STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

CRP/CSH Mountlake LLC
Mountlake Terrace Plaza
23303 58th Ave W
Mountlake Terrace, WA 98043

RE: Mountlake Terrace Plaza License # 2373

Dear Administrator:

This letter addresses Compliance Determination(s) 74213 (Completion Date 03/20/2026) and 70336 (Completion Date 01/13/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/20/2026 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-2660-1

The Department staff who did the off-site verification:
Hayley Pinkham, ALF Licensor

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Mountlake Terrace Plaza
Provider Type: Assisted Living Facility

License/Cert.#: 2373
Intake ID: 204666
Compliance Determination #: 70336
Region/Unit #: RCS Region 2 / Unit J
Investigator: Hayley Pinkham
Investigation Date(s): 12/18/2025 through 01/13/2026
Complainant Contact Date(s): 01/13/2026

Allegation(s):

1) The Named Resident (NR) left the Assisted Living Facility (ALF) and walked to a local grocery store. The NR told an attendant at the local grocery store to call 911. The NR was taken to the Emergency Room (ER).
2) The ALF administrative Staff Member (SM) told the ER staff the NR could not return home (ALF) without reviewing the clinical assessment from the ER.
3) The ALF may not be providing showers on a regular basis which may have contributed to the NR's confusion and diagnoses of [redacted].
4) A few months prior to the NR leaving the facility, the ALF sent the NR to the hospital for evaluation after a comment regarding suicidal ideation. The ER determined the NR was not at risk and the NR returned to the ALF. The SM requested the NR transfer to a family members' (FM) home due to the NRs' comment.

Investigation Methods:

Sample:	Total residents: 76 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Hospital records Facility policies

Investigation Summary:

1) Interview and observation of sampled residents at the ALF showed no voiced

concerns with care and/or services. Interview with the NR showed they reported wanting to walk to the grocery store and did not sign out. The NR reported having transitory confusion related to a treatable condition. The ALF was notified of the NR's absence by the police. The ALF notified the department of the NR leaving the ALF without signing out. No failed practice identified.
2) Interview and record review showed the ALF did not send a qualified assessor to the ER for evaluation of the NR after leaving the ALF, nor did ALF staff review the ER discharge records. The SM told the FM the NR could not return to the ALF without one-on-one, 24 hours/7 days a week, private caregiving services. The ALF did not provide reasonable accommodations that met the NR's preferences to return home. The ALF failed to meet minimum requirements of Resident rights, see Statement of Deficiencies (SOD) dated 01/13/2026.
3) Interview and record review showed that the NR received shower assist based on assessment and the Negotiated Service Agreement. Unable to substantiate the UTI is related to not receiving showers. No failed practice identified.
4) Interview and record review showed the NR was deemed safe to return to the ALF after the ER visit, the ER requested the NR follow up with a primary physician. Interview and record review showed the NR was receiving chemotherapy and having significant pain. Interview and record review showed the ALF requested the FM take the NR to another family members' house due to the NRs' comment and until a behavioral specialist could evaluate the NR before she could return to the ALF. Record review showed the NR did not have further comments regarding suicidal ideation from the first passing remarks.
Findings of deficient practice for resident rights. The ALF did not provide reasonable accommodations for the NR to return to her home (ALF) per the NR's preference. The same failed practice was found and the ALF failed to meet the minimum requirements of the Resident Rights regulations see SOD dated 01/13/2026.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Mountlake Terrace Plaza
Provider Type: Assisted Living Facility

License/Cert.#: 2373
Intake ID: 204462
Compliance Determination #: 70336
Region/Unit #: RCS Region 2 / Unit J
Investigator: Hayley Pinkham
Investigation Date(s): 12/18/2025 through 01/13/2026
Complainant Contact Date(s):

Allegation(s):

1) The Named Resident (NR) left the Assisted Living Facility (ALF) at an unknown time and the NR did not sign out.

