STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

WRG PHASE I EQUITIES EIGHT TOWNCENT
FOUNTAIN COURT ASSISTED LIVING
24200 224TH AVENUE SE
MAPLE VALLEY, WA 98038

RE: FOUNTAIN COURT ASSISTED LIVING License # 1568

Dear Administrator:

This letter addresses Compliance Determination(s) 79953 (Completion Date 07/06/2026) and 75921 (Completion Date 04/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/06/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2090-6-e, WAC 388-78A-2950-6, WAC 388-78A-2468-1, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2305-1, WAC 246-215-03339-2-a, WAC 246-215-04700, WAC 246-215-04705, WAC 246-215-02310-5, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-112A-0400-4-b, WAC 388-112A-0400-4-c, WAC 388-112A-0495-4, WAC 388-112A-0720-2-a, WAC 388-112A-0611-1-a, WAC 388-112A-0611-1-a-i, WAC 388-112A-0611-1-a-ii, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-1-a-iv, WAC 388-112A-0611-1-a-v, WAC 388-112A-0611-2, WAC 388-78A-3040-7-a-iv, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-c

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

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

Sincerely,

Jim Sherman

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

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 1568	Compliance Determination # 75921
Plan of Correction	FOUNTAIN COURT ASSISTED LIVING	Completion Date
Page 1 of 21	Licensee: WRG PHASE I EQUITIES EIGHT TOWNCENT	04/28/2026

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 04/20/2026 and 04/23/2026 of:
FOUNTAIN COURT ASSISTED LIVING
24200 224TH AVENUE SE
MAPLE VALLEY, WA 98038

The following sample was selected for review during the unannounced on-site visit: 7 of 46 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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

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

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

Jim Sherman
Residential Care Services

05-05-2026
Date

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

Administrator (or Representative)

5/6/26
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to document in the assessment that 1 of 1 sampled resident (Resident 3) was assessed safely use a medical device within 14 days of admission. This failure placed Resident 3 at risk of injury from improper use of a medical device.

Findings included...

Observation on 04/22/2026 at 2:45 PM, showed Resident 3 seated in a chair with a nasal cannula (type of oxygen mask with nasal prongs) inserted in their nose that was connected to an oxygen concentrator. Observation showed a Halo bed enabler (an upside-down U-shaped device) attached to the right side of the bed. Observation showed the bed enabler was partially covered with a fabric pouch that was fastened to one post, and the other side of the pouch was broken and detached from the second post. Observation showed the bed enabler was securely fastened to the bed frame with a 2-inch gap between the bed frame and mattress.

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Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] of 2026 with a diagnosis of [redacted]. The records showed that on 04/09/2026, the facility completed Resident 3's assessment. The assessment showed Resident 3 required assistance with assistive devices and escorts via wheelchair due to physical limitations. Review of the assessment showed that Resident 3 used a "Halo bed cane" The assessment did not provide documentation that there was an assessment of the Halo bed enabler to show it was safe and there were no entrapment-like qualities. There was no documentation that the Halo bed enabler was assessed and no assessment of the Halo bed enabler completed within 14 days of admission.

During an interview on 04/22/2026 at 2:45 PM, Resident 3 stated that they used the Halo bed enabler and pouch to hold the remote control and other small items.

During an interview on 04/23/2026 at 9:15 AM, Staff A, Resident Care Director, stated that the facility Collateral Contact 1 [(CC1) Registered Nurse Delegator (RND)] was responsible for completing assessments and new admission assessments for residents. Staff A stated that they spoke with CC1 who stated that they did not do a "formal assessment" of Resident 3's Halo bed enabler. Staff A stated that Staff CC1 stated "they just checked the box" to acknowledge the presence of the Halo bed enabler.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 6/12/26.

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

Administrator (or Representative) — Date: 5/6/25

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 hot water temperature of the bathroom sink in 1 of 7 sampled resident apartments (Resident 4) measured no lower than 105 degrees Fahrenheit (F). This failure placed Resident 4 at risk of diminished quality of life.

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Finding included...

Review of Resident 4's records showed that the facility admitted Resident 4 in [redacted] 2025.

