STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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

The department completed data collection for the unannounced on-site full inspection on 06/10/2026 and 06/15/2026 of:

Merrill Gardens at Auburn
18 1st St SE
Auburn, WA 98002

The following sample was selected for review during the unannounced on-site visit: 7 of 55 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licensor
Claudia Allis, ALF Licensor
Angelica Rios, ALF Licensor

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

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

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

Staci Oilg IDR PM for Reg 2D
Residential Care Services

August 12, 2026
Date

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

Administrator (or Representative)

Date

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a preadmission assessment before admitting 1 of 1 resident (Resident 1) to the assisted living facility. This failure placed Resident 1 at risk of unmet care needs.

Findings included...

Review of Resident 1's records showed that Resident 1 was admitted to the assisted living on [redacted]/2025. Review of Resident 1's records showed an assessment dated 12/12/2025 and 01/16/2026. Further review showed there was no assessment was conducted prior to their admission date of [redacted]/2025.

During an interview on 06/12/2026 at 10:42 AM, Staff A, General Manager/Administrator, stated that a preadmission assessment was not conducted for Resident 1. Staff A further stated that they were aware a preadmission assessment was required. Staff A stated that they did not have documentation to show a preadmission assessment was completed.

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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, Merrill Gardens at Auburn is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

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

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

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

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

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

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

(5) The assisted living facility may, through policy or procedure, require the resident's family member to immediately notify the assisted living facility of any changes in the medication or treatment plans for family assistance or administration.

This requirement was not met as evidenced by:

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Based on interview and record review, the facility failed to ensure a family plan was created for 1 of 1 resident (Resident 5) who received family assistance with their medication. This failure placed Resident 5 at risk of unmet medication care needs.

Findings included...

Review of Resident 5's records showed that Resident 5 was admitted to the facility on [redacted]/2026 and received family assistance with their medications. Further review showed no documentation of a family assistance medication plan for Resident 5.

During an interview on 06/12/2026 at 2:04 PM, Staff B, Resident Care Director, stated that they did not have a written family assistance plan for Resident 5. Staff B stated that they would contact Resident 5's family to request Resident 5's current medication list and ensure a medication plan was created.

During an interview on 06/18/2026 at 1:30 PM, Collateral Contact 1 (CC1), stated that they managed Resident 5's medications. CC1 further stated that the facility did not request a plan for family assistance with medication when Resident 5 was admitted to the facility.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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

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

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

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

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(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure nurse delegation was in place for 1 of 1 resident (Resident 1) before staff provided medication administration that required nurse delegation. This failure caused Resident 1 to receive skilled nursing tasks from nondelegated staff.

Findings included...

According to WAC 246-840-930 (1) Criteria for delegation, in community-based and in-home care settings, before delegating a nursing task, the registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: assess, plan, implement and evaluation.

Review of the facility's undated disclosure of services, showed that the facility provided nurse delegation services as needed.

Review of Resident 1's records showed that Resident 1 was admitted to the facility on [redacted]/2025. Review of Resident 1's combination assessment and service plan (equivalent to the negotiated service agreement) dated 01/16/2026 showed that Resident 1 had a [redacted] diagnosis [redacted] and had a crushed medication order. Further review of Resident 1's service plan showed no information regarding nurse delegated medication tasks.

Review of Resident 1's April, May and June 2026 Medication Administration Record (MAR) showed that Resident 1 was prescribed, memantine (a medication used to treat moderate to severe dementia) 10 milligrams (mg), take one tablet by mouth or crushed and taken with a bite of food twice daily, Atorvastatin (a medication used to lower cholesterol) 20 mg, take one tablet by mouth that may be crushed and taken with a bite of food daily, Melatonin (a hormone that helps regulate sleep) 5 mg, take 1 tablet at bedtime by mouth that may be crushed and taken with a bite of food. Further review showed that the Memantine was prescribed on 02/07/2026. Review showed Atorvastatin and Melatonin were prescribed on 02/05/2026. Additional review of Resident 1's MAR showed that crushed medications were administered from 04/01/2026 to 06/07/2026, by caregiving staff that were not licensed nurses.

Review of Resident 1's nurse delegation records showed Resident 1's crushed

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medication orders were not delegated until 06/07/2026.