Investigation Methods:

Sample:	Total residents: 76 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1) Interview and observation of sampled residents at the ALF showed no voiced concerns with care and/or services. Interview with the NR showed they reported wanting to walk to the local grocery store and did not sign out. The NR reported having transitory confusion related to a treatable condition. The NR reported wanting to return to home (ALF). Interview and record review showed the ALF did not review the Emergency Room (ER) records and did not send a qualified assessor to the ER. Interview and record review showed the ALF denied the NR's request to return and requested a family member (FM) to pay for 24 hour, 7 days a week private caregiving services at the ALF. The ALF requested transfer of the NR to a family members home. Interview and record review showed the ALF did not reasonably accommodate the NR's preference in returning to her home (ALF). The ALF did not allow the NR to return home (ALF) until 19 days later. Findings of deficient practice for Resident Rights. See intake #204666. See Statement of

Deficiency dated 01/13/2026.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 12/18/2025 of:

Mountlake Terrace Plaza
23303 58th Ave W
Mountlake Terrace, WA 98043

This document references the following complaint number(s): 204666, 204462

The following sample was selected for review during the unannounced on-site visit: 3 of 76 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2373	Compliance Determination # 70335
Plan of Correction	Mountlake Terrace Plaza	Completion Date
Page 2 of 6	Licensee: CRP/CSH Mountlake LLC	01/13/2026

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.

Residential Care Services — Date: 01/22/2026

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.

Nikki Bakken — Administrator (or Representative) — Date: 1/22/2026

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to protect and promote resident rights for 1 of 1 resident (Resident 1) when the resident was not permitted to return to the facility. This failure resulted in Resident 1 not being able to return to their home for 19 days.

Findings included...

NOTE: Revised Code of Washington (RCW) 70.129.110-Disclosure, transfer, and discharge requirements. (1) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: (3) Before a long-term care facility transfers or discharges a resident, the facility must: First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident.

NOTE: RCW 70.129.140 Quality of life-Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to: (f) Unless adjudged incompetent or otherwise found to be legally incapacitated, to direct his or her own service plan and changes in the service plan, and to refuse any particular service so long as such refusal is documented in the record of the resident.

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.

Administrator (or Representative) | Date

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Based on interview and record review, the Assisted Living Facility (ALF) failed to protect and promote resident rights for 1 of 1 resident (Resident 1) when the resident was not permitted to return to the facility. This failure resulted in Resident 1 not being able to return to their home for 19 days.

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NOTE: WAC 388-78A-2130 - Service agreement planning. The assisted living facility must: (5) Involve the following persons in the process of developing and updating a negotiated service agreement (NSA): (a) The resident; (b) The resident's representative to the extent he or she is willing and capable, if the resident has one; (6) Ensure: (a) Individuals participating in developing the resident's negotiated service agreement: (ii) Negotiate and agree upon the care and services to be provided to support the resident.

NOTE: WAC 388-78A-2080 - Qualified assessor - The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident: (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or (4) Is a physician with a valid state license to practice medicine; or (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

Review of the website seniorliving.org stated that urinary tract infections (UTI- a bacterial infection of the urinary system) are a common issue for seniors and can cause sudden confusion, disorientation and behavior changes that may resemble serious conditions like dementia (a group of symptoms that affects memory, thinking and interferes with daily life). The confusion and disorientation associated with UTI’s in seniors is reversable if the UTI is properly diagnosed and treated with antibiotics.

Record review showed the ALF admitted Resident 1 on [redacted]/2024, with an admission agreement to provide care with a diagnosis of [redacted]. Review of an Assessment and Negotiated Service Agreement (NSA), dated 05/28/2025, showed Resident 1 had no history of exit seeking or wandering, and was assessed as being safe to leave the building without an escort.

