STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC
Port Townsend Senior Living
1201 Hancock St
Port Townsend, WA 98368

RE: Port Townsend Senior Living License # 2408

Dear Administrator:

This letter addresses Compliance Determination(s) 82176 (Completion Date 08/13/2026) and 78646 (Completion Date 06/17/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/13/2026 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-2350-1, WAC 388-78A-2350-7-a, WAC 388-78A-2350-7-b, WAC 388-78A-2350-7, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-b, WAC 388-78A-2140-1-e, WAC 388-78A-2140-2, WAC 388-78A-2140-3, WAC 388-78A-2140-7, WAC 388-78A-2120-2-a, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3, WAC 388-78A-2490, WAC 388-78A-2371-3, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2260-1, WAC 388-78A-2650-1, WAC 388-78A-2650-2

The Department staff who did the on-site verification:
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit E

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

Residential Care Services

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 06/09/2026 and 06/11/2026 of:

Port Townsend Senior Living
1201 Hancock St
Port Townsend, WA 98368

The following sample was selected for review during the unannounced on-site visit: 9 of 61 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Laurie Anderson — Residential Care Services

06/18/2026 — 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.

Peder Berg — Administrator (or Representative)

6/26/26 — Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to coordinate care and services from external providers and integrate external providers information into the Service Plan (facilities version of the negotiated service agreement) for 2 of 3 sampled residents (Resident 2 and 7). This failure placed the residents at risk for unmet care needs.

Findings included...

Record review of the facility's policy titled, "Home Health and Other Outside Agencies," dated 06/01/2024, showed when a resident needed home health or other outside agency services, the services would be addressed in the resident's service plan.

In an interview on 06/10/2026 at 12:37 PM, Staff F, Resident Care Coordinator, stated that the facility's document titled, "COG Washington HSE with Packages and Billing v3 Results," was the facility's assessment document.

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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

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Administrator (or Representative) | Date

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Findings included…

Record review of the facility's policy titled, "Home Health and Other Outside Agencies," dated 06/01/2024, showed when a resident needed home health or other outside agency services, the services would be addressed in the resident's service plan.

In an interview on 06/10/2026 at 12:37 PM, Staff F, Resident Care Coordinator, stated that the facility's document titled, "COG Washington HSE with Packages and Billing v3 Results," was the facility's assessment document.

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Resident 2 (R2)
Record review of R2's medical records showed they moved into the facility on [redacted]/2024.

Record review of R2's assessment, dated 05/28/2026, showed they received bathing services through hospice.

Record review of R2's Outside Provider Summary Sheet, dated 06/04/2026, showed R2 received weekly scheduled nursing visits from hospice provider.

Record review of R2's Outside Provider Summary Sheet, dated 06/03/2026, showed R2 received bathing and personal care with the plan to see the resident weekly.

Record review of R2's Service Plan, dated 05/28/2026, showed there was no documentation that R2 received any hospice services.

In an interview on 06/09/2026 at 2:51 PM, R2 stated they received hospice services that included helping with R2's pain management, mail delivery of their medications, weekly showers from the hospice bath aide, weekly nursing visits, and monthly social worker visits.

Resident 7 (R7)
Record review of R7's medical records showed they moved into the facility on [redacted]/2021.

Record review of R7's Palliative Care Visit, dated 06/03/2026, showed they were seen for advanced Parkinson's dementia (a progressive brain condition that person experiences sever and progressive decline in thinking, memory and daily independence). The palliative care team would visit R2 in the next four to six weeks and as needed.

Record review of R7's Service Plan, dated 05/26/2026, showed there was nothing documented that R7 was on palliative care services.

In an interview on 06/11/2026 at 12:40 PM, Staff B, Health and Wellness Director, stated that they did not incorporate home health or any outside provider into the resident's service plan.

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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, Port Townsend Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/29/26 .

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

Peder Berg 6/26/26

Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

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

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

(7) The resident's ability to leave the assisted living facility premises unsupervised; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in the resident's service plan detail (the facility's version of the Negotiated Service Agreements [NSA]) the plan to provide the care and services necessary to support the residents care needs and the plan to provide the residents preference assistance with

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Plan/Attestation Statement

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

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Administrator (or Representative) Date

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(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

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

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

(7) The resident's ability to leave the assisted living facility premises unsupervised; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in the resident’s service plan detail (the facility’s version of the Negotiated Service Agreements [NSA]) the plan to provide the care and services necessary to support the residents care needs and the plan to provide the residents preference assistance with

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activities of daily living for 9 of 9 sampled residents (Resident 1, 2, 3, 4, 5, 6, 7, 8 and 9). This failure placed the residents at risk for unmet care needs.