Observation inside Resident'4 apartment on 04/22/2026 at 11:23 AM showed the hot water temperature of the resident's bathroom sink measured 75 degrees F, 30 degrees F below the lowest temperature allowed. Observation showed that when the faucet was turned to the hot temperature, the water flow dripped out in a thin line. During an interview at this time, Resident 4 stated that since they moved in over a year ago, there was no hot water from the bathroom sink. Resident 4 stated that the facility hired a plumber who looked into the issue a few months ago. Resident 4 stated that as of today, there was hot water from the shower and the kitchen sink, and there was no hot water from the bathroom sink.

Review of the facility's plumber service invoice, dated 06/30/2025, showed that on 07/02/2025, the facility completed some plumbing work.

Review of the facility's document titled "Logbook Documentation", dated 02/06/2026, showed the water temperature of Resident 4's apartment was 112 degrees F. The document did not show which water faucet or shower the water temperature was measured.

During an interview on 04/22/2026 at 1:10 PM, Staff F, Executive Director, stated that they were aware of the hot water temperature of Resident 4's bathroom was lower than the required temperature. Staff F stated that they hired a plumber who looked into the issue. Staff F stated that they submitted the repair estimate to the corporate office and waited for the corporate's approval.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 5/30/26 .

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

Administrator (or Representative) [signature] Date 5/6/26

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit the Washington state name and date of birth (WNDOB) background inquiry (BGI) for 4 of 4 sampled contracted staff (Staff I, Staff J, Staff K, and Staff L) within one business day after their start date. This failure placed 46 residents at risk for abuse and neglect from caregivers and staff persons with unknown backgrounds.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 46 residents received assisted living services.

STAFF I
Review of the facility's personnel files showed that the facility hired Staff I, Registered Nurse Delegator, on 10/01/2025. Review of Staff I's work schedule showed that Staff I provided care and services to the residents between 10/02/2025 and 04/14/2026. Review of Staff I's employee records showed that the facility completed the WNDOB BGI on 04/13/2026, 193 days after hire. The records showed Staff I provided care and services to the residents without a valid WNDOB BGI for 193 days of hire.

During an interview on 04/21/2026 at 2:50 PM, Staff F, Executive Director, stated that on 10/01/2025, the facility hired Staff I as the contracted Registered Nurse Delegator. Staff F stated that Staff I completed residents' assessments and provided nurse delegation services in the facility between October 2025 and April 2026. Staff F stated that they were unable to locate the initial WNDOB BGI for Staff I.

During an interview on 04/22/2026 at 1:10 PM, Staff F stated that their corporate office completed the initial WNDOB BGI for Staff I when Staff I was hired. Staff F stated that when they submitted the initial background check request to the Department, they entered the incorrect date of birth for Staff I on the background check request. Staff F stated that the WNDOB BGI result showed a different person other than Staff I.

STAFF J
Review of the facility's personnel files showed that the facility hired Staff J, Registered Nurse/Contracted Agency Staff, on 04/01/2026. Review of Staff J's work schedule

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showed that Staff J provided care and services to the residents between 04/01/2026 and 04/09/2026. Review of Staff J's employee records showed a background check result, dated 06/17/2025, was completed through a third-party background check company. There was no documentation that showed the facility completed the WNDOB BGI through the Department's Background Check Central Unit (BCCU) for Staff J.

STAFF K
Review of the facility's personnel files showed that the facility hired Staff K, Certified Nursing Assistant/Contracted Agency Staff, on 04/06/2026. Review of Staff K's work schedule showed that Staff K provided care and services to the residents between 04/06/2026 and 04/19/2026. Review of Staff K's employee records showed a background check result, dated 02/20/2026, was completed through a third-party background check company. There was no documentation that showed the facility completed the WNDOB BGI through the Department's BCCU for Staff K.

STAFF L
Review of the facility's personnel files showed that the facility hired Staff L, Registered Nurse/Contracted Agency Staff, on 04/15/2026. Review of Staff L's work schedule showed that Staff L provided care and services to the residents between 04/15/2026 and 04/17/2026. Review of Staff L's employee records showed a background check result, dated 03/20/2026, was completed through a third-party background check company. There was no documentation that showed the facility completed the WNDOB BGI through the Department's BCCU for Staff L.

During an interview on 04/22/2026 at 1:10 PM, Staff F stated that the facility hired care staff from a contracted healthcare agency. Staff F stated that the facility did not have a system in place to complete the background check for the contracted care staff on each of their start dates. Staff H stated that the contracted homecare agency completed the background check for the agency staff through a third-party background check company and provided them the background check results. Staff F stated that when they hired Staff J, Staff K and Staff L, the facility did not complete the WNDOB BGI for the contracted agency staff on their start dates.

