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

Sunrise Senior Living Management Inc
Sunrise of Issaquah
23599 SE Issaquah Fall City Rd
Issaquah, WA 98029

RE: Sunrise of Issaquah License # 2543

Dear Administrator:

This letter addresses Compliance Determination(s) 80122 (Completion Date 07/08/2026) and 77329 (Completion Date 05/19/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/08/2026 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-2730-1-b

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

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

Sincerely,

Jim Sherman

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

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

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

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 follow-up on 05/13/2026 of:

Sunrise of Issaquah
23599 SE Issaquah Fall City Rd
Issaquah, WA 98029

This document references the following SOD dated: 05/19/2026

The following sample was selected for review during the unannounced on-site visit: 6 of 76 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Yip, ALF Licensor
Thomas Forkgen, ALF Licensor
James Sherman, Field Manager

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.

Statement of Deficiencies	License #: 2543	Compliance Determination # 77329
Plan of Correction	Sunrise of Issaquah	Completion Date
Page 2 of 4	Licensee: Sunrise Senior Living Management Inc	05/19/2026

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 — 06/01/2026 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) — 6/3/26 Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow the required federal and state regulations to conduct medical tests in long term care facilities for 1 of 2 sampled residents (Resident 10). This failure placed Resident 10 at risk of potential errors from medical tests performed by facility's staff.

Findings included...

Review of the facility's document titled "Clinical Laboratory Improvement Amendments (CLIA) Management Process", revised in March 2024, showed the facility performed certain medical tests, such as, blood glucose test (a test that measures the level of sugar in the blood) that required a Medical Test Site Waiver (MTSW) license issued by the Department of Health (DOH).

Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed that the Assisted Living Facility (ALF) received a citation for this regulation on 03/19/2026 that included findings for Resident 10. The ALF signed an attestation statement that showed the facility would have a system in place and the deficiency corrected by 04/30/2026.

Review of the DOH's "Facility Search" website on 05/13/2026 showed that the facility's

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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…

Review of the facility's document titled "Clinical Laboratory Improvement Amendments (CLIA) Management Process", revised in March 2024, showed the facility performed certain medical tests, such as, blood glucose test (a test that measures the level of sugar in the blood) that required a Medical Test Site Waiver (MTSW) license issued by the Department of Health (DOH).

Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed that the Assisted Living Facility (ALF) received a citation for this regulation on 03/19/2026 that included findings for Resident 10. The ALF signed an attestation statement that showed the facility would have a system in place and the deficiency corrected by 04/30/2026.

Review of the DOH's "Facility Search" website on 05/13/2026 showed that the facility's

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Medical Test Site Waiver (MTSW) license issued by the DOH expired on 09/30/2025.

Review of the facility's untitled document, dated 05/12/2026, showed that the facility submitted the Certificate of Waiver Medical Test Site License Application to the DOH on 05/12/2026, 12 days after the facility's plan of correction date. There was no documentation for a valid MTSW license.

During an interview on 05/13/2026 at 1:00 PM, Staff A, Executive Director, stated that they initiated the DOH CLIA/MTSW license application in March 2026. Staff A stated that they made some mistakes in the application that delayed the application process. Staff A stated that they completed and submitted the CLIA/MTSW license application and the related application fee to the DOH on 05/12/2026.

Review of the DOH Credentialing's email, dated 05/19/2026, showed that the facility's MTSW license expired in September 2025. The email showed that as of 05/19/2026, the DOH has not received the facility's MTSW license application and payment.

RESIDENT 10
Review of Resident 10's records showed that the facility admitted Resident 10 in [redacted] 2024 with a medical diagnosis of [redacted] and [redacted]. Review of Resident 10's Service Plan Report, undated, showed that Resident 10 received blood glucose checks by the facility's nurses every morning before breakfast.

Review of Resident 10's May 2026 Medication Administration Records (MARs) showed a physician order of blood glucose check one time a day. The MARs showed that between 05/01/2026 and 05/14/2026, the facility's staff performed and signed off blood sugar tests for Resident 10 one time a day.

During an interview on 05/13/2026 at 3:23 PM, Staff H, Registered Nurse/Resident Care Director, stated that the facility nurses performed the blood sugar test for Resident 10 daily per the doctor's order. Staff H stated that they were aware the facility applied for the MTSW license. Staff H stated that when they performed the blood sugar tests for Resident 10, they were unsure the status of the MTSW license application.

This is an uncorrected deficiency previously cited on 03/19/2026 for WAC 388-78A-2730 subsection (1)(b).

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Statement of Deficiencies	License #: 2543	Compliance Determination # 77329
Plan of Correction	Sunrise of Issaquah	Completion Date
Page 4 of 4	Licensee: Sunrise Senior Living Management Inc	05/19/2026

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Sunrise of Issaquah is or will be in compliance with this law and / or regulation on (Date) 7/3/26.

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

Administrator (or Representative) — Date: 6/3/26

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, Sunrise of Issaquah 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

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

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 03/03/2026 and 03/09/2026 of:
Sunrise of Issaquah
23599 SE Issaquah Fall City Rd
Issaquah, WA 98029

The following sample was selected for review during the unannounced on-site visit: 9 of 76 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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

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

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

Jim Sherman
Residential Care Services

03-24-2026
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)

3/31/26
Date

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

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

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

WAC 246-215-03510 Temperature and time control Thawing (FDA Food Code 3-501.13). Except as specified in subsection of this section, time/temperature control for safety food must be thawed:

(2) Completely submerged under running water:

(a) At a water temperature of 70 F (21 C) or below;

(c) For a period of time that does not allow thawed portions of ready-to-eatfood to rise above 41 F (5 C); or

WAC 246-215-04565 Equipment Manual and mechanical warewashing equipment, chemical sanitization Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114). A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under WAC 246-215-04710 must meet the requirements specified under WAC 246-215-07220 , **must be used in accordance with the EPA-registered label use instructions, and must be used as follows:**

(3) A quaternary ammonium compound solution must:

(b) Have a concentration as specified under WAC 246-215-07220 and as indicated by the manufacturer's use directions included in the labeling; and

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

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

(2) Ensure employees working as food service workers obtain a food worker card

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.

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

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

(2) Ensure employees working as food service workers obtain a food worker card

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according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to test the sanitation solution to determine if the solution was at the correct concentration required to prevent contamination of clean equipment, counter surfaces, tables, and utensils for 1 of 3 kitchens (Kitchen 1 main Kitchen). The facility failed to properly thaw frozen poultry as required for 1 of 1 kitchen (Main Kitchen 1). The facility failed to ensure that 2 of 5 staff (Staff D and Staff E) who prepared food maintained and obtained a valid Food Worker card through the Washington state Public Health Department. These failures placed 76 residents at risk for food borne illness.

Findings Included…

Review of the facility's undated "Resident Characteristics Roster" showed 76 residents currently resided in the facility.

SANITATION BUCKETS

During an interview on 03/05/2026 at 11:57 AM, Staff I, Dining Services Coordinator 1, stated that the facility kitchen used quaternary ammonium sanitization solution (quat) to clean food preparation surfaces and stainless-steel serving counters after each use.

Observation on 03/05/2026 at 11:57 AM, showed Staff I used a test strip from a container that showed a concentration range in several shades of blue that indicated the concentration strength level of the quat sanitizer. Observation showed that Staff I dipped the test strip into the quat sanitization solution and stirred the strip around for a few seconds and compared the color on the test strip with the concentration chart on the test strip container. Observation showed that the sanitization showed the concentration strength was not within the required range to be effective. Observation showed that Staff I removed a second test strip from the container and tested the solution a second time with the same results. Observation showed that the test strips expired in 2022. Staff I obtained a new unexpired container of test strips and retested the quat sanitization solution with the same results of 0ppm (parts per million). Observation showed that Staff I removed a test strip form the container and tested the quat sanitization solution directly from the dispensing hose connected to the mixing valve located on the wall above the three-compartment sink located in the dishwasher room. The test showed the strength of the quat sanitization solution was not within the required effective range. Observation showed that the main quat sanitization container was full.