Record review of the Emergency Department (ED) Discharge Note (DN), dated [redacted]/2025, stated Resident 1 was brought to the ED after being found at a local grocery store. The DN stated Resident 1 presented to ED with an altered mental status, abnormal urinalysis (urinalysis is a laboratory test), and was diagnosed with a [redacted]. The DN showed Resident 1 was alert and oriented to self and place but not year. Resident 1’s presentation was, “overall, well appearing with benign [not harmful in effect] work up”. The DN showed the medical professionals that evaluated Resident 1 were aware she lived in an ALF and could be safely discharged back to the ALF in a stable condition. The DN showed Resident 1 had no other change in diagnosis and care needs, was prescribed antibiotics to resolve the UTI, and was not admitted to the hospital. The

record showed the ED staff spoke with ALF staff who stated they would not permit Resident 1 to return to the facility related to not being a memory care facility.

In interview, on 12/18/2025 at 12:34 PM, Staff A (ALF Administrator) stated that she determined, without an assessment, evaluation or negotiating and updating a care plan with Resident 1 or their representative, that Resident 1 needed 24-hour/seven days a week (24/7) one on one care (1:1) before Resident 1 could return to the ALF, or needed to find alternative placement. Staff A stated she determined this requirement without speaking with a medical professional or the ED staff at the hospital on [redacted]/2025. Staff A stated she did not review any records from the ED prior to making the 1:1 requirement. Staff A confirmed she was not a qualified assessor to determine the care needs of residents in an ALF. Staff A confirmed Resident 1 had never wandered or had exit seeking behavior prior to [redacted]/2025.

Record review showed, on the evening of [redacted]/2025, no qualified assessor from the ALF determined any additional interventions appropriate for Resident 1, in relation to the newly diagnosed [redacted], which was being treated with antibiotics to resolve the confusion that Resident 1 presented with when found at a local grocery store. Records showed the requirement of a 24/7 1:1 caregiver was determined without an evaluation, assessment or updated NSA.

In interview, on 12/17/2025 at 4:40 PM, Collateral Contact 1 (CC1 – Resident 1's Legal Representative) stated, on [redacted]/2025, Resident 1 decided to walk to a local grocery store. CC1 stated Resident 1 appeared confused while at the local grocery store so they notified the local police department. CC1 stated Resident 1 was transported to the hospital ED for evaluation. CC1 stated the ED found Resident 1 had a UTI, was prescribed antibiotics, was deemed medically stable, and cleared by medical professionals to return to the ALF. CC1 stated Resident 1 was not admitted to the hospital. CC1 stated the ED contacted the ALF who denied allowing Resident 1's return to their home (the ALF). CC1 stated they were not called regarding the situation and that they only received a text notification from Staff A who texted that Resident 1 could not return to the ALF without paying for 24/7 1:1 private caregiving even though Resident 1's elopement was due to her UTI which was treatable. CC1 stated that no one from the ALF conducted an assessment or attempted to negotiate a care plan with reasonable accommodation agreed upon by Resident 1 or CC1. CC1 stated that the ALF did not discuss alternate or more reasonable plans with him to allow Resident 1 to stay in their home at the ALF, such as more safety checks or allowing the family to assist Resident 1 while they recovered from her UTI. CC1 stated Resident 1, "was completely normal," and described the ALF's position as, "it was like get out". CC1 stated they had no choice but to bring Resident 1 home to stay with the family on [redacted]/2025 as they could not arrange 1:1 care and had nowhere else for Resident 1 to stay.

In a follow-up interview, on 01/12/2026 at 12:02 PM, when asked if the ALF told CC1 how much a 24/7 1:1 private caregiver would cost, CC1 stated, "no, it was completely left to me to find out". CC1 stated Staff A recommended a local private care agency. CC1 stated they did not look into 24/7 1:1 private caregiving because, "[it] would be crazy expensive" and it was not necessary.

In interview, on 12/18/2025 at 1:59 PM, Staff C (Regional Clinical Specialist) stated she was a licensed practical nurse that worked for the ALF in a regional capacity. Staff C stated she was aware of the situation regarding Resident 1. Staff C stated the ALF, “needed” to bring Resident 1 back to their home on the evening of [redacted]/2025 and an assessment and evaluation should have been conducted to determine if any changes in care was necessary. Staff C stated, regarding Resident 1’s confusion related to her treatable [redacted] diagnosis, that she would have updated the care plan and implemented increased safety checks. Staff C did not mention that 24/7 1:1 care would be the appropriate care level in this situation based on the information she had.

