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

SCRIBER GARDENS LLC

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

RE: SCRIBER GARDENS LLC License # 2203

Dear Administrator:

This letter addresses Compliance Determination(s) 80445 (Completion Date 07/15/2026) and 76958 (Completion Date 05/15/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/15/2026 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-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4

The Department staff who did the on-site verification:
Wesler Dumecquias, Community Complaint Investigator

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

Sincerely,

Jim Sherman

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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: SCRIBER GARDENS LLC **Provider Type:** Assisted Living Facility

License/Cert.#: 2203
Intake ID: 221800
Compliance Determination #: 76958
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 05/06/2026 through 05/15/2026
Complainant Contact Date(s): 04/29/2026

Allegation(s):
The facility did not promptly respond to a Named Resident who reported pain, experienced sweating, and had little to no urine output from their foley catheter, as well as another resident who exhibited seizure-like symptoms.

Investigation Methods:

Sample:
Total residents: 43
Resident sample size: 4
Closed records sample size: 1

Observations:
Identified resident
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members
Executive Director
Collateral contacts

Record Reviews:
Medical records
Facility policies
Personnel files
Care plans
Assessments
Physician orders
Medication administration and treatment records
Progress notes
Hospice referral
POLST
Witness statements
Facility investigation
Employee credential

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

Investigation Summary:

The facility did not promptly respond to a resident's complaint of pain, sweating, and minimal urine output related to their Foley catheter. This led to the resident needing critical care due to shock from a severe urinary tract infection. Additionally, the facility did not call 911 when another resident showed seizure-like symptoms and had a blood pressure reading of 60/50 reported by the care staff. Deficiencies were identified, and citations were issued.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: SCRIBER GARDENS LLC
Provider Type: Assisted Living Facility

License/Cert.#: 2203
Intake ID: 222515
Compliance Determination #: 76958
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 05/06/2026 through 05/15/2026
Complainant Contact Date(s):

Allegation(s):
The facility Licensed Nurse failed to provide nursing oversight when the Named Resident had a decline in their condition.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Executive Director Collateral contacts
Record Reviews:	Medical records Facility policies Personnel files Care plans Assessments Physician orders Medication administration and treatment records Progress notes Hospice referral POLST Witness statements Facility investigation Employee credential

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

Investigation Summary:

The facility did not promptly respond to a resident's complaint of pain, sweating, and minimal urine output related to their Foley catheter. This led to the resident needing critical care due to shock from a severe urinary tract infection. Failed practice was identified and a citation was issued.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: SCRIBER GARDENS LLC **Provider Type:** Assisted Living Facility

License/Cert.#: 2203
Intake ID: 223616
Compliance Determination #: 76958
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 05/06/2026 through 05/15/2026
Complainant Contact Date(s):

Allegation(s):
A family member discovered the Named Resident (NR) with a male resident in the NR's apartment, which was locked. This situation resulted in a confrontation between the NR's family member and the male resident.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Executive Director
Record Reviews:	Incident investigation Facility policies progress notes care plans assessments Staff schedule

Investigation Summary:
The facility did not complete an incident report or investigate the incident. Failed practice was identified, and a citation was issued.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

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☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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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 #: 2203	Compliance Determination # 76958
Plan of Correction	SCRIBER GARDENS LLC	Completion Date
Page 1 of 7	Licensee: SCRIBER GARDENS LLC	05/15/2026

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 an unannounced on-site complaint investigation on 05/06/2026 and 05/08/2026 of:

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

This document references the following complaint number(s): 221800, 222515, 223616

The following sample was selected for review during the unannounced on-site visit: 4 of 43 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

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

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Statement of Deficiencies	License #: 2203	Compliance Determination # 76958
Plan of Correction	SCRIBER GARDENS LLC	Completion Date
Page 2 of 7	Licensee: SCRIBER GARDENS LLC	05/15/2026

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

05-21-2026
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.

Betsy QRR
Administrator (or Representative)

5-26-26.
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to evaluate and take appropriate action for 2 of 2 residents (Resident 1 and 2) when Resident 1 complained of pain related to their foley catheter and when Resident 2 experienced a seizure-like episode. These failures resulted in ongoing pain and delayed medical treatment for Resident 1and placed Resident 2 at risk for health complications.

Findings included...