Findings included…

Record review of the facility policy titled, "Negotiated Service Agreements," dated 12/05/2025, showed NSA's would be updated as frequently as necessary to ensure they reflect current residents care needs and preferences.

Record review of the facility's policy titled, "Falls," dated 12/05/2025, showed all residents were evaluated for fall risk and their negotiated service agreement would be developed and updated accordingly. When a resident experienced a fall, staff would provide immediate care and follow through with the NSA planning. A fall evaluation would be completed upon move-in that identified the residents falls risks and address with recommended interventions documented on the NSA.

In an interview on 06/10/2026 at 12:37 PM, Staff F, Resident Care Coordinator, stated that the facility's document titled, "COG Washington HSE with Packages and Billing v3 Results," was the facility's assessment document.

Resident 1 (R1)
Record review of R1's medical records showed they moved into the facility on [redacted]/2022.

Record review of R1's NSA, dated 04/06/2026, documented R1 received minimal assistance with bathing twice weekly on Monday and Thursday. The NSA did not incorporate R1's preferred time to bathe. The housekeeping section showed no approximate dates or times listed.

Resident 2 (R2)
Record review of R2's medical records showed they moved into the facility on [redacted]/2024.

Record review of R2's NSA, dated 05/28/2026, showed there was nothing listed about R2's ability to leave the facility premises unsupervised.

Resident 3 (R3)
Record review of R3's medical records showed they moved into the facility on [redacted]/2026 with multiple medical diagnoses that included [redacted] an [redacted]

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Fall
Record review of R3's pre-move in assessment, dated 03/19/2026, showed R3 had mild vision impairment, used a seated walker to walk with, had a history of falling within the last three months, had secondary diagnoses, was weak when they walked or transferred, and forgot their limitations.

Record review of R3's NSA, dated 04/03/2026, showed there were no interventions or documentation that showed R3 had a history of falls and was at risk of further falls.

Record review of R3's Incident Form, dated 05/01/2026, showed a visitor reported to the staff that R3 fell and upon entering their room, found R3 seated on the floor. The form showed R3's NSA was not revised.

Record review of R3's TSP, dated 05/01/2026 through 05/04/2026, showed R3 experienced a non-injury fall in their apartment. There was no documentation to show R3's NSA was updated.

Record review of R3's Incident Form, dated 06/07/2026, showed R3 tripped on their carpet and was found sitting on the floor in their apartment. R3 got a skin tear on their left-hand middle finger that first aid was applied. The form showed R3's NSA was not revised and had no other incidents of similar nature without any interventions listed to prevent or reduce risk of recurrence.

Record review of R3's TSP, dated 06/07/2026 through 06/10/2026, showed R3 had a non-injury fall when they tripped on their living room carpet. The TSP did not document any interventions, or the NSA was updated.

Leaving Facility
Record review of R3's NSA, dated 04/03/2026, showed there was nothing listed about R3's ability to leave the facility premises unsupervised.

Showers
Record review of R3's pre-move in assessment, dated 03/19/2026, showed R3 required extensive assistance with their showers two times a week with preference to shower in the evening.

Record review of R3's NSA, dated 04/03/2026, showed R3 preferred showers two times a week with no listed days or preferred time documented.

Resident 4 (R4)
Record review of R4's medical records showed they moved into the facility on [redacted]/2026.

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Record review of R4's NSA, dated 02/06/2026, documented R4 received extensive assistance with bathing twice weekly with no approximate days or times listed. The medication section documented the facility staff provided medication management for R4 twice daily. The NSA did not indicate R4's family provided them with their supplements and the alternative plan if R4's family was unable to do so. The housekeeping section showed no approximate dates or times listed.

Record review of R4's, April 2026 "eMAR (electronic Medication Administration Record) Summary" documented R4 missed seven of 30 dosages of their probiotic formula (a blend of bacteria and yeasts that benefit an individual's body).