Record review showed the ALF did not follow up or conduct an assessment, that would provide the information needed, to complete an updated NSA with care and service agreed upon with Resident 1 until [redacted]/2025, five days after the ALF transferred Resident 1 out of the ALF. Review showed the ALF did not have any documentation from the ED visit on [redacted]/2025 to support Resident 1’s needs or determine appropriate care level.

Review of the Saint Louis University School of Medicine website (slu.edu) states that the Saint Louis University Mental Status exam (SLUM) is a standardized screening tool designed to assess cognitive function and detect early signs of cognitive impairment, including dementia. The test does not include questions related to wandering behavior and other symptoms of dementia and cannot measure global cognitive function, nor give a clinical diagnosis.

In interview, on 12/31/2025 at 1:43 PM, Staff D (Licensed Practical Nurse) stated she visited Resident 1, who looked well-kept, clean and appropriate, at Resident 1's family home on [redacted]/2025. Staff D stated she conducted a SLUM exam, an assessment, and developed a new negotiated service agreement. When asked if Staff D thought Resident 1 could return to the ALF without 24/7 1:1 care, Staff D stated, “Yes, I do, [the ALF] could have done additional safety checks.” Adding, “And maybe more in the night. Every 4 hours in the daytime and then in the evening maybe one to two hours would be appropriate, yes, we can do that.” Staff D stated a new care plan should have included, “to watch for increased signs of confusion and symptoms of a UTI, burning pain etc. keep [Resident 1] hydrated and let the nurse know.” Staff D stated Resident 1 and CC1’s goal was to have her go back to the ALF, “It’s [Resident 1’s] home that’s where [they] live that’s where [they] want to be.”

Record review showed Staff D completed an Elopement Risk Form (ERF) with Resident 1 on [redacted]/2025. The ERF showed Resident 1 was able to verbalize the importance of not leaving the community without informing staff and was not showing any signs of wandering behaviors.

In interview, on 12/18/2025 at 12:34 PM, after Staff D assessed Resident 1 on [redacted]/2025, Staff A stated she determined Resident 1 was still not allowed to return to

the ALF without 24/7 1:1 care related only to the results of a SLUM exam conducted by Staff D. When asked if the ALF could provide resident safety checks, Staff A stated, "Not to my knowledge".

In interview, on 12/18/2025 at 1:45 PM, Staff B (ALF Medication Technician) stated prior to being diagnosed with the treatable [redacted] Resident 1, "wasn't very confused" and was mostly independent with care. Staff B stated the ALF could, "manage every one-hour safety checks" for Resident 1.

In interview, on 12/23/2025 at 12:01 PM, Resident 1 stated they were still staying with family, and had been with them for, at that time, 16 days. Resident 1 stated they left the ALF on [redacted] 2025 and walked to a local grocery store. Resident 1 stated they had a UTI at the time, and it affected them leading to some confusion. Resident 1 stated after antibiotics they have improved. Resident 1 stated they know not to leave the ALF without an escort and would not do it again. Resident 1 stated they just wanted to go home (to the ALF).

In an interview, on [redacted] 2026 at 3:14 PM, CC1 stated that Resident 1 returned to the ALF on [redacted] 2025. In total Resident 1 stayed with family for 19 days.

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, Mountlake Terrace Plaza is or will be in compliance with this law and / or regulation on (Date) ~~2/11/2026~~ 2/27/2026.

SB confirmed POC date with provider on 1/27/2026.

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

Nikki Bakken
Administrator (or Representative)

1/22/2026
Date

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In an interview, on [redacted]/2026 at 3:14 PM, CC1 stated that Resident 1 returned to the ALF on [redacted]/2025. In total, Resident 1 stayed with family for 19 days.

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

_____ _____

Administrator (or Representative) Date