the bedrail.

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During an interview on 05/08/2024 at 1:30 PM, Staff G stated that they were unaware Resident 7 used a bedrail. Staff G stated that in February 2024, when they completed an assessment for Resident 7, they did not assess Resident 4's capabilities, care needs, and safety when they used bedrail.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/27/24

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

Administrator (or Representative) — Date: 5/26/24

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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

(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 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:

During an interview on 05/08/2024 at 1:30 PM, Staff G stated that they were unaware Resident 7 used a bedrail. Staff G stated that in February 2024, when they completed an assessment for Resident 7, they did not assess Resident 4's capabilities, care needs, and safety when they used bedrail.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

(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 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:

Statement of Deficiencies	License #: 2620	Compliance Determination # 40844
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Based on observation, interview, and record review, the facility failed to update the Negotiated Service Agreement (NSA) for 4 of 8 sampled residents (Resident 2, Resident 3, Resident 4, and Resident 5). This failure placed Resident 2, Resident 3, Resident 4, and Resident 5 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

RESIDENT 2
Review of Resident 2's records showed that the facility admitted Resident 2 in [redacted] 2023 with a medical diagnosis of [redacted]. Review of Resident 2's May 2024 medication orders showed that Resident 2 received 81 milligrams (mg) of Aspirin (a blood thinner medication), one time a day, by mouth. The orders showed Resident 2 received eight units of Lantus insulin (a medication used to regulate blood sugar levels), daily, injected subcutaneously (under skin). The records showed that on 04/09/2024, Staff G, Resident Services Director, completed Resident 2's assessment. The assessment showed Resident 2 received medication assistance with oral medications. The assessment showed Resident 2 self-monitored blood sugar levels and self-administered their insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus, such as hyperglycemia (high blood sugar levels), increased thirst, or excess urination. There was no documentation that explained the possible side effects of insulin usage, such as, low blood sugar levels. There was no documentation that explained the possible side effects of aspirin usage, such as increased risk for bruising and easy bleeding.

Review of Resident 2's NSA, dated 04/09/2024, showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that explained the possible side effects of insulin usage. There was no documentation that showed Resident 2 received aspirin. There was no documentation that explained the possible side effects of aspirin usage. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 3
Review of the facility's policy titled "Bed Rails and Enablers", dated 05/11/2022, showed that the facility permitted the use of side-in enabler that attached to the bed frame. The policy showed the facility required a physician's order for the device to be used for mobility. The policy showed the facility required the completion of resident consent and documentation in the resident's service plan along with instructions for monitoring.

Observation in Resident 3's apartment on 05/08/2024 at 10:15 AM showed a half-length bed enabler attached to the head of the bed, on the left side.

Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2023 with a medical diagnosis of [redacted]. The records showed that on 02/27/2024, Staff G completed Resident 3's assessment. The assessment showed Resident 3 required

Based on observation, interview, and record review, the facility failed to update the Negotiated Service Agreement (NSA) for 4 of 8 sampled residents (Resident 2, Resident 3, Resident 4, and Resident 5). This failure placed Resident 2, Resident 3, Resident 4, and Resident 5 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included…

RESIDENT 2
Review of Resident 2's records showed that the facility admitted Resident 2 in [redacted] 2023 with a medical diagnosis of [redacted]. Review of Resident 2's May 2024 medication orders showed that Resident 2 received 81 milligrams (mg) of Aspirin (a blood thinner medication), one time a day, by mouth. The orders showed Resident 2 received eight units of Lantus insulin (a medication used to regulate blood sugar levels), daily, injected subcutaneously (under skin). The records showed that on 04/09/2024, Staff G, Resident Services Director, completed Resident 2's assessment. The assessment showed Resident 2 received medication assistance with oral medications. The assessment showed Resident 2 self-monitored blood sugar levels and self-administered their insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus, such as hyperglycemia (high blood sugar levels), increased thirst, or excess urination. There was no documentation that explained the possible side effects of insulin usage, such as, low blood sugar levels. There was no documentation that explained the possible side effects of aspirin usage, such as increased risk for bruising and easy bleeding.