During an interview on 03/05/2026 at 12:00 PM, Staff I was asked if the test strips were the correct ones. Staff I stated that the test strips must be the wrong test strips. Staff I stated that the test strips were the ones provided by the vendor for the sanitization

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products. Staff I stated they would contact the vendor to get the correct sanitization test strips or determine what the problem was.

Observation on 03/05/2026 at 12:15 PM, showed the Department Licensor with Staff J, Cook, tested the quat sanitization solution with the Department issued quaternary ammonia test strips which showed that the sanitization solution was within effective range of 200ppm.

During an interview on 03/05/2026 at 12:15 PM, Staff J stated that the wrong test strips were used for quat buckets.

Observation on 03/09/2026 at 8:30 AM with Staff A, Executive Director, showed Staff J used new test strips for quat to test the quat bucket solution. Observation showed Staff J tore off a piece of test strip paper from the container and dipped the test strip into the quat sanitization solution and stirred the strip for several seconds before removing. Observation showed that the test strip container showed a concentration range with several shades of green and brown which indicated the levels of concentration strength of the solution. Observation showed that when the test strip was compared to the test range color chart of the test strip container it showed a level of concentration of 200 ppm (parts per million) which was within the effective range for sanitization.

During an interview on 03/09/2026 at 8:30 AM, Staff J stated that it made a difference when the correct test strips were used.

THAWING FROZEN POULTRY

During a kitchen observation on 03/04/2026 at 12:56 PM, three large packages of frozen meat wrapped in aluminum foil were seen in a two-compartment sink with water running over the packages. Observation showed that two of the three frozen packages floated on the surface with only two-thirds of the packages submerged in water. Observation showed the water flowing from the faucet only came into contact with one of the frozen poultry packages.

During an interview on 03/04/2026 at 1:00 PM, Staff I stated that generally frozen meats were thawed in the walk-in cooler over several days prior to use. Staff I stated that when there was not enough time to allow the frozen meat to thaw in the cooler a sink with cold running water was used to thaw the meat. Staff I stated that the frozen meat wrapped in aluminum foil was turkey. Staff I stated that the frozen poultry packages should be completely submerged under water when thawed.

FOOD HANDLERS CARD

Review of the facility’s Care Manager job description dated September 2023, showed that the Care Manager was responsible for serving meals in the dining room,

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assists with dining room set-up and clean up. The job description showed the Care Manager was responsible for following residents' diets as indicated on individual service plans and practice safe food handling in compliance with universal care precautions at all times.

STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Care Manager, on 08/22/2025.

Review of Staff D's employee records showed no documentation that Staff D completed a food handler training through the Washington state Public County Health Department.

STAFF E
Review of the facility's undated employee roster showed that the facility hired Staff E, Lead Care Manager, on 01/03/2022.

Review of Staff E's employee records on 03/04/2026 showed no documentation that Staff E completed a food handler training through the Washington state Public County Health Department.

Observation on 03/05/2026 at 12:15 PM, showed a dining room and kitchen server area located on the fourth floor of the secured "Transitional unit". Observation showed that care staff plated food for residents from containers that were transported from the facility's main kitchen in hot boxes (warming carts that hold food for transport).

Observation on 03/05/2026 at 12:30 PM showed a dining room and kitchen server area located on the third floor of the secured Memory Care unit (Reminiscence Unit). Observation showed that care staff plated food from containers onto yellow plates. Observation showed care staff replated special diet meals from white plates to yellow plates for Memory Care Residents with special diets.

During an interview on 03/05/2026 at 12:12 PM, Staff I stated that all the caregivers were required to have food worker cards to prepare food for residents on the secured units.

During an interview on 03/05/2026 at 4:15 PM, Staff A, Executive Director, stated that they were unaware their Care Managers did not complete the food handler training through the Washington state local health department.

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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, Sunrise of Issaquah is or will be in compliance with this law and / or regulation on (Date) 4/30/26

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

Administrator (or Representative) — Date: 3/31/26

WAC 388-78A-2300 **Food and nutrition services.**

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to maintain a current dietary manual that was reviewed and signed by a Registered Dietician (RD) for 1 of 1 kitchen (main facility kitchen) for dietary staff to use. This failure placed 76 residents at risk of not receiving correct diets and nutritionally balanced meals approved by a dietician.

Findings included...

Observation of the main kitchen on 03/04/2026 at 12:56 PM, showed one dietary staff prepared food while a second dietary staff plated food to be served to the residents in the main facility dining room.

During an interview on 03/04/2026 at 1:00 PM, Staff I, Dining Services Coordinator 1, stated that all the menus and instructions on how food was to be prepared were available through an online program with the facility's primary food vendor. Staff I stated that the online program included instructions for specialized and modified diets. Staff I stated that there was not a hard copy of a dietary manual in the kitchen. Observation showed Staff I was unable to show where a RD signed that the food

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review the facility failed to maintain a current dietary manual that was reviewed and signed by a Registered Dietician (RD) for 1 of 1 kitchen (main facility kitchen) for dietary staff to use. This failure placed 76 residents at risk of not receiving correct diets and nutritionally balanced meals approved by a dietician.

Findings included…

Observation of the main kitchen on 03/04/2026 at 12:56 PM, showed one dietary staff prepared food while a second dietary staff plated food to be served to the residents in the main facility dining room.

During an interview on 03/04/2026 at 1:00 PM, Staff I, Dining Services Coordinator 1, stated that all the menus and instructions on how food was to be prepared were available through an online program with the facility's primary food vendor. Staff I stated that the online program included instructions for specialized and modified diets. Staff I stated that there was not a hard copy of a dietary manual in the kitchen. Observation showed Staff I was unable to show where a RD signed that the food

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preparation instructions were reviewed.

During an interview on 03/04/2026 at 1:45 PM, Staff I stated that they spoke with the corporate Food Services Director who stated that all the menus were reviewed and signed by a Registered Dietician which met the Washington Administrative Code requirement.

Review of a Department of Social and Health Services Policy unit clarification document dated 03/09/2026 at 10:53 AM, showed that the WAC required a dietary manual to be reviewed and signed by a RD every five years. The Policy unit clarification document showed that menus signed by a Registered Dietician does not meet the WAC requirement.

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, Sunrise of Issaquah is or will be in compliance with this law and / or regulation on (Date) 4/30/26 .

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

Administrator (or Representative) — Date: 3/31/26

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to notify the Department of a change in the Assisted Living Facility Administrator within 10 days of hire for 2 of 2 sampled staff (Staff A and Staff K) as required. This failure to notify the department of a new administrator that met qualifications to oversee daily operations and ensure adequate care and services placed 76 residents at risk.

Findings included...

Review of the facility's undated "Resident Characteristics Roster" showed 76 residents resided in the facility.

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preparation instructions were reviewed.

During an interview on 03/04/2026 at 1:45 PM, Staff I stated that they spoke with the corporate Food Services Director who stated that all the menus were reviewed and signed by a Registered Dietician which met the Washington Administrative Code requirement.

Review of a Department of Social and Health Services Policy unit clarification document dated 03/09/2026 at 10:53 AM, showed that the WAC required a dietary manual to be reviewed and signed by a RD every five years. The Policy unit clarification document showed that menus signed by a Registered Dietician does not meet the WAC requirement.

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, Sunrise of Issaquah 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-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to notify the Department of a change in the Assisted Living Facility Administrator within 10 days of hire for 2 of 2 sampled staff (Staff A and Staff K) as required. This failure to notify the department of a new administrator that met qualifications to oversee daily operations and ensure adequate care and services placed 76 residents at risk.

Findings included…

Review of the facility's undated "Resident Characteristics Roster" showed 76 residents resided in the facility.

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Review of the Department's "Secure Tracking and Reporting Systems" (STARS) for tracking change in administrator showed that on 03/03/2026 Staff L, former administrator, was listed as the administrator of record 222 days after Staff L separated from the facility and the company as the Executive Director/Administrator.