During an interview on 06/12/2026 Staff A, General Manager/Administrator, and Staff B, Resident Care Director, stated that they were aware that nurse delegation was required for residents that had a physician's order for crushed medications. Staff A and Staff B stated that medication technicians were administering Resident 1's medication as prescribed from their admission date on [redacted]/2025. Staff B stated that Resident 1's medication was not delegated until 06/07/2026.

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Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 7 residents (Resident 2 and Resident 7) medical devices were safely secured to the resident's bed and free of entrapment hazards. This failure placed Resident 2 and Resident 7 at risk of potential harm or injury from the use of unsafe medical equipment.

Findings included...

Review of the facility policy titled, "Assistive Devices", dated 10/19/2023, showed that the definition of an assistive device included a bedside mobility device (BMD), which is a device on the side of the bed that attaches to the structure of the bed, and bed rails, which are adjustable bars that attach to the side of the bed. These devices are used to assist the residents with bed mobility and/or getting in and out of bed. Review showed that a BMD or bed rail must be installed and maintained by a third-party provider such as a therapist or durable medical equipment (DME) supplier under a qualified medical

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provider order. Review of the policy showed that a physical or occupational therapist, or hospice provider must complete an assessment of the resident to determine the possible benefit to the resident and the risk of entrapment. When the BMD or bed rail is installed, the therapist, hospice provider, or DME supplier must complete a documented measurement of gaps for entrapment risk. Review showed that any openings within the device exceeding 4 ¾ inches requires a cover to be in place that allows for safe gripping and for the device to be used for its intended purpose. A BMD that slides under the mattress and not securely attached to the structure of the bed are not permitted.

Review of the facility's Resident Characteristic Roster showed the facility provided care and services for residents with medical devices.

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 on [redacted]/2017. Review of Resident 2's combination assessment and service plan (equivalent to the negotiated service agreement), dated 03/16/2026, showed that Resident 2 was assessed for use of bilateral siderails on their bed for positioning and support. A review of the records showed no documentation that an assessment was performed by a physical, occupational, or hospice therapist. There was no documentation that the bed siderails were installed and maintained by a third-party provider. Review showed no documentation that measurements of gaps for entrapment risk were performed.

Observation of Resident 2's apartment on 06/12/2026 at 10:15 AM, showed half bed rails on both the left and right sides of Resident 2's at the top of the bed. Observation showed the bed rails had horizontal openings of 3.5 inches. The bed siderails were uncovered.

During an interview at the time, Staff G, Memory Care Director. stated that Resident 2 used the bed siderails as a positioning aid. Staff G stated that facility staff looked at the bedrails in the mornings when the bed linens were changed. Staff G stated that the facility staff did not document that they had checked the bed rails in Resident 2's apartment.

RESIDENT 7
Review of Resident 7's records showed the facility admitted Resident 7 on [redacted]/2024. Review of Resident 7's combination assessment and service plan (equivalent to the negotiated service agreement), dated 01/19/2026, showed that Resident 7 was assessed for use of a bed cane on one side of their bed for positioning and support. Review of the records showed no documentation that an assessment was performed by a physical, occupational, or hospice therapist. There was no documentation that the bed cane was installed and maintained by a third-party provider. Review showed no documentation that measurements of gaps for entrapment risk were performed.

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Observation of Resident 7's apartment on 06/15/2026 at 12:13 PM, showed a bed cane on the left side of Resident 7's bed at the head of the bed. Observation showed the base of the bed cane was slid between the mattress and bed frame and not attached to the bed frame structure. The bed cane was loose and slid away from the mattress and bed frame with minimal force, introducing a gap between the bed cane and the mattress. Observation showed the bed cane handle had an opening of 10.5 inches by 5 inches. The bed cane opening was uncovered. During an interview at the time, Resident 7 stated that they used the bed cane to get in and out of their bed. Resident 7 stated that their family member installed the bed cane.

During an interview on 06/16/2026 at 1:30 PM, Staff A, General Manager/Administrator, stated that they were aware that Resident 2 and Resident 7 utilized bedside medical devices. Staff A stated that they were unaware that Resident 2 and Resident 7's bedside medical devices did not meet the facility's policies for the use of bedside medical devices.