Review of Resident 2's NSA, dated 04/09/2024, showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that explained the possible side effects of insulin usage. There was no documentation that showed Resident 2 received aspirin. There was no documentation that explained the possible side effects of aspirin usage. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 3
Review of the facility's policy titled "Bed Rails and Enablers", dated 05/11/2022, showed that the facility permitted the use of slide-in enabler that attached to the bed frame. The policy showed the facility required a physician's order for the device to be used for mobility. The policy showed the facility required the completion of resident consent and documentation in the resident's service plan along with instructions for monitoring.

Observation in Resident 3's apartment on 05/08/2024 at 10:15 AM showed a half-length bed enabler attached to the head of the bed, on the left side.

Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2023 with a medical diagnosis of [redacted]. The records showed that on 02/27/2024, Staff G completed Resident 3's assessment. The assessment showed Resident 3 required

assistance with medication management, transfers, and ambulation. The assessment showed Resident 3 used a bed enabler to get in and out of the bed.

Review of Resident 3's NSA, dated 02/07/2024, showed no documentation that explained the possible signs and symptoms related to diabetes mellitus. The NSA did not provide staff any instructions about the safe use of a bed enabler.

RESIDENT 4
Review of Resident 4's records showed that the facility admitted Resident 4 in [redacted] 2023 with a medical diagnoses of [redacted]. The records showed that on 02/08/2024, Staff G completed Resident 4's assessment. The assessment showed Resident 4 received 2.5 mg of Eliquis (a blood thinner medication) oral tablet, two times per day, by mouth. The assessment showed Resident 4 self-monitored their blood sugar levels and self-administered their oral medications and insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that explained the possible side effects of insulin usage. There was no documentation that explained the possible side effects of Eliquis usage, such as increased risk for bruising and easy bleeding.

Review of Resident 4's NSA, dated 02/12/2024, showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that showed Resident 4 received insulin. There was no documentation that explained the possible side effects of insulin usage. There was no documentation that explained the possible side effects of Eliquis usage. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 5
Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2023. Review of Resident 5's May 2024 medication orders showed Resident 5 received five mg of Eliquis oral tablet, two times a day, by mouth. The records showed that on 11/07/2023, Staff G completed Resident 5's assessment. The assessment showed Resident 5 self-administered their medications.

Review of Resident 5's NSA, dated 01/31/2024, showed no documentation that Resident 5 received Eliquis. There was no documentation that provided care staff with guidance about the possible side effects from Eliquis usage. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 05/08/2024 at 1:30 PM, Staff G stated that when they completed the recent assessments for the residents, they did not update in the service plans with the signs and symptoms of diabetes mellitus, the side effects of the use of insulin, the side effects of the use of blood thinner medications, with staff instructions for actions needed related to side effects, and with staff instructions for the use of a bed enabler.

assistance with medication management, transfers, and ambulation. The assessment showed Resident 3 used a bed enabler to get in and out of the bed.

Review of Resident 3's NSA, dated 02/07/2024, showed no documentation that explained the possible signs and symptoms related to diabetes mellitus. The NSA did not provide staff any instructions about the safe use of a bed enabler.

RESIDENT 4
Review of Resident 4's records showed that the facility admitted Resident 4 in [redacted] 2023 with a medical diagnoses of [redacted] The records showed that on 02/08/2024, Staff G completed Resident 4's assessment. The assessment showed Resident 4 received 2.5 mg of Eliquis (a blood thinner medication) oral tablet, two times per day, by mouth. The assessment showed Resident 4 self-monitored their blood sugar levels and self-administered their oral medications and insulin injections. There was no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that explained the possible side effects of insulin usage. There was no documentation that explained the possible side effects of Eliquis usage, such as increased risk for bruising and easy bleeding.

Review of Resident 4's NSA, dated 02/12/2024, showed no documentation that identified the possible signs and symptoms related to diabetes mellitus. There was no documentation that showed Resident 4 received insulin. There was no documentation that explained the possible side effects of insulin usage. There was no documentation that explained the possible side effects of Eliquis usage. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 5
Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2023. Review of Resident 5's May 2024 medication orders showed Resident 5 received five mg of Eliquis oral tablet, two times a day, by mouth. The records showed that on 11/07/2023, Staff G completed Resident 5's assessment. The assessment showed Resident 5 self-administered their medications.

Review of Resident 5's NSA, dated 01/31/2024, showed no documentation that Resident 5 received Eliquis. There was no documentation that provided care staff with guidance about the possible side effects from Eliquis usage. There were no instructions for staff about what actions were needed for such side effects.