Review of an email correspondence on 03/09/2026 at 10:48 AM, Staff A stated that Staff L separated from the facility and the company on 07/24/2026. Staff A stated that Staff K, Traveling Executive Director for the company, assumed the role of administrator of record for the facility from 07/24/2025 to 12/05/2025.

Review of facility records found no documentation to show Staff K submitted an attestation form for change of administrator to the Department of Business Operations Analysis Unit (BOAU).

During an interview on 03/04/2026 at 4:00 PM, Staff A stated that they were hired as the Executive Director/Administrator on 12/05/2026.

During an interview on 03/09/2026 at 3:45 PM, Staff A stated that they submitted an attestation form for change of administrator to BOAU. Staff A stated that there was no documentation to show Staff K submitted an attestation of change of administrator to BOAU.

Review of email correspondence dated 01/12/2026 at 4:44 PM, showed that BOAU requested clarification from the facility to verify that there was not an administrator from July 2025 until December 2025. The email showed a request from BOAU staff for documentation if there was an interim administrator during the gap between the current administrator, Staff A, and previous administrator Staff L.

Review of email correspondence dated 03/09/2026 at 4:24 PM, showed an attached document (attestation for change in administrator) was submitted to BOAU by Staff A. Review of the attestation form for change in administrator showed it was dated 01/12/2026 33 days after Staff A was hired as the Executive Director/Administrator and not within 10 days as required.

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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.

Administrator (or Representative) — Date: 3/31/26

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete one test for Tuberculosis [TB (a respiratory infection)] for 2 of 6 sampled staff (Staff A and Staff D) with a history of a negative blood test. This failure placed 76 residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings Included...

Review of the facility's TB Policy dated 06/2021 showed all facilities "must always follow the strictest requirements. To be sure that you are doing this you must compare your State regulatory requirements to the requirements in the Infection Prevention and Control Program (IPCP) and determine which are the most stringent". The policy showed that if an employee received a documented negative two-step TB test during the previous 12 months prior to hire, only a one-step TB test was required. The policy showed that a QuantiFERON (blood test for TB) was acceptable in place of a TB skin test. The policy did not show that if an employee received a documented negative QuantiFERON blood test during the previous 12 months prior to hire, only a one-step TB test was required unless there was a documented history of a positive TB test.

Review of the facility's undated "Resident Characteristic Roster" showed 76 residents received assisted living services.

Staff A
Review of the facility's undated staff roster showed that the facility hired Staff A, as the

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Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete one test for Tuberculosis [TB (a respiratory infection)] for 2 of 6 sampled staff (Staff A and Staff D) with a history of a negative blood test. This failure placed 76 residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings Included…

Review of the facility's TB Policy dated 06/2021 showed all facilities "must always follow the strictest requirements. To be sure that you are doing this you must compare your State regulatory requirements to the requirements in the Infection Prevention and Control Program (IPCP) and determine which are the most stringent". The policy showed that if an employee received a documented negative two-step TB test during the previous 12 months prior to hire, only a one-step TB test was required. The policy showed that a QuantiFERON (blood test for TB) was acceptable in place of a TB skin test. The policy did not show that if an employee received a documented negative QuantiFERON blood test during the previous 12 months prior to hire, only a one-step TB test was required unless there was a documented history of a positive TB test.

Review of the facility's undated "Resident Characteristic Roster" showed 76 residents received assisted living services.

Staff A
Review of the facility's undated staff roster showed that the facility hired Staff A, as the

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Executive Director, on 12/05/2026. Review of Staff A's employee records showed documentation of an Interferon Gamma Release Assays [(IGRA) a blood test for TB], dated 11/18/2025, with negative results. Review of Staff A's record showed a two-step negative TB test dated 11/15/2023. Review of Staff A's employee record showed no documentation Staff A completed a one-step TB test upon hire, as required.

During an interview on 03/05/2026 at 4:00 PM, Staff A stated that they did not receive the Bacillus Calmette-Guerin (BCG) vaccine (a vaccine that is used to protect against tuberculosis). Staff A stated that they had a copy of a previous negative two-step TB test. Staff A stated that they thought the IGRA test done prior to hire met the TB requirement.

STAFF D
Review of the facility's undated staff roster showed that the facility hired Staff D, Care Manager, on 08/22/2025. Review of Staff D's employee records showed that on 08/14/2025, eight days before hire, Staff D completed a QuantiFERON-TB Gold Plus (a blood test for TB) with a negative result. Review of Staff D's record showed no documentation that Staff D completed a TB test within three days of employment as required.

During an interview on 03/05/2026 at 4:15 PM, Staff A stated that they were unaware Staff D completed the TB test more than a week prior to hire. Staff A stated that they were unaware Staff D's TB test was done "too early".

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Administrator (or Representative) — Date: 3/31/26

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:

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Executive Director, on 12/05/2026. Review of Staff A's employee records showed documentation of an Interferon Gamma Release Assays [(IGRA) a blood test for TB], dated 11/18/2025, with negative results. Review of Staff A's record showed a two-step negative TB test dated 11/15/2023. Review of Staff A's employee record showed no documentation Staff A completed a one-step TB test upon hire, as required.

During an interview on 03/05/2026 at 4:00 PM, Staff A stated that they did not receive the Bacillus Calmette-Guerin (BCG) vaccine (a vaccine that is used to protect against tuberculosis). Staff A stated that they had a copy of a previous negative two-step TB test. Staff A stated that they thought the IGRA test done prior to hire met the TB requirement.

STAFF D
Review of the facility's undated staff roster showed that the facility hired Staff D, Care Manager, on 08/22/2025. Review of Staff D's employee records showed that on 08/14/2025, eight days before hire, Staff D completed a QuantiFERON-TB Gold Plus (a blood test for TB) with a negative result. Review of Staff D's record showed no documentation that Staff D completed a TB test within three days of employment as required.

During an interview on 03/05/2026 at 4:15 PM, Staff A stated that they were unaware Staff D completed the TB test more than a week prior to hire. Staff A stated that they were unaware Staff D's TB test was done "too early".

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Administrator (or Representative) Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:

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(i) A certified home care aide;

(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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

(2) Assisted living facilities.

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

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

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

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure 1 of 2 sampled care staff (Staff F) maintained a valid first-aid card and 2 of 2 sampled care staff (Staff E and Staff F) completed the continuing education (CE) training as required. This failure placed the 76 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

Review of the facility's Job Description for Care Managers dated September 2023 showed that the facility required all Care Mangers to possess a current Cardiopulmonary Resuscitation and First aid certificate per state regulations. The job description showed that the Care Managers were required to maintain "compliance in assigned required training and all training required by state or other regulating authorities as applicable to the role" to ensure that the facility standards were always met.

Review of the facility's undated Characteristics Roster showed that 76 residents

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received assisted living services.

FIRST AID

STAFF F
Review of the facility's Employee Roster showed that the facility hired Staff F on 02/16/2024 as a Care Manager. Review of the facility's Care Staff Schedule showed that Staff F worked in February 2025 and March 2025.

Review of the employee records showed that as of 03/04/2026, there was no documentation that showed Staff F had a valid first aid card. Staff F's employee records showed a current basic life support card without first aid.

CONTINUING EDUCATION

STAFF E
Review of Staff E's employee records showed the facility hired Staff E as a Lead Care Manager on 01/03/2022. The records showed Staff E maintained an active Nursing Assistant Certified credential. The records showed no documentation that Staff E completed the required 12 hours of continuing education approved by the Department of Social and Health Services (DSHS) from their June 2024 birthday to their June 2025 birthday.

STAFF F
Review of Staff F's employee records showed the facility hired Staff F as a Care Manager on 12/16/2024. The records showed Staff F maintained an active Nursing Assistant Certified credential. The records showed no documentation that Staff F completed the required 12 hours of continuing education approved by the Department of Social and Health Services (DSHS) from their October 2024 birthday to their October 2025 birthday.

Review of Staff F's continuing education documentation provided by the Regional Human Resource Director showed training documents approved by DSHS were prior to 2024 or the training documents did not show they were approved by DSHS.