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Administrator (or Representative) Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

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(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

(4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 9 residents (Resident 2, Resident 5, Resident 6, and Resident 7) initial and updated service plans (equivalent to negotiated service agreement) met current and changing needs to include care staff instructions and interventions. This placed Resident 2, Resident 5, Resident 6, and Resident 7 at risk for unmet needs and a decreased quality of life.

Findings included...

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 on [redacted]/2017. The records showed Resident 2 admitted with diagnoses that included [redacted] and [redacted].

Review of Resident 2's service plan, dated 03/16/2026, showed no directions for care staff of actions to be taken when Resident 2 was observed demonstrating signs and symptoms of disruptive behaviors. Review of Resident 2's Assessment dated 03/16/2026 showed no description of Resident 2's disruptive behaviors. Review of Resident 2's service plan, dated 03/16/2026, showed no directions for care staff of actions to be taken when Resident 2 was heard or observed demonstrating signs and symptoms of paranoia. The NSA showed no instructions for staff about what documentation was needed in Resident 2's records. The service plan showed no documentation of guidance for care staff to provide supportive care to Resident 2. Resident 2's NSA showed no documentation of instructions for care staff to report observations concerning any signs and symptoms of major depression and anxiety to facility nursing staff.

RESIDENT 5

Review of Resident 5's records showed that Resident 5 was admitted to the facility on [redacted]/2026. Records showed that Resident 5 received wound care from home health services (an external provider) in the facility for an active ulcer (an open sore on the skin). Further review showed that Resident 5 managed their medications independently.

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Review of Resident 5's service plan dated 04/15/2026, showed that Resident 5 took hypoglycemics (medications that lower blood glucose levels). Review showed no current list of medications and no guidance for care staff regarding signs and symptoms related to hyperglycemia (high blood sugar). Further review of Resident 5's service plan showed that Resident 5 had an active wound. Review showed no information was provided to the facility care staff about Resident 5's active ulcer.

During an interview on 06/18/2026 at 1:30 PM, Collateral Contact 1 (CC1), stated that they managed all of Resident 5's medications. CC1 further stated that Resident 5 no longer received home health services in the facility because they went out to a nearby clinic for wound care.
During an interview on 06/12/2026 at 2:04 PM, Staff B, Resident Care Director, stated that the facility was monitoring Resident 5's active wound and that care staff reported observations to them. Staff B stated that they would contact CC1 to receive a list of Resident 5's current medications. Staff B further stated that they would update Resident 5's service plan to show they received family assistance with their medication and include information regarding their use of hypoglycemic medication and wound care.

RESIDENT 6

Review of Resident 6's records showed the facility admitted Resident 6 on [redacted]-2024. The records showed Resident 6 admitted with diagnoses that included [redacted].

Review of Resident 6's April 2026, May 2026, and June 2026 Medication Administration Record (MAR) showed that Resident 6 received 81 milligrams (mg) of aspirin (medication used to prevent blood platelets from clumping together, reducing the risk of blood clots and blocking blood flow) 1 tablet, once daily, by mouth.

Review of Resident 6's service plan, dated 02/23/2026, showed no documentation that provided the facility care staff with guidance about monitoring and reporting of possible side effects from the chronic use of daily aspirin therapy, including an increased risk of bruising or bleeding.

RESIDENT 7

Review of Resident 7's records showed the facility admitted Resident 7 on [redacted]/2024. The records showed Resident 7 admitted with diagnoses that included [redacted].

Review of Resident 7's April 2026, May 2026, and June 2026 MAR's showed that Resident 7 received 81 mg of aspirin, 1 tablet, once daily, by mouth.

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Review of Resident 7's service plan, dated 01/19/2026, showed no documentation that provided the facility care staff with guidance about monitoring and reporting of possible side effects from the chronic use of daily aspirin therapy, including an increased risk of bruising or bleeding.

During an interview on 06/12/2026 at 1:20 PM, Staff A, General Manager/Administrator, stated that they were aware of the comprehensive elements required in resident service plans. Staff A stated that the facility utilized an electronic documentation system. Staff A stated that they thought the electronic documentation system met the required service plan comprehensive components

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

_____ _____

Administrator (or Representative) Date

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