In an interview on 06/09/2026 at 10:30 AM, R4 stated that they preferred to shower in the morning and received help on Wednesday and Saturday. R4 stated that their daughter brought all their supplements into the facility.

In an interview and observation on 06/10/2026 at 12:11 PM, Staff C, Medication Technician pulled up R4's April 2026 eMAR on the computer and stated that R4 missed their probiotic formula medication because R4's daughter did not bring in the medication. Staff C stated that R4's daughter provided all R4's supplements.

In an interview and observation on 06/11/2026 at 12:40 PM, Staff B, Health and Wellness Director pulled up R4's April 2026 eMAR on the computer and stated that R4 missed their medication because their family member did not bring in their medication. Staff B stated that R4 had two daughters and if one was not available to bring in R4's medication then the other would.

Resident 5 (R5)
Record review of R5's medical records showed they moved into the facility on [redacted]/2026.

Record review of R5's NSA, dated 05/27/2026, showed there was nothing listed about R5's ability to leave the facility premises unsupervised.

Resident 6 (R6)
Record review of R6's medical records showed they moved into the facility on [redacted]/2026.

Record review of R6's NSA, dated 03/05/2026, documented R4 used a cane (mobility device) and did not indicate they were a fall risk. The bathing section showed R4 required extensive hands-on assistance with showering with no approximate days or times listed. The housekeeping section showed no approximate dates or times listed.

Record review of R6's Progress Notes, dated 02/23/2026, showed R6 reported a non-

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injury fall that occurred in their apartment.

Record review of R6's Progress Notes, dated 03/07/2026, showed R6 had a non-injury fall that occurred in their apartment.

In an observation and interview on 06/09/2026 at 3:00 PM, R6 was inside of their apartment with a four wheeled walker next to them. R6 stated that they only used their four wheeled walker and did not use a cane. R6 stated that they showered independently and the facility staff did not help them. R6 stated that the housekeeper came and cleaned their apartment when they were able to with no set date or time.

Resident 7 (R7)
Record review of R7's medical records showed they moved into the facility on [redacted]/2021.

Assistive Device
Record review of R7's NSA, dated 05/26/2026, showed R7 was independent with ambulation with use of a walker and required moderate assistance transferring from staff.

In an observation on 06/09/2026 at 12:30 PM, Staff E, Care Partner, pushed R7 in a wheelchair to their apartment. Staff E stated that R7 walked around independently and was not supposed to.

In an interview on 06/11/2026 at 10:50 AM, Staff E stated that R7 used a wheelchair all the time and is unable to walk.

In an interview on 06/11/2026 at 10:04 AM, Collateral Contact 1 (CC1), Power of Attorney for R7, stated that R7 could hardly walk and used the wheelchair most of the time.

Leave Facility
Record review of R7's NSA, dated 05/26/2026, showed there was nothing listed about R7's ability to leave the facility premises unsupervised.

Housekeeping
In an observation on 06/09/2026 at 12:30 PM, under the side table in R7's room was a pad and multiple brown dried spilled areas on the floor.

In an interview on 06/10/2026 at 4:14 PM, Staff F, Resident Care Coordinator, stated that R7 spilled a lot of drinks daily on the floor and required more housekeeping services from housekeeping and/or caregiver staff. Staff F stated that the pad under the

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side table next to R7's bed was there to absorb the spills from their drinks.

Record review of R7's NSA, dated 05/26/2026, showed staff were to remove R7's trash daily. There was nothing documented that staff were to clean spilled messes in R7's room when observed or daily overall cleaning.

Smoking
In an interview and observation on 06/10/2026 at 4:10 PM, R7 stated that they go either in front or in the back of the facility to smoke marijuana. On the counter there was marijuana and smoking materials with a lighter.

Record review of R7's NSA, dated 05/26/2026, showed R7 used a marijuana vape pen. There was nothing about R7 burning marijuana and interventions listed for safety.

Fall
Record review of R7's Incident Form, dated 04/20/2026, showed when the staff came into R7's apartment they found R7 on the floor on their hands and knees. R7 reported to the staff that they had tried to get a drink from the fridge and fell.

In an interview on 06/11/2026 at 10:04 AM, Collateral Contact 1 (CC1), Power of Attorney for R7, stated that R7 had some falls and was getting increasingly weaker, unable to walk and in a wheelchair more.