During an interview on 05/08/2024 at 1:30 PM, Staff G stated that when they completed the recent assessments for the residents, they did not update in the service plans with the signs and symptoms of diabetes mellitus, the side effects of the use of insulin, the side effects of the use of blood thinner medications, with staff instructions for actions needed related to side effects, and with staff instructions for the use of a bed enabler.

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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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/27/24

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

Administrator (or Representative) Date 5/20/24

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to obtain a complete family assistance medication management plan for 1 of 1 sampled resident (Resident 2), who received family assistance with blood sugar checks and insulin injections. This failure placed Resident 2 at risk for possible medication errors and compromised health.

Findings included...

Review of the facility's Disclosure of Services showed that the facility permitted family members to provide medication services to residents if the facility did not provide the medication services.

Review of the facility's policy titled "Family Assistance with Medications and Treatments", dated 08/18/2021, showed that the facility required family assistance with medication management to be done in accordance with the State requirements.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to obtain a complete family assistance medication management plan for 1 of 1 sampled resident (Resident 2), who received family assistance with blood sugar checks and insulin injections. This failure placed Resident 2 at risk for possible medication errors and compromised health.

Findings included…

Review of the facility's Disclosure of Services showed that the facility permitted family members to provide medication services to residents if the facility did not provide the medication services.

Review of the facility's policy titled "Family Assistance with Medications and Treatments”, dated 06/18/2021, showed that the facility required family assistance with medication management to be done in accordance with the State requirements.

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Plan of Correction	Cogir of Kent	Completion Date
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Review of Resident 2's records showed that the facility admitted Resident 2 in [redacted] 2023 with a medical diagnosis of [redacted]. The records showed that on 04/11/2023, Staff G, Resident Services Director, completed Resident 2's "Medication Self-Administration Evaluation" and "Plan for Family Assistance with Mediations or Treatments". The records showed that Resident 2 self-administered blood sugar checks and insulin (a medication used to regulate blood sugar levels) injections. The records showed that Resident 2 had a history of non-compliance with their medication regiment. The records showed that the facility identified Resident 2 themselves as the alternate plan if Resident 2 was unable to self-administer blood sugar checks and insulin injections. There was no documentation that showed Resident 2's family member provided any medication administration assistance when needed. There was no documentation that showed what type of medication management the family member provided. There was no documentation that showed an alternate plan if the family member was unable to provide any assistance.

During an interview on 05/09/2024 at 1:00 PM, Staff G stated that in April 2024, they completed the recent assessment for Resident 2. Staff G confirmed that Resident 2 self-administered blood sugar checks and insulin injections. Staff G stated that Resident 2's family provided blood sugar checks and insulin administration when Resident 2 was unable to self-administer their own blood sugar checks and insulin injections. Staff G stated that when they completed Resident 2's Plan for Family Assistance with Mediations, they were unaware an alternative medication management plan was not developed.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/7/24

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

Administrator (or Representative) — Date: 5/20/24

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1

Review of Resident 2's records showed that the facility admitted Resident 2 in [redacted] 2023 with a medical diagnosis of [redacted]. The records showed that on 04/11/2023, Staff G, Resident Services Director, completed Resident 2's "Medication Self-Administration Evaluation" and "Plan for Family Assistance with Mediations or Treatments". The records showed that Resident 2 self-administered blood sugar checks and insulin (a medication used to regulate blood sugar levels) injections. The records showed that Resident 2 had a history of non-compliance with their medication regiment. The records showed that the facility identified Resident 2 themselves as the alternate plan if Resident 2 was unable to self-administer blood sugar checks and insulin injections. There was no documentation that showed Resident 2's family member provided any medication administration assistance when needed. There was no documentation that showed what type of medication management the family member provided. There was no documentation that showed an alternate plan if the family member was unable to provide any assistance.

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Plan/Attestation Statement

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Administrator (or Representative) Date

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Statement of Deficiencies	License #: 2620	Compliance Determination # 40844
Plan of Correction	Cogir of Kent	Completion Date
Page of 18	Licensee: FC Kent Senior Living, LLC	05/14/2024

sampled staff (Staff J, Medication Care Partner) completed nurse delegation training and on-going oversight for 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk of medication errors and potential decline in their health when unqualified staff provided care.

Findings included...