Review of facility policy titled, "MEDICAL EMERGENCIES" dated 12/06/2019 showed Major Emergency Limitation: Life threatening was defined as, but limited to convulsions, severe bleeding, blocked airway/choking, non-responsiveness/no pulse or respiration. Or, if the following was evident: broken skin, severe pain the staff would follow the

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facility guidelines which include assessing the situation, call 911, if necessary and if the residents do not want 911 called, but if staff feels it was necessary, staff will call 911.

Resident 1

Review of the face sheet showed Resident 1 was admitted to the facility on [redacted] 2026 with several diagnoses, including [redacted].

Record review of Resident 1's admission pre-assessment conducted by the facility on 04/08/2026 showed Resident 1 had a urinary foley catheter (a thin, flexible tube inserted into the bladder to drain urine).

In an interview on 05/06/2026 at 1:24 PM, Staff B, Memory Care Coordinator, stated that Resident 1 was admitted to the facility with a urinary foley catheter in place.

In an interview on 05/13/2026, at 11:07 AM, Staff E, Medication Technician (MT) stated that they worked the evenings of 04/20/2026, and 04/21/2026. Staff E stated that Resident 1 began to complain of pain in their lower abdomen, experienced an urge to urinate but could not, and was sweating. They noted that the foley catheter urine bag was empty and there was no urine flow. Staff E informed Staff G, Director of Nursing Services, who indicated they would change the catheter the following morning (04/21/2026). Staff E gave pain medication, but Resident 1 continued to experience pain at the end of Staff E's shift on 04/20/2026. On the evening of 04/21/2026, Staff E learned from Staff I, caregiver, that Staff G had changed Resident 1's catheter earlier in the day. Staff E observed that Resident 1 was still in pain, sweating and observed that the foley catheter urine bag contained urine that was cloudy with a pinkish color which looked like blood. Staff E reached out to Staff G and requested immediate call to 911 because of what they observed. Staff E stated that Staff G informed them that they would first personally contact the family before calling 911. Staff E further stated that Resident 1's daughter visited, and both Staff E and the daughter decided to call 911 on [redacted]/2026. The paramedics arrived and transported Resident 1 to the hospital.

In an interview on 05/06/2026 at 1:47 PM, Staff C, Caregiver, stated that they began their morning shift on 04/21/2026. Staff C stated that Staff D, MT/Caregiver and Staff E, MT/caregiver informed them that Resident 1 had experienced pain throughout the night and had a strong urge to urinate but was unable to do so. On the same day, (04/21/2026), around 6:40 AM, Staff C heard Resident 1 screaming and complaining about the urge to urinate without being able to do so. Staff C stated they informed Staff F, MT about the situation. Staff C stated that Staff G, the Director of Nursing, was on their way to change Resident 1's catheter. Staff C stated that they had been instructed by Staff G not to call 911, but to instead contact Staff G directly.

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In an interview on 05/06/2026 at 2:16 PM, Staff H, Caregiver, stated that they worked both the morning and evening shifts on 04/20/2026. Staff H stated that part of what they do for Resident 1 was to empty the urine from the foley catheter bag. Staff H stated that they typically emptied approximately 250 to 300 Milliliter (mL) of urine during a shift. Staff H stated that they observed swelling in both of Resident 1's legs and noted a five-pound weight increase the previous day. Staff H also reported seeing blood in Resident 1's urine. Staff H stated that they informed Staff G, the Director of Nursing, about these observations. Staff H stated that Staff G informed them that they would change the foley catheter the following day. Staff H stated that when they finished their evening shift on 04/20/2026 they emptied about 150 mL of urine from Resident 1's foley catheter bag.

In an interview on 05/14/2026 at 8:39 AM, Staff I, MT/caregiver stated that they worked the morning shifts of 04/20/2026 and 04/21/2026. Staff I stated that they took Resident 1's weight in the morning and it increased to 5.9 pounds from their weight on the previous day (04/20/2026). Staff I stated that they observed Resident 1 as totally different the following day (April 21,2026). Staff I stated that Resident 1 complained of pain, was yelling and could not pass urine.

Record review of Resident 1's medical records from the hospital emergency dated [redacted]/2026 showed Resident 1 met the hospital criteria for critical care due to the high probability of imminent deterioration in their condition. The medical record showed Resident 1 presented septic shock (a life-threatening, advanced stage of sepsis where severe infection causes a dramatic drop in blood pressure and cellular dysfunction, leading to organ failure) secondary to urinary tract infection. Resident 1 was hospitalized from [redacted]/2026 to [redacted]/2026.

Resident 2

Review of the face sheet showed Resident 2 was admitted to the facility on [redacted]/2022 with several diagnoses including [redacted].