Record review of R7's NSA, dated 05/26/2026, showed there was nothing documented that indicated R7 was at risk or had a history of falling.

Resident 8 (R8)
Record review of R8's medical records showed they moved into the facility on [redacted]/2025.

Record review of R8's NSA dated 12/17/2025, documented R4 was independent with ambulation and did not include they used a walker. The housekeeping section showed no approximate dates or times listed. The laundry section showed no approximate dates or times listed.

In an observation and interview on 06/09/2026 at 12:32 PM, inside of R8's apartment there was a walker and R8 said that they used their walker to ambulate.

Resident 9 (R9)
Record review of R9's medical records showed they moved into the facility on [redacted]/2023.

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Record review of R9's NSA dated 06/09/2026, documented the facility staff performed medication management. The NSA did not indicate R9's family provided them with their supplements and the alternative plan if R4's family was unable to do so. The housekeeping section showed no approximate dates or times listed.

In an observation on 06/11/2026 at 9:46 AM, inside R9's apartment on the kitchenet counter showed a weekly pill box with multiple medications inside.

In an interview on 06/11/2026 at 9:46 AM, R9 stated that their daughter provided them with their supplements. R9 stated that they were unsure what day and time the housekeeper was supposed to come to clean their apartment.

In an interview on 06/11/2026 at 10:54 AM, Staff C stated that R9's daughter brought their supplements into the facility.

In an interview on 06/11/2026 at 12:40 PM, Staff B stated they tried to incorporate residents shower days and preferred times into their NSA's but sometimes the days changed. Staff B stated they did not incorporate the housekeeping days and preferred times into resident NSA's because they were unsure what the housekeeping schedule was. Staff B stated they did not incorporate outside services a resident was on such as home health, palliative care and hospice care. Staff B stated the areas covered in the resident's assessment would be documented in the resident's NSA.

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, Port Townsend Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/29/26 .

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

Peder Berg — Administrator (or Representative)

6/24/26 — 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:

(a) Departure from the resident's customary range of functioning; or

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

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Record review of R9's NSA dated 06/09/2026, documented the facility staff performed medication management. The NSA did not indicate R9's family provided them with their supplements and the alternative plan if R4's family was unable to do so. The housekeeping section showed no approximate dates or times listed.

In an observation on 06/11/2026 at 9:46 AM, inside R9's apartment on the kitchenet counter showed a weekly pill box with multiple medications inside.

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Administrator (or Representative) 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:

(a) Departure from the resident's customary range of functioning; or

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

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(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.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to monitor 1 of 4 residents (Resident 3 [R3]) well- being after a fall. This failure placed R3 at risk for unmet and unidentified care needs.

Findings included…

Record review of the facility's policy titled, "Falls," dated 12/05/2025, showed the health and wellness director or designee would document the fall and for 48 hours after any fall each shift would monitor the resident and make a brief narrative charting entry.

Record review of R3's medical records showed they moved into the facility on [redacted]/2026 with multiple medical diagnoses that included [redacted].

Record review of R3's Progress Note, dated 05/01/2026, showed R3 was found seated on the floor in their apartment living room after their visitor came to the charting room and alerted the facility staff.

Record review of R3's progress note, dated 05/04/2026, showed they were discontinued off alert charting from their fall last week. There were no documented progress notes about R3's condition on 05/02/2026 and 05/03/2026.

In an interview and observation on 06/09/2026 at 3:22 PM, R3's left hand middle finger was dark purple, blue and brown in color with a bandage. R3 stated that they fell a few days prior when their foot got stuck on the carpet. R3 stated that they got the bruise and a cut on their middle finger from the fall.

Record review of R3's progress note, dated 06/07/2026, showed R3 had not complained of any discomfort after their fall. There was nothing documented about the injuries R3 sustained. The prior progress note was dated 05/04/2026, that did not document R3 had fallen.

In an interview on 06/11/2026 at 1:20 PM, Staff B, Health and Wellness Director, acknowledged that the ongoing monitoring for R3 after their fall on 05/01/2026 and the actual fall event on 06/07/2026, was not documented.

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This is a recurring deficiency previously cited on 10/24/2024.