During the entrance interview on 03/03/2026 at 9:47 AM, Staff A, Executive Director, stated that the facility did not have a current Business Office Director. Staff A stated that the corporation's Regional Business Office Director and Regional Human Resource Director covered the facility's Business office Director functions which included employee records.

During an interview on 03/09/2026 at 3:45 PM, Staff A stated that the staff continuing education documents provided by the Regional Human Resource Director was all the

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documents they had.

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

(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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the individualized service plan for 2 of 9 sampled residents (Resident 7 and Resident 8). This failure placed Resident 7 and Resident 8 at risk of unmet care needs and a diminished quality of life.

Findings included...

RESIDENT 7
Observation in the memory care unit on 03/09/2026 at 1:48 PM showed Resident 7 sat on a Roho cushion (a pressure relief cushion that is made of soft, flexible air cells to decrease the amount of pressure on the sitting area) in their wheelchair. Observation inside Resident 7's apartment showed Staff R, Care Manager, assisted Resident 7 transfer from the wheelchair to their bed. During an interview at this time, Staff R stated that they were aware Resident 7 used a Roho cushion. Staff R stated that Resident 7 received hospice care service. Staff R stated that the hospice provided the Roho cushion. Staff R stated that the hospice nurse visited twice a week. Staff R stated that the hospice nurse was responsible for maintaining the Roho cushion that included ensuring the Roho cushion was properly inflated. Staff R stated that they did not check

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documents they had.

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(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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the individualized service plan for 2 of 9 sampled residents (Resident 7 and Resident 8). This failure placed Resident 7 and Resident 8 at risk of unmet care needs and a diminished quality of life.

Findings included…

RESIDENT 7
Observation in the memory care unit on 03/09/2026 at 1:48 PM showed Resident 7 sat on a Roho cushion (a pressure relief cushion that is made of soft, flexible air cells to decrease the amount of pressure on the sitting area) in their wheelchair. Observation inside Resident 7’s apartment showed Staff R, Care Manager, assisted Resident 7 transfer from the wheelchair to their bed. During an interview at this time, Staff R stated that they were aware Resident 7 used a Roho cushion. Staff R stated that Resident 7 received hospice care service. Staff R stated that the hospice provided the Roho cushion. Staff R stated that the hospice nurse visited twice a week. Staff R stated that the hospice nurse was responsible for maintaining the Roho cushion that included ensuring the Roho cushion was properly inflated. Staff R stated that they did not check

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the Roho cushion regularly. Staff R stated that they were unsure how to assess whether the Roho cushion was properly inflated.

Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2021 with a medical diagnosis of [redacted]. The records showed that on 02/11/2026, the facility completed an assessment. The records showed Resident 7 was chairfast and required transfer assistance. There was no documentation that showed Resident 7 used a Roho cushion on their wheelchair.

Review of Resident 7's Service Plan Report, dated 02/12/2026, showed that Resident 7 used a wheelchair. The Service Plan did not show Resident 7 used a Roho cushion in the wheelchair. There was no documentation that instructed care staff how to assess and adjust the Roho cushion for proper inflation. There was no documentation that instructed care staff what to do if the Roho cushion was deflated.

RESIDENT 8
Observation of Resident 8's room in the memory care unit on 03/05/2026 at 12:40 PM, showed a regular bed with a 'Halo Safety Ring' (an adjustable bed mobility device) attached to the right side of the head of the bed. Observation showed the Halo Safety Ring was attached sturdily to the bed, with 2 inches gap between the bedrail and the mattress.

Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2025. The records showed that on 01/27/2026, the facility completed a full assessment. The assessment showed Resident 8 required mobility and transfer assistance. The records showed that on 01/15/2026 and 02/16/2026, the facility completed the Bed Assistive Device Evaluation of the 'Halo Safety Ring' for Resident 8.

Review of Resident 8's Service Plan Report, dated 02/03/2026, showed no documentation that Resident 8 used a 'Halo Safety Ring'. There was no documentation that showed who was responsible for maintaining and ensuring the safety of the 'Halo Safety Ring'. There was no documentation that instructed care staff what to do if the "Halo Safety Ring' became malfunctioned.

During an interview on 03/09/2026 at 1:30 PM, Staff H, Registered Nurse/Resident Care Director, stated that they did not update the individualized service plan for Resident 7 and Resident 8.

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

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 6 mobile medication carts (Medication Cart 1) was locked. This failure placed assisted living residents at risk of injury from ingestion of unprescribed medication.

Findings included...

Review of the facility's undated "Assisted Living Facility Resident Characteristic Roster" showed that 76 resident received assisted living care and services.

Observation on 03/04/2026 at 8:46 AM showed a mobile medication cart (Medication Cart 1) was unattended by staff in the hallway on the second floor. Observation showed Medication Cart 1 contained residents' routine and as-needed prescription medications. Observation showed that unidentified assisted living residents walked by the unlocked Medication Cart 1 in the hallway.

During an interview on 03/04/2026 at 8:48 AM, Staff H, Registered Nurse/Resident Care Director, stated that the medication carts were to be secured at all times and not be left unlocked when they were unattended by the staff. Staff H stated that Staff N, Medication Care Manager, was assigned to Medication Cart 1. Observation at this time showed that Staff H took a photo of the unlocked medication cart and sent a text message to notify Staff N. Further observation showed Staff H locked Medication Cart 1.

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Based on observation, interview, and record review, the facility failed to ensure that 1 of 6 mobile medication carts (Medication Cart 1) was locked. This failure placed assisted living residents at risk of injury from ingestion of unprescribed medication.

Findings included…

Review of the facility's undated "Assisted Living Facility Resident Characteristic Roster" showed that 76 resident received assisted living care and services.

Observation on 03/04/2026 at 8:46 AM showed a mobile medication cart (Medication Cart 1) was unattended by staff in the hallway on the second floor. Observation showed Medication Cart 1 contained residents' routine and as-needed prescription medications. Observation showed that unidentified assisted living residents walked by the unlocked Medication Cart 1 in the hallway.

During an interview on 03/04/2026 at 8:48 AM, Staff H, Registered Nurse/Resident Care Director, stated that the medication carts were to be secured at all times and not be left unlocked when they were unattended by the staff. Staff H stated that Staff N, Medication Care Manager, was assigned to Medication Cart 1. Observation at this time showed that Staff H took a photo of the unlocked medication cart and sent a text message to notify Staff N. Further observation showed Staff H locked Medication Cart 1.

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During an interview on 03/04/2026 at 8:57 AM, Staff N stated that medication carts were to be secured at all times when unattended. Staff N stated that they did not leave Medication Cart 1 unlocked and unattended. Staff N stated that not only the assigned Medication Care Manager held the key for Medication Cart 1, and all the licensed nurses on duty also held a copy of the key for Medication Cart 1. Staff N stated that both the assigned Medication Care Manager and Licensed Nurses were able to unlock the medication cart and access the prescription medications inside the medication cart. Staff N stated that they did not know why Medication Cart 1 was unlocked and unattended, and they did not know who left Medication Cart 1 unlocked and unattended.

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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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to properly implement oxygen therapy for 1 of 1 sampled resident (Resident 9). This failure placed Resident 9 at risk for treatment errors and potential medical complications.

Findings included...

Review of the facility's undated "Disclosure of Services" showed the facility provided certain nursing services. The document showed that the facility's intermittent nursing services are provided based on their registered nurse's assessment in accordance with the resident's individualized service plan and in coordination with resident's primary care physician.

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During an interview on 03/04/2026 at 8:57 AM, Staff N stated that medication carts were to be secured at all times when unattended. Staff N stated that they did not leave Medication Cart 1 unlocked and unattended. Staff N stated that not only the assigned Medication Care Manager held the key for Medication Cart 1, and all the licensed nurses on duty also held a copy of the key for Medication Cart 1. Staff N stated that both the assigned Medication Care Manager and Licensed Nurses were able to unlock the medication cart and access the prescription medications inside the medication cart. Staff N stated that they did not know why Medication Cart 1 was unlocked and unattended, and they did not know who left Medication Cart 1 unlocked and unattended.