Review of Resident 2's care plan dated 06/07/2025, showed Resident 2 had a history of seizure -like type of activity or shakiness.

Review Resident 2's progress notes dated 02/10/2026 and 04/25/2026, showed Resident 2 had seizure like episodes.

In an interview on 05/06/2026 at 1:47 PM, Staff C stated that they personally observed Resident 2 having a seizure-like episode on a night shift around 5:00 AM and called 911. Staff C stated that they called Staff G, who informed them the family did not like staff calling 911.

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On 05/06/2026 at 2:47 PM, Staff H stated that they observed Resident 2 experience a seizure-like episode. Staff H stated that they followed facility protocols. Staff H stated that as they were preparing to call 911, they received a return call from Staff G after several unanswered attempts. Staff H stated that Staff G advised them against calling 911. Staff H stated that upon checking Resident 2's vital signs, Staff H noted a blood pressure reading of 60/50. After reporting this reading to Staff G, they were instructed by Staff G to have Resident 2 lay in bed. Staff H expressed feeling anxious at that moment, as Resident 2 did not exhibit normal behavior, and believed that Resident 2 should have been evaluated at a hospital.

Review of available records did not show any call was made to 911 regarding Resident 2's seizure-like incident on 05/06/2026.

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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) 6-29-26.

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

Administrator (or Representative) Betsy ORR Date 5-22-26

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

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

(2) Determine the circumstances of the event;

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

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate, document their findings and institute measures to protect 1 of 1 resident (Resident 3) regarding an incident on 04/28/2026. This failure resulted in the facility being unable to rule out abuse and placed Resident 3 at risk for safety concerns.

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Findings included...

Review of facility policy, "RESIDENT FALLS/ACCIDENTS/INCIDENCES" dated 09/06/2022 showed it was the policy of the facility to review and investigate all incidences, accidents, and/or injuries that happen within the community or on community outings. The policy showed the facility would ensure that an incident Report would be started immediately to include phase I of the investigatory process which is intended to rule out abuse, neglect and/or exploitation.

Review of Resident 3's face sheet showed they were admitted to the facility on [redacted]/2025, with multiple diagnoses including [redacted].

In an interview on 05/08/2026, at 11:57 AM, Staff A, Executive Director, stated that Resident 3 had a consensual relationship with another resident, Resident 4. Staff A mentioned that Collateral Contact 1 (CC1), resides in the facility as an independent living resident. Staff A noted that CC1 visited Resident 3 on 04/28/2026, and knocked on their door, which was locked. A staff member opened the door, and CC1 reportedly overheard a voice saying, "Let me put on my pants." Staff A stated that this situation disturbed CC1 and resulted in verbal exchanges with Resident 4. Staff A also stated that there was no incident report or investigation at that time (04/28/2026), as they were waiting for the staff to complete the incident report.

In interview on 05/08/2026, at 12:38 PM, Staff B, the Memory care coordinator, stated that Resident 3 began a relationship with Resident 4 shortly after moving into the Memory care unit. Staff B stated that Staff G, the Director of Nursing, had a conversation with CC1 regarding this relationship but they were not part of the conversation. According to Staff B, Resident 4 exhibited aggressive behavior towards CC1.

In an interview on 05/08/2026, at 1:18 PM, CC1 stated that they visited Resident 3 on April 28, 2026, accompanied by Collateral Contact 2 (CC2). CC1 stated that when they knocked on Resident 3's apartment door, there was no response. A staff member subsequently opened the door. Upon entering, CC1 described hearing a male voice saying, "wait a minute I need to put on my pants." CC1 recounted seeing Resident 4 exit Resident 3's apartment in an agitated and aggressive manner. A verbal altercation occurred, with both Resident 4 and CC1 raising their voices. Staff members intervened to separate them. CC1 stated that they were informed Resident 3 had a friend but were not told that Resident 4 had been inside Resident 3's apartment with the doors locked. CC1 expressed uncertainty about whether Resident 3 was safe with Resident 4. CC1 stated that they discussed their concerns with Staff A, who responded by asking what action they wished to take. CC1 stated that they felt Staff A brushed off their concerns.

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Review of an undated Witness statement showed Staff H, Caregiver, observed the verbal altercation between Resident 4 and CC1.

Review of the facility's records did not show documentation of an investigation and incident report for 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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) 10-29-26.

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

Betsy Orr — Administrator (or Representative)

5-26-26 — Date

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