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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 6/12/26 .

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

Administrator (or Representative) [signature] Date 5/6/26

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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:

Based on observation, interview, and record review, the facility failed to assess 1 of 5 sampled residents (Resident 6) for their ability to safely use medical devices at least annually. The facility failed to assess 1 of 3 sampled residents (Resident 7) their ability to safely use oxygen when Resident 7's Individual Service Plan no longer addressed their care needs. The facility failed to assess 1 of 1 sampled resident (Resident 1) for change of condition. These failures placed Resident 6, Resident 7, and Resident 1 at risk for unmet care needs and injury.

Findings included...

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

Review of the facility's undated Disclosure of Services showed that the facility generally has a licensed Registered Nurse in the facility four days a week for a total of 32 hours a week.

RESIDENT 6
Observation inside Resident 6's apartment on 04/23/2026 at 12:05 PM showed a quarter-length bedrail (mobility device) attached to the right side of the head of the bed and between the bed and bedside console. Observation showed the bedrail was uncovered and was sturdily attached to the bed with less than 2 inches of gap between the bedrail and mattress. During an interview at this time, Resident 6 stated that they used the bedrail since they moved into the facility. Resident 6 stated that they used the

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bedrail to pull themselves up from the bed every day.

Review of Resident 6's records showed the facility admitted Resident 6 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 10/22/2025, the facility completed the full assessment for Resident 6. The assessment showed that Resident 6 used a halo bed cane (mobility device) to position themselves in bed. There was no documentation that showed the facility completed an assessment for the resident's ability to safely use the mobility device.

During an interview on 04/23/2026 at 3:05 PM, Staff F, Executive Director, stated that they were unfamiliar with the requirements for medical device assessments. Staff F stated that in December 2024 at the previous inspection, they completed the initial assessment of the bedside mobility device for Resident 6. Staff F stated that they were unaware that the facility was required to complete an assessment for the medical device every year. Staff F stated that they were unable to locate the medical device assessment for the most recent year for Resident 6.

Review of Staff F's email titled "(No Subject)", dated 04/27/2026, showed that Staff F confirmed they did not complete an "assisted device assessment" in the full assessment in 2025 for Resident 6.

Review of Staff F's email titled "Request of Facility Policy", dated 04/28/2026, showed that the facility did not have a policy on bed rails and bed canes.

RESIDENT 7
Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed a physician order, dated 08/26/2025, of "oxygen (O2) gas for inhalation, 2 liters (L), as needed (PRN)". The records showed that on 12/26/2025, the facility completed an assessment for Resident 7. The assessment showed that Resident 7 was independent with oxygen. The assessment showed care staff instructions that "staff to assist with getting oxygen nasal cannula (a device that delivers oxygen via a tube through the nose) on and encourage Resident 7 to rest if the resident complained of 'SOB' (shortness of breath). Staff to call 'RN' (Registered Nurse) if Resident 7 has O2 'sat' (saturation) below 90 after resting on oxygen for three minutes. Call 911 for respiratory distress, chest pain, or changes in level of consciousness."

Review of Resident 7's January 2026, February 2026, March 2026, and April 2026 Medication Administration Records (MARs) showed a PRN medical order of "two liters of oxygen via nasal cannula as needed for SOB/comfort. The MARs showed that between 01/01/2026 and 04/20/2026, there was no staff sign-off on the order.

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Review of Resident 7's Individual Service Plan (ISP), dated 12/26/2025, showed that Resident 7 used oxygen supplies independently. The ISP showed care instructions included "staff to be aware that resident is independently with use of oxygen due to respiratory distress. Staff be aware that her prescribed dose is one to two liters per minute. Staff to notify Registered Nurse (RN)/Medical Doctor (MD) for any concerns with independent use of inhaled medications or use of oxygen."

Review of the facility's Nurse Delegation documents showed no documentation that Resident 7 received oxygen therapy administered by care staff through nurse delegation.