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(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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to properly implement oxygen therapy for 1 of 1 sampled resident (Resident 9). This failure placed Resident 9 at risk for treatment errors and potential medical complications.

Findings included…

Review of the facility's undated "Disclosure of Services" showed the facility provided certain nursing services. The document showed that the facility's intermittent nursing services are provided based on their registered nurse's assessment in accordance with the resident's individualized service plan and in coordination with resident's primary care physician.

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Review of the facility's policy document titled "Shadowing and Skills - Oxygen", dated 2017, showed that "oxygen therapy required a doctor's order. Ensure the flow rate and amount of time/day is specified". The document showed the facility considered that "oxygen is a medication and must be administered/adjusted by a nurse per physician's order". The document showed that the facility's care managers were allowed to assist a resident with applying the nasal cannula. The document showed that the facility's care managers were not allowed to adjust the flow rate.

Review of Resident 9's records showed that the facility admitted Resident 9 in [redacted] 2025. The records showed Resident 9's medical diagnoses included [redacted] and [redacted] The records showed that on 08/21/2025, the facility completed an assessment. The assessment showed no documentation that Resident 9 required oxygen therapy.

Review of Resident 9's physician order showed a medical order of "two liters oxygen via nasal cannula (a tube that delivers oxygen through the nose). Titrate up to four liters if symptomatic" with an order start date of 09/30/2025.

Review of Resident 9's "Hospice Certification and Plan of Care", dated 02/27/2026, showed that Resident 9 was admitted to the hospice care in February 2026. The records showed a medical order of "administer two to four liters of oxygen via nasal cannula as needed (PRN)".

Review of Resident 9's February 2026 and March 2026 Medication Administration Records (MARs) showed medical orders that included "check oxygen saturation – apply supplemental oxygen only if oxygen 92 percent (%) or below at rest, three times a day" and "primary care physician (PCP) suggest to not use oxygen when oxygenation is 94% at room air. Use oxygen if oxygenation is at 92 or below at room air, or having shortness of breath or air hunger three times a day for oxygen saturation related to respiratory failure with hypoxia (low levels of oxygen in the body tissue)".

Review of Resident 9's Individualized Service Plan (ISP), dated 08/21/2025, showed that Resident used two liters oxygen via nasal canula and titrated up to 4 liters if symptomatic (short of breath or difficulty breathing, air hunger). The ISP showed that the facility's nurses were responsible for administering the oxygen therapy for Resident 9. There was no documentation that showed Resident 9 received oxygen therapy by unlicensed care staff through registered nurse delegation.

Observation inside Resident 9's apartment on 03/04/2026 at 9:30 AM showed Resident 9 laid in bed in the bedroom. Observation showed Resident 9 used a nasal cannula to receive supplemental oxygen. Observation showed the nasal cannula was connected to

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an oxygen concentrator (a device that generates oxygen), which was placed on the floor in the living area in the next room. Observation showed the oxygen concentrator was set to deliver oxygen at two liters per minute. Observation showed Staff P, Certified Nursing Assistant (CNA)/Terrace Club Coordinator, and Staff Q, Lead Care Manager, assisted Resident 9 transfer from the bed to the manual wheelchair. Observation showed that while Resident 9 was seated in the manual wheelchair, Staff Q brought a portable oxygen machine from the living room to the bedroom and hung the portable oxygen machine on the resident's wheelchair. Observation showed that Staff Q turned on the portable oxygen machine, which indicated the flow rates set at three liters per minute. Observation showed Staff Q alerted Staff P that the flow rates set at three liters per minute. Observation showed Staff P adjusted the portable oxygen machine from three liters per minute to two liters per minute. Observation showed Staff P disconnected the nasal cannula from the oxygen concentrator and connected the nasal cannula to the portable oxygen machine. Observation showed Staff P maintained the oxygen at two liters per minute and propelled Resident 9 in the wheelchair to the bathroom. Observation showed Staff P did not assess Resident 9's vital signs and oxygen saturation. Observation showed that Resident 9 did not provide Staff P and Staff Q any direction to adjust the oxygen flow rate on the portable oxygen machine for them. Observation showed Staff P did not verify Resident 9's medical order and service plan. Observation showed Staff P did not notify the licensed nurse about the oxygen rate setting on the portable oxygen machine and staff P did not call the licensed nurse for assistance with adjusting the oxygen flow rate on the portable oxygen machine.

During an interview on 03/05/2026 at 12:10 PM, Staff P stated that they were unaware nursing assistants were not allowed to administer and adjust the oxygen for residents. Staff P stated that when they administered oxygen for Resident 9 yesterday, they did not notify the licensed nurse.

During an interview on 03/09/2026 at 9:48 AM, Staff H, Registered Nurse, Resident Care Director, stated that they did not provide any intermittent nursing services through nurse delegation. Staff H stated that they were not the Registered Nurse Delegator and they did not delegate Staff P and Staff Q to administer oxygen for Resident 9. Staff H stated that their facility required licensed nurses to administer oxygen for residents. Staff H stated that nursing assistants were not allowed to administer oxygen for residents.

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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.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to verify medical orders with outside healthcare providers for 1 of 9 sampled residents (Resident 6). This failure placed Resident 6 at risk of improper care and services from staff without proper instructions and at risk for potential medical complications.

Findings included...

Review of Resident 6's records showed the facility admitted Resident 6 in [redacted] 2024. The records showed that on 07/17/2025, the facility completed a full assessment for Resident 6. The assessment showed multiple medical diagnoses that included [redacted] and [redacted] The assessment showed that Resident 6 required assistance with medication management. The assessment showed that Resident 6 required assistance with coordination of care and services with external healthcare providers.

Review of Resident 6's Service Plan Report, dated 01/18/2026, showed that the facility was responsible for ensuring Resident 6 receive services from desired source and providing "continued, uninterrupted support of service".

Review of Resident 6's physician orders showed an order of "notify primary care physician (PCP) if systolic blood pressure [(SBP) the top number in a blood pressure (BP) reading, representing the pressure in the arteries (blood vessels) when the heart contracts] is greater than 160 or diastolic blood pressure [(DBP) the bottom number in a BP reading, representing the pressure in the arteries when the heart muscle is relaxed]

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Administrator (or Representative) 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.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to verify medical orders with outside healthcare providers for 1 of 9 sampled residents (Resident 6). This failure placed Resident 6 at risk of improper care and services from staff without proper instructions and at risk for potential medical complications.

Findings included…

Review of Resident 6's records showed the facility admitted Resident 6 in [redacted] 2024. The records showed that on 07/17/2025, the facility completed a full assessment for Resident 6. The assessment showed multiple medical diagnoses that included [redacted] and [redacted]. The assessment showed that Resident 6 required assistance with medication management. The assessment showed that Resident 6 required assistance with coordination of care and services with external healthcare providers.

Review of Resident 6's Service Plan Report, dated 01/18/2026, showed that the facility was responsible for ensuring Resident 6 receive services from desired source and providing "continued, uninterrupted support of service".

Review of Resident 6's physician orders showed an order of "notify primary care physician (PCP) if systolic blood pressure [(SBP) the top number in a blood pressure (BP) reading, representing the pressure in the arteries (blood vessels) when the heart contracts] is greater than 160 or diastolic blood pressure [(DBP) the bottom number in a BP reading, representing the pressure in the arteries when the heart muscle is relaxed]

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is greater than 90, every day shift for blood pressure", with a start date 09/25/2025.