Plan/Attestation Statement

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

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

WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-823-0040 , that is the resident's primary special need.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 3 sampled staff (Staff E) completed the required developmental disability specialty training. This failure placed Resident 1 (R1) and Resident 10 (R10) at risk for unmet care needs and support services provided by untrained staff.

Findings included...

Washington Administrative Code (WAC) 388-112A-0400 "What is specialty training and who is required to take it? (1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (a) Developmental disabilities specialty training as described in WAC 388-112A-0420... (4) All long-term care workers including those exempt from basic training who work in an

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This is a recurring deficiency previously cited on 10/24/2024.

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WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-823-0040 , that is the resident's primary special need.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 3 sampled staff (Staff E) completed the required developmental disability specialty training. This failure placed Resident 1 (R1) and Resident 10 (R10) at risk for unmet care needs and support services provided by untrained staff.

Findings included…

Washington Administrative Code (WAC) 388-112A-0400 “What is specialty training and who is required to take it? (1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities. (2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC 388-112A-0010 (36), or DSHS approved. (3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula: (a) Developmental disabilities specialty training as described in WAC 388-112A-0420…(4) All long-term care workers including those exempt from basic training who work in an

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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: (a) Developmental disabilities specialty training as described in WAC 388-112A-0420".

Revised Code of Washington (RCW) 18.20.270 Long-term caregiver training. "(5) For assisted living facilities that serve residents with special needs such as dementia, developmental disabilities, or mental illness, specialty training is required of administrators, or designees, and caregivers. (b) Specialty training must be completed by caregivers within one hundred twenty days of the date on which they begin to provide hands on care to a resident having special needs. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training. Until competency in the core specialty areas has been demonstrated, caregivers shall not provide hands-on personal care to residents with special needs without direct supervision."

Record review of the facility's undated Characteristic Roster showed R1 and R10 had developmental disabilities.

Record review of the facility's policy titled, "Staffing and Training Requirements," dated 06/01/2026, showed all care staff would be trained in accordance with state regulations and documented in the employee's file.

Record review of the facility's undated document titled, Department of Social and Health Services (DSHS) Staff showed Staff E, Care Partner, started employment at the facility on 12/11/2025.

Record review on 06/10/2026 of Staff E's employee records showed no documentation of any specialty training certificate for developmental disabilities.

In an interview on 06/11/2026 at 1:20 PM, Staff A, Executive Director, acknowledged that Staff E had not yet completed the course to receive their certificate for developmental disabilities specialty training.

This is a recurring deficiency previously cited on 10/24/2024.

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

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, Port Townsend Senior Living is or will be in compliance with this law and / or regulation on (Date) 7|29|26 .

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

Administrator (or Representative) — Date: 6|26|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;

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document appropriate measures for 3 of 3 sampled residents (Resident 3, 4 and 7) and complete an investigation when a fire started in a resident's apartment. These failures placed the residents at risk for similar situations to recur and placed the residents at risk for unmet care needs.

Findings included...

Record review of the facility policy titled, "Incident Reports," dated 06/01/2025, showed an occurrent investigation report was completed by staff for all unusual occurrences, injuries, injuries of unknown origin and incidents. An incident report would be completed by the Health and Wellness Director or by designated staff and should include steps to prevent similar incidents from occurring in the future. An incident report was completed in the electronic health record including all that were reportable to the state or required modifications to resident monitoring or plans of care. The reports would be written and include the residents name, age, sex, date of admission, date, nature of event, attending physician's name, findings, treatment, and disposition of incident. The investigation shall include but not limited to a review of the factors leading up to the incident, nature of event/incident, disposition of the incident and steps to prevent similar incidents from occurring in the future. The community would provide reports to

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Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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(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;

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document appropriate measures for 3 of 3 sampled residents (Resident 3, 4 and 7) and complete an investigation when a fire started in a resident's apartment. These failures placed the residents at risk for similar situations to recur and placed the residents at risk for unmet care needs.