Observation inside Resident 7's apartment on 04/22/2026 at 2:40 PM showed Resident 7 laid in bed. Observation showed Resident 7 pressed the call pendant for transfer and mobility assistance. Observation showed Resident 7 used a nasal cannula to receive supplementary oxygen. Observation showed the nasal cannula was connected to an oxygen concentrator (a device that generates oxygen), which was placed on the floor behind the footboard of the electric hospital bed. Observation showed that Resident was unable to reach the oxygen concentrator from the bed. Observation showed the oxygen concentrator was set to deliver oxygen at three liters per minute. During an interview, Resident 7 stated that they were unsure how much supplemental oxygen they received. Resident 7 stated that "someone said the oxygen to be set at two L per minute, and someone said the oxygen to be set at three L per minute." Resident 7 stated that they did not know who set the oxygen flow rate to three L per minute. Resident 7 stated that they thought they received two to three liters per minute of oxygen.

Observation inside Resident 7's apartment on 04/22/2026 at 2:57 PM showed Staff M, Nursing Assistant Registered (NAR)/Assisted Living-Caregiver, entered the resident's room. Observation showed that while Resident remained in sitting position in bed, Resident 7 independently measured the oxygen saturation that showed their oxygen saturation was 90 percent. Observation showed Staff M checked the oxygen flow rate setting on the oxygen concentrator. Observation showed that Staff M adjusted the oxygen flow rate to two liters per minute. Observation showed that Resident 7 did not provide Staff M with any direction to adjust the oxygen flow rate on the oxygen concentrator for them. Observation showed Staff M did not verify Resident 7's medical order and service plan. Observation showed Staff M did not notify the licensed nurse about the oxygen rate setting on the oxygen concentrator and staff M did not call the licensed nurse for assistance with adjusting the oxygen flow rate on the oxygen concentrator. During an interview at this time, Staff M stated that Resident 7 was prescribed two liters per minute of supplemental oxygen. Staff M stated that they did not know why and who changed the oxygen flow rate to three liters per minute. Staff M stated that they adjusted the oxygen flow rate as prescribed.

During an interview on 04/22/2026 at 3:50 PM, Staff A, Resident Services Director, stated that Resident 7 was independent with oxygen therapy. Staff A stated that Resident 7 sometimes adjusted the oxygen flow rate on their own. Staff A stated that Resident 7 did not receive oxygen administration by Medication Technicians (unlicensed staff who assist and administer medication and intermittent nursing services through nurse delegation). Staff A stated that their Medication Technicians were not supposed to

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adjust the oxygen flow rate for Resident 7.

During an interview on 04/23/2025 at 2:50 PM, inside Resident 7's apartment, Staff N, Assisted Living-Medication Technician, stated that they were responsible for making sure Resident 7 receive their oxygen therapy as prescribed. Staff N stated that in each shift, they checked Resident 7 using oxygen, made sure the nasal cannula was delivering oxygen and not clinging, and refilled the humidifier with distilled water when the water level ran low. Staff N stated that Resident 7 sometimes requested additional oxygen during transfer and ambulation. Staff N while looking at the oxygen concentrator, stated that when Resident 7 said they needed "a little more oxygen", their Medication Technicians adjusted the oxygen flow rate from two liters per minute to 2.5 or three liters per minute. Staff N stated that they understood "a little more oxygen" as 2.5 or three liters. Staff N stated that Resident 7 did not give them directions for how many liters of oxygen they should adjust to. Observation showed that Staff N pointed at the flow rate indicator on the oxygen concentrator that showed the flow rates they adjusted for Resident 7.

RESIDENT 1
During the entrance conference interview on 04/20/2026 at 10:39 AM, Staff F stated that the facility was without a licensed nurse. Staff F stated that the facility used a contracted nurse to provide nurse delegation and new resident assessments.

Review of the facility's undated characteristics Roster showed the facility admitted Resident 1 in [redacted] of 2019. Review of Resident 1's records showed they were admitted with the diagnosis of [redacted] and [redacted].

Review of Resident 1's "Observations" documentation on 03/30/2026, showed Resident 1 had trouble keeping food down when they ate. The observation note showed staff would monitor Resident 1. Documentation on 03/31/2026 showed Resident 1 was placed on alert for not feeling well, emesis (vomit) and for spitting up throughout the day. Review of the observation note dated 04/01/2026 showed Resident 1 complained of feeling sick after taking their morning medications. The documentation showed Resident 1 complained of being too nervous to eat their lunch meal. The observation note showed that Resident 1's family representative was present and stated that Resident 1 experienced the same issue while in hospital. Resident 1's family representative stated that they contacted Resident 1's primary care provider. Observation notes between 04/04/2026 and 05/08/2026 showed that Resident 1 stated they were feeling better, there were no further documented episodes of emesis and Resident 1 was able to retain food. On 04/08/2026 an observation note showed Resident 1 was removed from alert monitoring. There were no additional documented observations of emesis or difficulty swallowing.