Review of Resident 6's January 2026, February 2026, and March 2026 Medication Administration records (MARs) showed that Resident 6's BP was measured three times daily by the Medication Care Managers (unlicensed care staff who provide medication assistance). The MARs showed that Resident 6's BP was measured twice as scheduled for 8:00 AM and 1:00 PM during the day shift. The MARs showed that on 01/05/2026, 01/09/2026, 01/14/2026, 01/21/2026, 01/23/2026, 01/27/2026, 01/29/2026, 02/02/2026, 02/17/2026, 02/19/2026, 02/23/2026, 02/25/2026, 02/26/2026, 03/03/2026, and 03/05/2026, Resident 6's BP readings were above the parameters set by PCP at the 1:00 PM scheduled time, during the day shift. There was no documentation that showed on the listed days, the care staff notified their facility's Licensed Nurses about Resident 6's high BP. There was no documentation that showed on the listed days, the facility's Licensed Nurses rechecked BP for Resident 6. There was no documentation that showed on the listed days, the facility notified the PCP about the high BP readings.

During an interview on 03/09/2026 at 1:15 PM, Staff S, Medication Care Manager, stated that they measured and documented Resident 6's BP before they dispensed the BP medications to Resident 6. Staff S stated that they were aware of Resident 6's physician order of monitoring BP and the BP parameters as set by the PCP. Staff S stated that when Resident 6's BP was measured above the parameters, they notified the facility's Licensed Nurses. Staff S stated that they did not notify the PCP per the PCP's order. Staff S stated that the facility's Licensed Nurses were responsible for notifying the resident's PCP.

During an interview on 03/09/2026 at 1:40 PM, Staff T, Licensed Practical Nurse (LPN)/Wellness Nurse, stated that they were responsible for monitoring Resident 6's blood pressure and reporting to the physician. Staff T stated that when the Medication Care Managers notified them about Resident 6's high blood pressure readings, they reviewed the BP readings measured and documented in the MARs by the Medication Care Managers and determined whether reporting to PCP was required. Staff T stated that they did not retake Resident 6's BP.

During an interview on 03/09/2026 at 1:45 PM, Staff H, Registered Nurse/Resident Care Director, stated that they were aware Resident 6's physician order of monitoring BP and the BP parameters as set by the PCP. Staff H stated that when they identified the high BP readings in the MARs, they retook the BP for Resident 6. Staff H stated that they notified the PCP if Resident 6's BP retaken was above the parameters. Staff H stated that they did not notify the PCP if Resident 6's BP retaken was within the parameters. Staff H stated that the physician order did not specify who the facility's staff was responsible for reporting the high BP to PCP. Staff H stated that the facility required the Medication Care Managers to notify their Licensed Nurses when Resident 6's BP was measured above the parameters. Staff H stated that they were unaware of the inconsistent practice among their care staff and Licensed Nurses. Staff H stated that they were unaware there was a lack of consistent communication between the Medication Care Managers, Licensed Nurses, and resident's PCP.

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During an interview on 03/09/2026 at 2:05 PM, Staff M, LPN, stated that they were responsible for monitoring Resident 6's blood pressure. Staff M stated that they were aware of Resident 6's physician order of monitoring BP and the BP parameters as set by the PCP. Staff M stated that they reviewed Resident 6's BP readings measured and documented by the Medication Care Managers in the MARs in the morning. Staff M stated that when they identified the high BP readings in the MARs, they retook the BP for Resident 6. Staff M stated that they did not notify the PCP if Resident 6's BP retaken was within the parameters.

During an interview on 03/17/2026 at 3:15 PM, Staff H stated that the facility's day shift was between 6:00 AM and 2:00 PM. Staff H stated that they were aware Resident 6's BP was measured two times during the day shift. Staff H stated that they were unaware Resident 6's BP measured by the care staff was high at the 1:00 PM schedule on several days between January 2026 and March 2026. Staff H stated that they were unsure whether the care staff notified the PCP about the high BP at the 1:00 PM schedule on those days. Staff H stated that the physician's order for BP monitoring was unclear. Staff H stated that they reached out to the resident's physician for clarification.

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 3/31/26

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide information for visitors, facility staff, and external providers how to exit 2 of 2 dementia care units (Terrace Club Unit and Reminiscence Care Unit) without sounding the alarm. This failure prevented visitors, staff, and external providers from departing the memory care units without staff assistance.

Findings included...

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

During an interview on 03/09/2026 at 2:05 PM, Staff M, LPN, stated that they were responsible for monitoring Resident 6's blood pressure. Staff M stated that they were aware of Resident 6's physician order of monitoring BP and the BP parameters as set by the PCP. Staff M stated that they reviewed Resident 6's BP readings measured and documented by the Medication Care Managers in the MARs in the morning. Staff M stated that when they identified the high BP readings in the MARs, they retook the BP for Resident 6. Staff M stated that they did not notify the PCP if Resident 6's BP retaken was within the parameters.

During an interview on 03/17/2026 at 3:15 PM, Staff H stated that the facility's day shift was between 6:00 AM and 2:00 PM. Staff H stated that they were aware Resident 6's BP was measured two times during the day shift. Staff H stated that they were unaware Resident 6's BP measured by the care staff was high at the 1:00 PM schedule on several days between January 2026 and March 2026. Staff H stated that they were unsure whether the care staff notified the PCP about the high BP at the 1:00 PM schedule on those days. Staff H stated that the physician's order for BP monitoring was unclear. Staff H stated that they reached out to the resident's physician for clarification.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide information for visitors, facility staff, and external providers how to exit 2 of 2 dementia care units (Terrace Club Unit and Reminiscence Care Unit) without sounding the alarm. This failure prevented visitors, staff, and external providers from departing the memory care units without staff assistance.

Findings included…

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

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed the facility provided care to 23 residents in the Reminiscence Care Unit (memory care unit) with a medical diagnosis of [redacted], and [redacted]. The Characteristic Roster showed that the facility provided care to 21 residents in the Terrace Club Unit (memory care unit), for whom seven of the 21 residents were diagnosed with [redacted], and [redacted].

Observation on 03/03/2026 between 11:40 AM and 12:15 PM, during the environmental tour, showed that the Terrace Club Unit on the fourth floor and the Reminiscence Care Unit on the third floor of the building were identified as secured memory care units. Observation showed that each of the two units had three locked exits, one by the exit door to the elevators and the two stairwells located at opposite ends of the hallway. There were keypads at each exit door to the elevators and each stairwell exit door. All six exits showed no signage or instructions for visitors, facility staff, and external providers, such as home health care providers, medical practitioners, and others how to depart the memory care units without staff assistance. Further observation during the environmental tour showed Staff G, Maintenance Coordinator, assisted the Department Licensors leave the Terrace Club Unit and the Reminiscence Care unit through the stairwell exit doors. The alarm was activated when the stairwell exit doors were opened without entering the passcodes or the correct passcodes.

Observation on 03/03/2026 at 11:59 AM showed an unidentified visitor standing by the exit door to the elevators in the Terrace Club Unit on the fourth floor. Observation showed Staff P, Terrace Club Coordinator, asked the visitor if they needed any assistance. Observation showed the visitor told Staff P that they wanted to leave the unit and they were waiting for someone to unlock the exit door for them. Observation showed that Staff P unlocked the exit door to let the visitor leave the unit. During an interview at this time, Staff P stated that they shared the passcodes only limited to the Resident's representatives who frequently came to the units and no other people. During an interview at this time, Staff G stated that the facility used to post the exit door codes in Roman numbers as a prompt by the exits that instructed visitors and other external providers how to depart the memory care units. Staff G stated that after the previous Department's inspection, the facility changed their policy. Staff G stated that the facility removed the prompts by the exits and did not share the door codes to persons other than the facility's staff to prevent the memory care residents from inappropriately departing the units. Staff G stated that each exit door was assigned with a unique passcode. Staff G stated that the memory care staff were tasked to assist visitors or external providers to exit the units. Staff G assisted the Department Licensors leave the unit.

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Administrator (or Representative) — Date: 3/31/26

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to evaluate 1 of 1 resident's (Resident 8) need for electronic monitoring and failed to obtain a written consent signature from the resident or resident representative. This placed Resident 8 at risk for violation of their privacy.

Findings included...

Review of the facility's undated document titled "Cameras in Resident Rooms – 'Nanny Cams'" showed that the facility was committed to keeping all residents safe and maintaining both their privacy and personal security. The document showed that the facility was responsible for complying with all applicable laws, including those designed to protect personal privacy.

Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2025 with a medical diagnosis of [redacted]. The records showed that on 01/27/2026, the facility completed an assessment for Resident 8. The assessment showed no documentation that Resident 8 used electronic monitoring equipment. The records showed no documentation that the facility evaluated the need for electronic monitoring. There was no signed consent completed in writing, signed and dated by the resident or resident's representative.

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to evaluate 1 of 1 resident's (Resident 8) need for electronic monitoring and failed to obtain a written consent signature from the resident or resident representative. This placed Resident 8 at risk for violation of their privacy.

Findings included…

Review of the facility's undated document titled "Cameras in Resident Rooms – 'Nanny Cams'" showed that the facility was committed to keeping all residents safe and maintaining both their privacy and personal security. The document showed that the facility was responsible for complying with all applicable laws, including those designed to protect personal privacy.

Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2025 with a medical diagnosis of [redacted]. The records showed that on 01/27/2026, the facility completed an assessment for Resident 8. The assessment showed no documentation that Resident 8 used electronic monitoring equipment. The records showed no documentation that the facility evaluated the need for electronic monitoring. There was no signed consent completed in writing, signed and dated by the resident or resident's representative.

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On 03/05/2026 at 1:00 PM, observation showed Resident 8 was seated in the activity area in the memory care unit. Observation of Resident 8's apartment showed a sign of "camera in use" was posted on the entry door. Observation inside Resident 8's apartment with Staff O, Reminiscence Coordinator, showed two button-shape wired electronic monitoring devices that were placed a foot apart under the TV on the console in the sleeping area. Observation showed one of the monitoring devices was placed in the middle of the console, and the other device was placed at the end of the console near the bathroom door and entry door. During an interview at this time, Staff O stated that Resident 8 used the electronic monitoring devices for one year. Staff O stated that Resident 8's family installed the devices. Staff O stated that they were unsure whether the monitor devices were only video monitoring and no audio monitoring. Staff O stated that the family viewed the video and the facility's staff were unable to view what the devices captured. Staff O stated that they were unsure whether the facility completed a consent for monitoring device use with Resident 8 and their family.

During an interview on 03/09/2026 at 1:30 PM, Staff H, Registered Nurse/Resident Care Director, stated that they were unsure when the resident's family installed the electronic monitoring devices in the room. Staff H stated that Resident 8's family installed the devices and monitored the resident in their room. Staff H stated that they were unsure where the monitoring devices were aimed at. The facility was unable to view what areas were monitored. Staff H stated that when the resident's family requested installing the monitoring devices in the resident's room, Staff K, Traveling Administrator/former Administrator, completed the consent with the resident's family. Staff O stated that they were unable to locate the resident family's written and signed consent anywhere in the resident's records. Staff O stated that they were unfamiliar with the requirements for the use of electronic monitoring inside a resident's room. Staff O stated that they did not evaluate the need for electronic monitoring with Resident 8 quarterly.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 3/31/26

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

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On 03/05/2026 at 1:00 PM, observation showed Resident 8 was seated in the activity area in the memory care unit. Observation of Resident 8's apartment showed a sign of “camera in use" was posted on the entry door. Observation inside Resident 8's apartment with Staff O, Reminiscence Coordinator, showed two button-shape wired electronic monitoring devices that were placed a foot apart under the TV on the console in the sleeping area. Observation showed one of the monitoring devices was placed in the middle of the console, and the other device was placed at the end of the console near the bathroom door and entry door. During an interview at this time, Staff O stated that Resident 8 used the electronic monitoring devices for one year. Staff O stated that Resident 8's family installed the devices. Staff O stated that they were unsure whether the monitor devices were only video monitoring and no audio monitoring. Staff O stated that the family viewed the video and the facility’s staff were unable to view what the devices captured. Staff O stated that they were unsure whether the facility completed a consent for monitoring device use with Resident 8 and their family.

During an interview on 03/09/2026 at 1:30 PM, Staff H, Registered Nurse/Resident Care Director, stated that they were unsure when the resident's family installed the electronic monitoring devices in the room. Staff H stated that Resident 8’s family installed the devices and monitored the resident in their room. Staff H stated that they were unsure where the monitoring devices were aimed at. The facility was unable to view what areas were monitored. Staff H stated that when the resident's family requested installing the monitoring devices in the resident's room, Staff K, Traveling Administrator/former Administrator, completed the consent with the resident's family. Staff O stated that they were unable to locate the resident family’s written and signed consent anywhere in the resident's records. Staff O stated that they were unfamiliar with the requirements for the use of electronic monitoring inside a resident’s room. Staff O stated that they did not evaluate the need for electronic monitoring with Resident 8 quarterly.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

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(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow the required federal and state regulations to conduct medical tests in long term care facilities for 2 of 2 sampled residents (Resident 10 and Resident 11). This failure placed Resident 10 and Resident 11 at risk of potential errors from medical tests performed by facility's staff.

Findings included…

Review of the facility's document titled "Clinical Laboratory Improvement Amendments (CLIA) Management Process", revised in March 2024, showed the facility performed certain medical tests, such as, blood glucose test (a test that measures the level of sugar in the blood) that required a Medical Test Site Waiver (MTSW) license issued by the Department of Health (DOH).

Review of the DOH's "Facility Search" website on 03/03/2026 showed that the facility's Medical Test Site Waiver (MTSW) license issued by the DOH expired on 09/30/2025.

Observation on 03/05/2026 at 12:25 PM showed the facility's DOH MTSW license expired in September 2025. During an interview at this time, Staff A, Executive Director, stated that they were unaware the facility's DOH MTSW license expired. Staff A stated that they would reach out to their corporate office and obtain the valid DOH MTSW license. Staff A stated that their facility performed medical tests including blood sugar checks for assisted living residents.

During an interview on 03/05/2026 at 2:30 PM, Staff A stated that the facility did not hold a valid DOH MTSW license.

During an interview on 03/09/2026 at 8:10 AM, Staff M, Licensed Practical Nurse (LPN), stated that they performed "traditional" blood sugar tests for Resident 10 and Resident 11 in the memory care units. Staff M stated that when they performed the blood sugar tests for Resident 10 and Resident 11, they used a lancet to prick the resident's finger, obtained a blood drop from the resident, ran the blood sugar test with the residents' blood sugar meter, and documented the blood sugar results in their Medication Administration Records (MARs). Observation at this time, at the medication cart in the memory care unit, Staff M showed the blood sugar meter, lancet pen, and test strips for Resident 10 that were kept in the facility's medication cart. Staff M stated that they performed blood sugar tests with the blood sugar meter and test strips for Resident 10.

RESIDENT 10

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

Review of Resident 10's records showed that the facility admitted Resident 10 in [redacted] 2024 with a medical diagnosis of [redacted] and [redacted]. The Records showed that on 08/05/2025, the facility completed an assessment for Resident 10. The assessment showed Resident 10 required assistance with blood glucose management.

Review of Resident 10's January 2026, February 2026, and March 2026 MARs showed a physician order of "blood sugar check every morning". The MARs showed that between 01/01/2026 and 03/09/2026, the facility's staff performed and signed off blood sugar tests for Resident 10 one time a day.

RESIDENT 11
Review of Resident 11's records showed that the facility admitted Resident 11 in [redacted] 2024 with a medical diagnosis of [redacted]. The Records showed that on 12/23/2025, the facility completed an assessment for Resident 11. The assessment showed Resident 11 required assistance with blood glucose management.

Review of Resident 11's January 2026, February 2026, and March 2026 MARs showed the physician order of "check fasting blood glucose daily". The MARs showed that between 01/01/2026 and 03/09/2026, the facility's staff performed and signed off blood sugar tests for Resident 11 every day.

During the exit interview on 03/09/2026 at 3:45 PM, Staff A stated that when their previous DOH MTWS license expired, they did not renew the MTWS license. Staff A stated that they did not hold a valid MTWS license when they performed the blood sugar tests for the residents.