Review of the facility's Disclosure of Services showed the facility provided intermittent nursing services that included medication administration by trained unlicensed staff through nurse delegation.

Review of the facility's policy titled "Nurse Delegation", dated 06/14/2023, showed that the facility required all nurse delegation to be done in accordance with the State requirements. The document showed that the nurse delegation protocols included supervision and determination of competency of the delegated staff by the Registered Nurse Delegator

Review of Resident 1's record showed that the facility admitted Resident 1 in [redacted] 2023 with medical diagnoses of [redacted] and [redacted].

Observation on 05/08/2024 at 9:40 AM showed that Resident 1 received staff assistance with medication management. Observation showed delegated Staff I administered Resident 1's eye drops. Observation showed Staff I provided medicabon management of Resident 1's oral medications.

Review of Resident 1's May 2024 "Medication Administration Record (MAR)" showed that Resident 1 received Levothyroxine (a medication used to treat thyroid disorders) oral tablet, Dorzolamide-Timolol (a medication used to treat glaucoma) eye drops, Prednisolone (a medication used to treat eye conditions) eye drops, and Refresh tears (a medication used to lubricate the eyes) Ophthalmic (eye) Solution. The MAR showed that on 05/04/2024, Staff J signed off the administration of Levothyroxine oral tablet one time, Dorzolamide-Timolol eye drops one time, Prednisolone eye drops one time, and Refresh tears Ophthalmic Solution one time. The MAR showed that on 05/05/2024, Staff J signed off the administration of Refresh tears Ophthalmic Solution one time.

Review of Resident 1's nurse delegation documentation showed that on 01/19/2023, Resident 1 consented for nurse delegation. The document showed that Staff G, Resident Services Director, Registered Nurse Delegator, delegated a Medication Care Partners (unlicensed staff persons who dispense medications), for Resident 1's medication administration of oral medications and eye drops. There was no documentation that showed Staff J, Medicabon Care Partner was delegated to assist Resident 1 with medication management.

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Statement of Deficiencies	License #: 2620	Compliance Determination # 40844
Plan of Correction	Cogir of Kent	Completion Date
Page of 18	Licensee: FC Kent Senior Living, LLC	05/14/2024

During an interview on 05/06/2024 at 2:40 PM, Staff G stated that the facility hired them as the Registered Nurse Delegator. Staff G stated that they provided nurse delegation that included staff evaluation and supervision. Staff G stated that Staff J, hired on 04/29/2024, was in training and did not meet the required competency to be delegated. Staff G stated that they did not delegate Staff J for Resident 1's medication administration. Staff G stated that they were unaware Staff J administered Resident 1 medications prior to Staff J being properly delegated.

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, Cogir of Kent is or will be in compliance with this law and / or regulation on (Date) 6/27/24

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

Administrator (or Representative) — 5/20/24 Date

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_____ _____

Administrator (or Representative) Date

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

05/17/2024

FC Kent Senior Living, LLC
Cogir of Kent
25035 104th Ave SE
Kent, WA 98030

RE: Cogir of Kent # 2620

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/14/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

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

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

05/17/2024

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

Kent, WA 98032

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

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2680 Electronic monitoring equipment Audio monitoring and video monitoring.

(2) The assisted living facility may video monitor and video record activities in the facility or on the premises, without an audio component, only in the following areas:

(a) Entrances, exits, and elevators as long as the cameras are:

(i) Focused only on the entrance or exit doorways; and

(ii) Not focused on areas where residents gather.

The facility failed to protect the privacy of the residents by placing a video camera in the resident dining room that focused on tables where residents ate meals. During the full inspection, the facility corrected the issue.

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

(1) Provide an adequate number of garbage containers to store refuse generated by the assisted living facility:

(c) Cleaned and maintained to prevent:

(i) Entrance of insects, rodents, birds, or other pests;

(ii) Odors; and

(2) Assure garbage and waste containers are emptied frequently to prevent hazards and nuisances; and

The facility failed to ensure food garbage disposed of in the outside garbage area during weekends was disposed in a garbage bin. During the full inspection, the facility corrected the issue.

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

You May:
• Contact me for clarification of the deficiency or deficiencies found.

Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
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In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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You Are Not:
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You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

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

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

If You Have Any Questions:

• Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

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

Enclosure

In Addition, You May:

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If You Have Any Questions:

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

Enclosure