Review of Resident 1's annual assessment dated 12/16/2025, showed that the assessment showed Resident 1 received a regular diet and did not require assistance eating. Review of Resident 1's records found no documentation for an assessment that addressed Resident 1's swallowing difficulties and challenges with eating.

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Observation and interview on 04/21/2026 at 2:52 PM, showed Resident 1 seated in a wheelchair eating portions of their lunch. Observation showed that after each bite of food Resident 1 would spit the food out into the garbage can. Resident 1 repeated the behavior with every bite of food and sips of liquids. Resident 1 stated they have been unable to swallow their food very well which caused them to spit the food out. Resident 1 stated that they were unable to swallow water without spitting up. Resident 1 demonstrated the behavior by taking a sip of water and proceeded to spit it out. Resident 1 stated their throat felt constricted. Resident 1 stated that they lost a few pounds due to the swallowing difficulties.

Observation and interview on 04/21/2026 at 3:00 PM, showed Staff M, Assisted Living Medication Technician, entered Resident 1's room. Resident 1 continued to eat their food and spit it out in the garbage can. Staff M asked Resident 1 if they were feeling ok. Resident 1 asked Staff M to listen to their lungs. Staff M informed Resident 1 that a lung assessment was beyond their scope of practice. Staff M instructed Resident 1 to take deep slow breaths and to relax. Staff M stated that Resident 1's episodes of difficulty swallowing and spitting up food were an ongoing problem. Staff M stated they did not know what the problem was.

During an interview on 04/23/2026 at 9:50 AM, Staff F stated that the facility failed to have Resident 1 assessed either by the contracted licensed nurse or another licensed nurse.

Plan/Attestation Statement

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

Administrator (or Representative) [signature] Date 5/6/26

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

(5) After handling soiled equipment or utensils;

WAC 246-215-03339 Preventing contamination from equipment, utensils, and linens Wiping cloths, use limitation (FDA Food Code 3-304.14).

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(2) Cloths in-use for wiping counters and other equipment surfaces must be:

(a) Held between uses in a chemical sanitizer solution at a concentration specified under WAC 246-215-04565 ; and

WAC 246-215-04700 Objective Food-contact surfaces and utensils (FDA Food Code 4-701.10). equipment, food-contact surfaces, and utensils must be sanitized.

WAC 246-215-04705 Frequency Before use after cleaning (FDA Food Code 4-702.11). utensils and food-contact surfaces of equipment must be sanitized before use and after cleaning.

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

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility failed to follow proper sanitation procedures for 1 of 1 kitchen (Kitchen 1, main kitchen). This failure placed 46 residents at risk of consuming contaminated food and contracting food borne illnesses.

Findings included...

Review of the facility's "infection Control" policy dated 01/21/2026, showed that the facility standard was to provide a "safe, sanitary, and comfortable environment" and to prevent transmission of communicable diseases and infections. The policy showed that infection prevention and control was a facility wide effort that involved all disciplines. The policy showed that staff would be educated on "cleaning and disinfection techniques".

Review of the facility's undated "Comprehensive Job Description Server/Dishwasher" showed that the dishwasher was responsible to assist with kitchen sanitization. The job description showed that the server/dishwasher was responsible for washing tabletops, condiment containers after each meal, washing edges and legs of the tables, and chairs after each meal. The job description showed that the server/dishwasher was to be familiar with "Health Codes, rules, and regulations".

Review of the facility's undated "Comprehensive Job Description" for cook showed that they were responsible to keep the kitchen clean and orderly following a cleaning schedule. The job description showed that the cook was to be familiar with stated "Health Codes" and instruct the kitchen staff on the rules and regulations. The job description showed that the cook was to attend to details necessary to ensure sanitation in all work areas.