Plan/Attestation Statement

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

[signature] 3/31/26

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

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Review of Resident 10's records showed that the facility admitted Resident 10 in [redacted] 2024 with a medical diagnosis of [redacted] and [redacted]. The Records showed that on 08/05/2025, the facility completed an assessment for Resident 10. The assessment showed Resident 10 required assistance with blood glucose management.

Review of Resident 10's January 2026, February 2026, and March 2026 MARs showed a physician order of "blood sugar check every morning". The MARs showed that between 01/01/2026 and 03/09/2026, the facility's staff performed and signed off blood sugar tests for Resident 10 one time a day.

RESIDENT 11
Review of Resident 11's records showed that the facility admitted Resident 11 in [redacted] 2024 with a medical diagnosis of [redacted]. The Records showed that on 12/23/2025, the facility completed an assessment for Resident 11. The assessment showed Resident 11 required assistance with blood glucose management.

Review of Resident 11's January 2026, February 2026, and March 2026 MARs showed the physician order of "check fasting blood glucose daily". The MARs showed that between 01/01/2026 and 03/09/2026, the facility's staff performed and signed off blood sugar tests for Resident 11 every day.

During the exit interview on 03/09/2026 at 3:45 PM, Staff A stated that when their previous DOH MTWS license expired, they did not renew the MTWS license. Staff A stated that they did not hold a valid MTWS license when they performed the blood sugar tests for the residents.

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

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

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that are a:

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to monitor the blood pressure of 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk for compromised health due to medication parameter orders not being followed as prescribed.

Findings included…

Refer to Washington Administrative Code (WAC) 388-78A-2290 (3)(a)(b)(c)(d)(e)(6), Family assistance with medications and treatments in this report.

Review of the facility's undated Resident Characteristics Roster showed the facility admitted Resident 1 in [redacted] of 2024 with a diagnosis of [redacted]

Review of Resident 1's Individual Service Plan dated 11/06/2025 showed that Collateral Contact 1 (CC1), Resident's 1's spouse, "administered" Resident 1's medications.

Review of Resident 1's electronic Medication Administration Record (eMAR) dated January 2026, February 2026, and March 2026, showed an order for Cozaar (to control elevated blood pressure) 50 milligrams (MG) to be given once a day, hold medication for systolic blood pressure (SBP) < 110 (the force of the blood flow when blood is pumped out of the heart) and Metoprolol Tartrate (to control high blood pressure) 50 MG tablet 0.5 tablet twice a day, hold if SBP<110.

During an interview on 03/09/2026 at 12:18 PM, Staff H, Resident Care Director, stated that Collateral Contact 1, (CC1) managed Resident 1's medications. Staff H stated that CC1 measured Resident 1's blood pressure before administering blood pressure medications.

During an interview on 03/09/2026 at 1:45 PM, Staff M, Licensed Practical Nurse, Medication Care Manager, stated that they checked Resident 1's blood pressure twice a week. Staff M stated that they did not check Resident 1's blood pressure before CC1 gave Resident 1 their blood pressure medications. Staff M stated that CC1 monitored Resident 1's blood pressure since CC1 managed Resident 1's medications.

During an interview on 03/09/2026 at 2:00 PM, CC 1, stated that they did not check

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Resident 1's blood pressure before they gave Resident 1 their hypertensive medications. CC1 stated that the Licensed nurse checked Resident 1's blood pressure a couple of times a week. CC1 sated it was above their "pay grade" to check Resident 1' blood pressure.

Observation on 03/09/2026 at 8:00 AM, showed Resident 1 seated at the dining room table eating breakfast with spouse. Resident 1 was alert and responsive.

During an interview at the exit conference on 03/09/2026 at 3:45 PM, Staff H stated that they would need to review Resident 1's medications and speak with CC1 to determine who was responsible for Checking Resident 1's blood pressure before hypertensive medications were administered.

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

Administrator (or Representative) — Date 3/31/26

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

(e) Other information determined necessary by the assisted living facility.

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Resident 1's blood pressure before they gave Resident 1 their hypertensive medications. CC1 stated that the Licensed nurse checked Resident 1's blood pressure a couple of times a week. CC1 sated it was above their "pay grade" to check Resident 1' blood pressure.

Observation on 03/09/2026 at 8:00 AM, showed Resident 1 seated at the dining room table eating breakfast with spouse. Resident 1 was alert and responsive.

During an interview at the exit conference on 03/09/2026 at 3:45 PM, Staff H stated that they would need to review Resident 1's medications and speak with CC1 to determine who was responsible for Checking Resident 1's blood pressure before hypertensive medications were administered.

Plan/Attestation Statement

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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

(e) Other information determined necessary by the assisted living facility.

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete a written family medication assistance plan for 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk of not receiving their medications as prescribed.

Findings included…

Review of the facility's "Washington Family Assistance with Medications and Treatments" document dated 01/08/2020, showed that a Medication Assistance/Administration primary plan included a description "of the medication assistance or administration that the family member will provide". The document showed that a "plan must be submitted in writing to the community regarding the family assistance/management of medications". The document showed an alternate plan and emergency contact information was required.

Review of the facility's undated Resident Characteristics Roster showed that the facility admitted Resident 1 in [redacted] of 2024 with a diagnosis of [redacted], and [redacted].

Review of Resident 1's electronic Medication Administration Record (eMAR) dated January 2026, February 2026, and March 2026, showed Resident 1 received multiple prescription medications which included blood pressure medications and blood thinner medication that were self-administered without supervision.

Review of Resident 1's Individualized Service Plan dated 11/06/2025 showed that Resident 1's spouse, Collateral Contact 1 (CC1), administered Resident 1's medications. The service plan did not show an alternate plan if Resident 1's spouse was unable to administer Resident 1's medications.

Review of Resident 1's record found no documentation of a family plan that showed the family member/Resident Representative contact information, a list of prescribed medications, and an alternate plan as required.

During an interview on 03/04/2026 at 2:06 PM, CC1 stated that they administered Resident 1's medications. CC1 stated that if they cannot administer Resident 1's medications the facility staff would administer the medications for Resident 1. CC1 stated that all of Resident 1's medications were stored in the apartment they shared.

During an interview on 03/09/2026 at 12:18 PM, Staff H, Registered Nurse, Resident Care Director, stated that the previous administrator Staff K, Traveling Executive

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

Director, was supposed to have completed a family medication plan for Resident 1.

During an interview on 03/09/2026 at 3:45 PM, Staff H stated that there was a previous family assistance medication plan for Resident 1 completed by Staff K. Staff H stated that they were unable to locate the plan. Staff H stated that they would complete a new family assisted medication plan.

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, Sunrise of Issaquah is or will be in compliance with this law and / or regulation on (Date) 4/30/26 .

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

Administrator (or Representative) — Date: 3/31/26

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Director, was supposed to have completed a family medication plan for Resident 1.

During an interview on 03/09/2026 at 3:45 PM, Staff H stated that there was a previous family assistance medication plan for Resident 1 completed by Staff K. Staff H stated that they were unable to locate the plan. Staff H stated that they would complete a new family assisted medication plan.

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, Sunrise of Issaquah 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

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

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

Sunrise Senior Living Management Inc
Sunrise of Issaquah
23599 SE Issaquah Fall City Rd
Issaquah, WA 98029

RE: Sunrise of Issaquah # 2543

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 03/19/2026 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

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

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

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (03/19/2026), no later than 05/03/2026 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-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

The Assisted Living Facility failed to ensure one memory care resident's Individualized Service Plan was signed by the resident representative at least annually. During the Department's licensing inspection, the facility obtained the resident representative's signature on the most recent Service Plan.

The deficiency was corrected by the exit conference.

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

The Assisted Living Facility failed to ensure one staff (Staff B) was tested for tuberculosis (TB) within three days of employment. Staff B completed the QuantiFERON-TB Gold Plus test (a blood test for tuberculosis) on the fourth day of employment.

The deficiency was corrected by the exit conference.

You Are Not:

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

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

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 (206)305-3489.

Sincerely,

Jim Sherman

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

Enclosure

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