Findings included…

Record review of the facility policy titled, "Incident Reports," dated 06/01/2025, showed an occurrent investigation report was completed by staff for all unusual occurrences, injuries, injuries of unknown origin and incidents. An incident report would be completed by the Health and Wellness Director or by designated staff and should include steps to prevent similar incidents from occurring in the future. An incident report was completed in the electronic health record including all that were reportable to the state or required modifications to resident monitoring or plans of care. The reports would be written and include the residents name, age, sex, date of admission, date, nature of event, attending physician's name, findings, treatment, and disposition of incident. The investigation shall include but not limited to a review of the factors leading up to the incident, nature of event/incident, disposition of the incident and steps to prevent similar incidents from occurring in the future. The community would provide reports to

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the Department that included but not limited to accidental or unintended fires, incidents requiring the implementation of the Community's disaster plan and circumstances that threaten the Community's ability to ensure that continuation of services to residents.

Record review of the facility policy titled, "Temporary Care Plans (TCP)s," dated 12/13/2024, showed TCP's were used to document a residents status change or need that results in a change in care needs expected to resolve within 14 days or less. TCPs provided director to care staff for resident care during this limited time without the need to update the resident's NSA.

Record review of the facility's policy titled, "Falls," dated 12/05/2025, showed a fall evaluation would be completed after each fall, that would identify the residents falls risks and address with recommended interventions documented on the NSA. The person completing the fall evaluation would select the interventions to implement on the NSA.

Resident 3 (R3)
Record review of R3's medical records showed they moved into the facility on [redacted]/2026 with multiple medical diagnoses that included [redacted].

Record review of R3's Service Plan (Facility's version of the NSA), dated 04/03/2026, showed R3 had moderate memory impairment, mild vision impairment, walked and transferred independently with the use of a cane. The NSA did not list R3 at risk of falling or history of falling.

Record review of R3's Incident Form, dated 05/01/2026, showed a visitor reported to the staff that R3 fell and upon entering their room found R3 seated on the floor. The form showed R3's NSA was not revised, the incident was not avoidable, and there were no listed interventions to help prevent further occurrences.

Record review of R3's Temporary Service Plan (Facility's version of the Temporary Care Plan), dated 05/01/2026 through 05/04/2026, showed R3 experienced a non -injury fall in their apartment. The TSP listed signs and symptoms to monitor R3 for, without any listed interventions to prevent the incident from happening again.

Record review of R3's Incident Form, dated 06/07/2026, showed R3 tripped on their carpet and was found sitting on the floor in their apartment. R3 got a skin tear on their left-hand middle finger that first aid was applied. The form showed R3's NSA was not revised and had not had any other incidents of similar nature without any interventions list to prevent or reduce risk of incident occurring.

Record review of R3's TCP, dated 06/07/2026 through 06/10/2026, showed R3 had a non-injury fall when they tripped on their living room carpet. The TCP listed signs and symptoms to monitor R3 for, without any listed interventions to prevent the incident from happening again.

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Resident 4 (R4)
Record review of R4's medical records showed they moved into the facility on [redacted]/2026.

Record review of R4's NSA, dated 02/06/2026, documented R4 was independent with their ambulation and used a walker and wheelchair. R4 had a history of falling within the last three months.

Record review of R4's Incident Form, dated 03/31/2026, documented R4 had a fall in the morning in the lobby attempting to get up and go to work. R4 confirmed they hit their head, R4 complained of right leg pain, the emergency medical services were called and R4 went to get evaluated at the emergency department. The report showed R4's NSA was followed at the time of the fall and was not updated. There were no documented interventions included as to how to prevent the situation in the future.

Record review of R4's TCP, dated 03/31/2026 through 04/03/2026, documented R4 had a fall in the lobby on 03/31/2026 and denied any pain or hitting their head. R4 right foot and leg were edematous, (abnormally swollen with fluid) warm and painful to light touch. Care staff were to monitor for any new pain, change in R4's mobility or gait or change in mentation. There were no documented interventions included as to how to prevent the situation in the future.

In an interview on 06/11/2026 at 12:40 PM, Staff B, Health and Wellness Director, stated that they were unable to pull up a copy of R4's TCP dated 03/31/2026 through 04/03/2026 to reference. Staff B stated that they tried to incorporate interventions in residents TCPs.

Resident 7 (R7)
Record review of R7's medical records showed they moved into the facility on [redacted]/2021.

Record review of R7's NSA, dated 05/26/2026, showed moderate memory impairment, mild vision impairment, required every two to three hours checks and moderate assistance with transfers.

Fire
Record review of R7's progress note, dated 05/20/2026, showed on 05/19/2026 R7 placed a takeout container of food in their microwave, turned it on and did not watch it. The container and the food cough fire in the microwave that filled R7's apartment with smoke. R7 was coughing and evaluated by emergency medical services.