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SANITIZATION BUCKETS
Observation on 04/20/2026 at 11:39 AM, showed that Staff G, Culinary Director, used a test strip to test the solution in the sanitation bucket located on service line/cooking area. Observation showed Staff G removed a test strip from a container that was labeled with a concentration range in several shades of light brown and shades of green that indicated the concentration strength of the sanitization solution. Staff G stirred the test strip in the bucket of sanitization solution for over 30 seconds and removed the test strip and compared the color on the test strip with the concentration level chart on the test strip container. Observation showed that the test strip sanitization concentration measured zero and showed it was not an effective concentration to sanitize surface areas. Review of the test strips used by Staff G showed they expired in 2020. Staff G obtained a new container of test strips and retested the sanitization solution. Observation showed the solution tested zero.

During an interview on 04/20/2026 at 11:39 AM, Staff G stated that the test strips were the correct test strips for testing the sanitization solution. Staff G identified the sanitization solution as "Barrier II". Staff G stated that the sanitization solution buckets were changed every two hours and the bucket needed to be changed. Staff G stated that even though the staff tested the sanitization buckets the results were not recorded.

Observation on 04/20/2026 at 11:45 AM, showed Staff G poured out the sanitization solution and refilled the bucket with fresh sanitization solution from the dispenser mixing valve located above the dishwashing three compartment sink. Staff G retested the sanitization solution which showed the solution measured zero. Observation showed that the dispenser mixing valve was connected by a clear tube to a full container of sanitization solution. Staff G stated they would contact the vendor to evaluate the system to see what the problem was.

Observation and interview on 04/20/2026 at 12:30 PM, Collateral Contact 1 (CC1), sanitization solution vendor, stated that the sanitization solution was Quaternary ammonium sanitization solution (Quat). CC1 stated that the sanitization solution concentration should measure 200-400 parts per million (ppm). Observation showed CC1 filled the bucket with sanitization solution from the dispenser and tested the solution. Observation showed that the solution tested zero. CC1 stated that the mixer valve on the dispenser needed to be adjusted.

Observation and interview on 04/20/2026, Staff G approached the Department Licensor and provided an in-service log dated 04/20/2026 that showed the kitchen staff were trained on the proper method of how to test and record the Quat sanitization solution. Observation and review of pictures on Staff G's phone showed Staff G tested the Quat sanitization solution with the correct unexpired test strip and it measured zero. Staff G stated they would contact the vendor, CC1, to come back out and adjust the mixing valve concentration on the sanitization dispenser.

During an interview on 04/20/2026 at 3:00 PM, Staff G stated that CC1 returned to the facility kitchen and readjusted the mixing valve on the dispenser to a concentration of 300-400 ppm. Staff G stated they would continue to observe the dilution rate.

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HANDWASHING
Review of the facility's undated "Comprehensive Job Description Sever/Dishwasher" showed that the dishwasher was responsible to follow "established procedures" for washing, drying, and storing dishes.

Observation on 04/22/2026 at 12:19 PM showed Staff H, Food Service Dishwasher/Server, with bare hands rinsed off soiled dishes and then proceeded to put away clean dishes without washing their hands in-between. Observation showed Staff H entered the dining room area and proceed to buss tables of soiled dishes and then served coffee to residents without washing their hands in-between clean and dirty tasks.

Observation on 04/22/2026 at 12:25 PM, showed Staff H, rinsed off soiled plates, silverware, and cups which were placed in a dishwasher rack. Observation showed Staff H removed the clean dish rack from the clean side of the dishwasher and pushed the dirty dish rack into the dirty side of the dishwasher. Observation showed Staff H rinsed off more soiled dishes and loaded them into the dishwasher rack. Observation showed Staff H returned to the clean side of the dishwasher, removed the clean dishes and utensils from the dish rack and put them away. Observation showed that Staff H wore disposable gloves and did not change gloves or wash hands in-between handling dirty and clean dishes. Observation showed that Staff H repeated the process of going from dirty dishes to clean dishes several more times without washing their hands or changing gloves. Observation showed that Staff H then walked over to the back of the kitchen and picked up a tray of deserts and served them to residents in the main dining room without changing gloves or washing their hands.

Observation and interview on 04/2/2026 at 12:30 PM, showed Staff G observed Staff H clean off food debris from soiled dishes and utensils placed them in a dishwasher rack and walk over to the clean side of the dishwasher and put away cleaned dishes without washing their hands or changing their soiled gloves. Staff G stated that Staff H's failure to wash hands or change gloves was not an acceptable practice.

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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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 6/12/26 .