Record review of R7's TCP, dated 05/19/2026 through 05/22/2026, showed R7 placed a takeout container in their microwave that caught on fire. The TSP listed signs and

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symptoms to watch R7 for, without any listed interventions to prevent the incident from happening again.

In an interview on 06/11/2026 at 11:09 AM, Staff C, Medication Technician, stated that the fire alarm system sounded throughout the facility and noticed there was a lot of smoke coming from R7's room. Staff C stated that when R7's apartment door was opened there was a large amount of smoke and a fire inside of the microwave. Staff C stated that the other care partner removed R7 from the room to a safe area. Staff C stated that they opened the microwave and put the fire out with water. Staff C stated the fire department and emergency medical services came to the facility in response to the fire alarm system, all the fire doors shut themselves and the staff followed the fire disaster plan.

In an interview on 06/11/2026 at 9:15 AM, Staff B stated that they did not complete an incident investigation for the fire that occurred in R7's microwave.

As of 06/15/2026 at 5:30 PM, the Department had not received an incident investigation to review.

Fall
Record review of R7's Incident Form, dated 04/20/2026, showed when the staff came into R7's apartment they found R7 on the floor on their hands and knees. R7 reported to the staff that they tried to get a drink from the fridge and fell.

Record review of R7's Incident Form, dated 04/20/2026, showed R7 had other incidents of similar nature, it was unavoidable and R7's service plan was not revised. There were no interventions listed as to how to prevent further occurrences.

Record review of R7's TCP, dated 04/20/2026 through 04/23/2026, showed R7 reported that they had fallen when they were found on the floor on hands and knees. The TCP listed signs and symptoms to watch for from falling without any interventions implemented to prevent or reduce the incident from occurring again.

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Plan/Attestation Statement

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

Peder Berg — 6/26/26

Administrator (or Representative) — Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all medications were stored and locked in a secure manner in 1 of 5 sample resident rooms (Resident 8). This failure placed all residents at risk of access to and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff or visitors within the facility.

Findings included...

Record review of the facility policy titled, "Medication Storage – Centrally Stored Medications," dated 12/05/2025, documented all medications, including over the counter medications, would always be kept in locked storage.

Resident 8 (R8)
Record review of R8's medical records showed they moved into the facility on [redacted]/2025.

Record review of R8's Service Plan Detail, dated 12/17/2025, documented the facility staff performed medication management for R8 which included bringing R8 their medication and remain present until R8 swallowed their medication.

Record review of R8's June 2026 eMAR (electronic Medication Administration Record) an order for calcium antacid (medication that neutralizes stomach acid) three times a day.

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Plan/Attestation Statement

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Administrator (or Representative) Date

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Findings included…

Record review of the facility policy titled, “Medication Storage – Centrally Stored Medications,” dated 12/05/2025, documented all medications, including over the counter medications, would always be kept in locked storage.

Resident 8 (R8)
Record review of R8’s medical records showed they moved into the facility on [redacted]/2025.

Record review of R8’s Service Plan Detail, dated 12/17/2025, documented the facility staff performed medication management for R8 which included bringing R8 their medication and remain present until R8 swallowed their medication.

Record review of R8’s June 2026 eMAR (electronic Medication Administration Record) an order for calcium antacid (medication that neutralizes stomach acid) three times a day.

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In an observation of R8's apartment on 06/10/2026 at 3:34 PM, showed a clear plastic cup with one green circular tablet inside on the table in their dining room.

In an interview and observation on 06/10/2026 at 3:34 PM, R8 said that the green circular tablet on their table was their antacid medication. R8 stated that the facility staff brought them their medication and the staff left their medication on their table for them to take it when they got around to it.

In an interview on 06/11/2026 at 10:54 AM, Staff C, Medication Technician, stated that R8 received antacid medication three times a day and their antacid medication should not be left out on their table for R8 to take at their leisure.

In an interview on 06/11/2026 at 12:40 PM, Staff B, Health and Wellness Director, stated that facility staff should not leave R8's medication on their table for them to take at their leisure.