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

Administrator (or Representative) [signature] Date 5/6/26

WAC 388-112A-0400 What is specialty training and who is required to take it?

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(b) Dementia specialty training as described in WAC 388-112A-0440 ; and

(c) Mental health specialty training as described in WAC 388-112A-0450 .

WAC 388-112A-0495 What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities? Adult family homes.

(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training.

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 12 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 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

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(iv) A person with special education training and an endorsement granted by the Washington state office of superintendent of public instruction, as described in RCW 28A.300.010 ; and

(v) An assisted living facility administrator or the administrator designee as provided under WAC 388-112A-0060 .

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

(2) Assisted living facilities.

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

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

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

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 3 sampled staff (Staff C) obtained a valid first aid card within 30 days of hire, 1 of 3 sampled staff (Staff C) completed the specialty trainings, and 1 of 2 sampled staff (Staff D) completed the required 12 continuing education hours between their 2024 and 2025 birthdays. These failures placed the 46 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

FIRST AID TRAINING
STAFF C
Review of the facility's undated Employee List showed that the facility hired Staff C, Assisted Living Caregiver (AL-Caregiver), on 06/06/2025. Review of Staff C's employee records showed that on 10/04/2024, Staff C completed the Adult Basic Life support training. Staff C's record showed they completed the Adult First Aid and Cardiopulmonary Resuscitation course on 04/20/2026, during the Departments visit and 318 days after hire. There was no documentation that showed Staff C completed first

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aid training within 30 days of hire as required.

SPECIALTY TRAINING
STAFF C
Review of the facility's undated Characteristics Roster showed that seven residents were identified with dementia/Alzheimer's/cognitive impairment. Review of resident files showed that four of seven sampled residents were identified with mental health needs.

Review of Staff C's employee records showed no documentation that Staff C completed the Department of Social and Health Services (DSHS) Dementia and Mental Health specialty training 318 days after hire as required.

Review of the facility's caregiver schedule showed that Staff C provided care and services to assisted living residents in January 2026, February 2026, March 2026, and April 2026.

During an interview on 04/23/2026 at 2:30 PM, Staff A, Resident Services Director, stated that Staff C did not have any certificates that showed they completed the DSHS approved specialty training for dementia and mental health as required. Staff G stated that Staff C stated that the specialty training courses were incorporated in the caregiver curriculum. Staff F, Executive Director, stated that they contacted the school where Staff C completed their caregiver training and were told that the course covered specialty training for dementia and mental health. Staff F stated that the school did not issue certificates of completion for specialty training that showed the specialty trainings met the DSHS requirements.

CONTINUING EDUCATION (CE)
STAFF D
Review of the facility's undated Employee List showed that the facility hired Staff D, AL Caregiver, on 05/27/2021. Review of Staff D's employee records showed Staff D maintained an active Certified Nursing Assistant credential with the first issue date 05/01/2023. The records showed that Staff D completed five of the required 12 hours of CE approved by the Department of Social and Health Services (DSHS) between their 2024 and 2025 birthdays. The records showed that as of 04/21/2026, Staff D completed 12 hours of CE approved by the DSHS after their 2025 birthday.

During an interview on 04/21/2026 at 2:50 PM, Staff A, Resident Services Director, stated they were aware that Staff D did not complete the required 12 hours of CE training for their 2024 and 2025 birthdays. Staff A stated that when they found out Staff D was short of CE hours between their 2024 and 2025 birthdays, Staff D's 2025 birthday was already passed. Staff A stated that Staff D completed additional CE training that made up the CE hours for their 2024 and 2025 birthdays.

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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, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 8/12/26 .

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

Administrator (or Representative) [signature] Date 5/6/26

WAC 388-78A-3040 Laundry.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the exhaust fan in 1 of 3 laundry rooms (2nd floor staff commercial laundry room) was functional. This failure contributed to caused poor ventilation in the facility laundry room.

Findings included...

Observation on 04/20/2026 between 11:36 AM and 1:30 PM, during the facility environmental tour with Staff F, Executive Director, showed a ventilation exhaust system in the second-floor commercial laundry room. When tested the exhaust ventilation system failed to draw and hold a partial paper towel when placed over the ventilation grill cover to indicate negative pressure.

During an interview on 04/20/2026 at 1:15 PM, Staff F stated that the facility was currently without a maintenance director and therefore would need to contact an outside contractor to inspect the ventilation system in the facility commercial laundry room.