Plan/Attestation Statement

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Preeler Berg — 6/26/26

Administrator (or Representative) — Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the assisted living facility;

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report to the department's aging and disability services administration when the facility implemented their fire disaster plan after a fire occurred in 1 of 1 resident (Resident 7) microwaves. This failure placed all residents at risk of potential harm and prevented the Department from

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In an observation of R8's apartment on 06/10/2026 at 3:34 PM, showed a clear plastic cup with one green circular tablet inside on the table in their dining room.

In an interview and observation on 06/10/2026 at 3:34 PM, R8 said that the green circular tablet on their table was their antacid medication. R8 stated that the facility staff brought them their medication and the staff left their medication on their table for them to take it when they got around to it.

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In an interview on 06/11/2026 at 12:40 PM, Staff B, Health and Wellness Director, stated that facility staff should not leave R8's medication on their table for them to take at their leisure.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the assisted living facility;

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report to the department's aging and disability services administration when the facility implemented their fire disaster plan after a fire occurred in 1 of 1 resident (Resident 7) microwaves. This failure placed all residents at risk of potential harm and prevented the Department from

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being able to evaluate systems that were in place to protect residents.

Findings included…

Record review of the facility's polity titled, "Incident Reports," dated 06/01/2025, showed the community will furnish to the licensing agency immediately reports as the Department requires that included the community would provide reports to the Department that included but not limited to accidental or unintended fires, incidents requiring the implementation of the Community's disaster plan and circumstances that threaten the Community's ability to ensure that continuation of services to resident's. State required incident reports would be submitted per regulatory requirements.

Record review of R7's progress note, dated 05/20/2026, showed on 05/19/2026, R7 placed a takeout container of food in their microwave, turned it on and did not watch it. The container and the food caught fire in the microwave that filled R7's apartment with smoke. R7 was coughing and evaluated by emergency medical services.

In an interview on 06/11/2026 at 11:09 AM, Staff C, Medication Technician, stated the fire alarm system sounded throughout the facility. Staff C stated that they noticed there was a lot of smoke coming from R7's room. Staff C stated that when R7's apartment door was opened, a large amount of smoke and a fire were seen inside of the microwave. Staff C stated that another care partner removed R7 from the room to a safe area. Staff C stated that they opened the microwave and put the fire out with water. Staff C stated that the fire department and emergency medical services came to the facility in response to the fire alarm system, all the fire doors shut themselves, and the staff followed the fire disaster plan.

In an interview on 06/11/2026 at 12:11 PM, Staff A, Executive Director, stated they had not reported to the Department when the facility implemented the fire disaster plan after R7's apartment filled with smoke.

In an interview on 06/11/2026 at 1:10 PM, Staff B, Health and Wellness Director, stated that they did not report the fire incident in R7's apartment to the Department.

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

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, Port Townsend Senior Living is or will be in compliance with this law and / or regulation on (Date) 7/29/26 .

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

Peder Berg — 6/29/26

Administrator (or Representative) — Date

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Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

06/18/2026

NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC
Port Townsend Senior Living
1201 Hancock St
Port Townsend, WA 98368

RE: Port Townsend Senior Living # 2408

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 06/17/2026 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:

Laurie Anderson, Community Field Manager
Residential Care Services
Region 3, Unit E
Preferred methods:

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

eFax: (360) 992-7969
Email: rcsregion3email@dshs.wa.gov
Optional method:
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (06/17/2026), no later than 08/01/2026 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-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

The facility failed to ensure that all combustible tanks were chained, secured, and not free standing on the facility premises. The facility chained and secured the six tanks before the inspection was completed to correct this deficiency.

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

The facility failed to ensure all staff members were screened for tuberculosis within three days of their employment. A designated staff member was responsible for ensuring the facility staff were screened for tuberculosis within three days of their employment. The facility corrected this deficiency prior to completion of the full inspection.

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(1) Cooperate with the department during any on-site inspection or complaint investigation;

(2) Provide requested records to the representatives of the department; and

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

The facility delayed providing requested records to the Department during the full inspection. The facility provided the requested records prior to completion of the full inspection to correct this deficiency.

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

If You Have Any Questions:

• Please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

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

The facility delayed providing requested records to the Department during the full inspection. The facility provided the requested records prior to completion of the full inspection to correct this deficiency.

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.

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If You Have Any Questions:

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Sincerely,

Laurie Anderson, Community Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

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