Observation on 04/21/2026 at 1:15 PM, showed the second-floor facility commercial laundry room ventilation cover removed. The ventilation exhaust fans and duct work

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showed it was full of dust and debris.

During an interview on 04/21/2026 at 1:15 PM, Staff G, Culinary Director, shared a video that showed the outside contractor tested all the common bathroom and laundry room exhaust vents. The video showed that the second-floor facility commercial laundry room exhaust ventilation system was not working. Staff G stated that the vendor stated the vent system fan and duct work needed to be cleaned.

Review of the outside vendor report dated 04/20/2026 showed that the second-floor commercial laundry room ventilation exhaust system fan and duct "plugged up with lint and debris". The report showed that the facility would contact another outside vendor to clean the commercial laundry room fan and ducts.

Plan/Attestation Statement

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Administrator (or Representative) — Date 5/6/26

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to maintain the carpet in the resident hallway/common areas in good repair for 1 of 1 hallway (Second floor Southeast Hallway). This failure posed a hazard and placed the 46 residents at risk.

Findings include...

Review of the facility's undated Resident Characteristics Roster showed that 46 Assisted Living Residents resided at the facility.

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Observation on 04/20/2026 at 1:30 PM showed the southeast second floor carpet located at the fire doors had separated which allowed for a gap large enough for a residents' mobility device (front wheeled walker or four wheeled walker) to potentially become stuck. Observation showed two areas located on the southeast hallway, one in front of the second-floor attic access door that was greater than two inches in width and a second circular divot located in front of the stairwell door. Both divots posed a tripping hazard for residents and their mobility devices. Observation during the facility environmental tour on 04/20/2026 between 11:40 AM and 3:00 PM, showed several unidentified residents ambulating through the hallways on the first and second floor with the use of mobility devices.

Observation on 04/22/2026 at 12:30 PM of the main facility dining room located on the first floor showed multiple residents used mobility devices for ambulation such as four wheeled walkers, front wheeled walkers and wheelchairs.

During the Resident Group Meeting on 04/22/2026 at 10:30 AM, several unidentified residents stated that it was difficult to navigate their mobility devices (walkers) over the gaps left in the carpet. One unidentified resident stated, "it just needed to push harder to get over the rips". The unidentified resident stated that they were told the carpet was to be replaced and the interior painted. An unidentified resident stated that "there was ripped carpet by the stairwells". Another unidentified resident stated that they moved in three years ago, and the facility staff stated the carpet would be replaced at that time. The unidentified resident stated that the carpet was not replaced.

During an interview on 04/20/2026 at 1:30 PM, Staff F, Executive Director, stated they were aware of the poor condition of the carpets and that the carpet needed to be replaced throughout the facility.

During an interview on 04/24/2026 at 3:06 PM, during the exit conference, Staff F stated that the facility budgeted for carpet replacement. Staff F stated that there was no timeline for when the carpet would actually be replaced.

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Statement of Deficiencies	License #: 1568	Compliance Determination # 75921
Plan of Correction	FOUNTAIN COURT ASSISTED LIVING	Completion Date
Page 21 of 21	Licensee: WRG PHASE I EQUITIES EIGHT TOWNCENT	04/28/2026

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, FOUNTAIN COURT ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 6/12/26 .

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

Administrator (or Representative) [signature] Date 5/6/26

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

WRG PHASE I EQUITIES EIGHT TOWNCENT
FOUNTAIN COURT ASSISTED LIVING
24200 224TH AVENUE SE
MAPLE VALLEY, WA 98038

RE: FOUNTAIN COURT ASSISTED LIVING # 1568

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/28/2026 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 Return the Plan/Attestation Statement and report with signatures to:

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

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eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (04/28/2026), no later than 06/12/2026 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-3030 Toilet rooms and bathrooms.

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

(e) Provide mechanical ventilation to the outside; and

The
Assisted Living Facility failed to ensure that the exhaust fan in the southeast first floor common bathroom operated. During the Licensing inspection the facility contacted a vendor who replaced the exhaust fan and corrected the problem. This deficiency was corrected by the exit conference.

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

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

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o You can make an IDR request and find directions on the IDR web page at:
    https://www.dshs.wa.gov/altsa/idr

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

If You Have Any Questions:

- Please contact me at (206)305-3489.

Sincerely,

Jim Sherman

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

Enclosure

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