Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 234475
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s): 08/06/2026, 08/07/2026

Allegation(s):

1. Staff sleeping on the job.
2. Staff working 16-24 hour shifts.
3. Resident care neglected.
4. Retaliation to staff who report concerns.
5. Staff threatening to call police on residents.
6. Resident locked in room.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Victim's Representative Staff Management Residents Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets *Incident investigations *Characteristic roster *Team chat conversations *Disclosure of Services

*Drug and alcohol policy
*Email communication
*ADL documentation
*Behavior tracking
*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. Staff, residents, and resident representatives all reported that they have observed some staff sleeping while on their shift. The department went in the facility after hours on two separate occasions and discovered stall sleeping. Failed practice identified under Resident Rights 388-78A-2660 (1) and RCW 70.129.140 (1)(2)(a), and Licensee Responsibility 388-78A-2730 (1)(a)(b)(c), Implementation of the NSA 388-78A-2160.

2. Staff and residents reported that the facility was chronically short staffed. Staff interviewed said that there were some caregivers that were on the schedule for multiple shifts in a row without any shifts off. The schedule showed several staff were assigned shift in excess of 16 hours. Failed practice identified under Required ALF Services 388-78A-2170 (1).

3. Staff reported concerns that some residents were not receiving care per their care plan. The Alleged Victim (AV) was observed and their records reviewed. The AV's records and observations showed they had only been showered one time in a month and their feet were not cared for. Some sampled residents required 24-hour supervision and their assigned staff were observed to be sleeping on shift. Failed practice identified under Implementation of the NSA 388-78A-2160.

4. Interviewed staff reported that they did not have concerns of retaliation. Records of terminated staff were reviewed and the staff had multiple disciplinary coaching sessions prior to their termination. The facility denied taking shifts away from staff that reported concerns. No failed practice identified.

5. Care staff that were interviewed said they did not threaten to call the police as a tactic. Care staff reported that the police were only called when they felt the resident and or other residents were are risk of harm. The police department provided police reports that showed they had some residents that had volatile, unpredictable behavior that often did require intervention by law enforcement. No failed practice identified.

6. Multiple unannounced facility visits were made, and the Alleged Victim (AV) was never observed to have been locked alone in their room. The AV was observed in their room and staff were lying on the floor blocking the door. The staff were asleep during two of the night shift observations and both times they were inside the room blocking the door. A sampled residents door was locked at night and staff were asleep inside the room. It is undetermined if either resident had the cognitive ability to unlock the doors on their own. The AV was non-verbal with severe autism and the sampled resident had significant cognitive deficits. Failed practice identified under Resident Rights 388-78A-2660 (3).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 235565
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s): 08/11/2026, 09/28/2026

Allegation(s):

1. Physical and verbal abuse of a resident by staff.
2. Staff giving a resident cold showers as punishment. (Allegation added based on statement made during complainant contact)

Investigation Methods:

Sample:
Total residents: 27
Resident sample size: 16
Closed records sample size: 1

Observations:
Alleged Victim
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter
Alleged Victim
Residents
Staff
Management
Resident Representatives

Record Reviews:
*Incident reports
*Abuse neglect and exploitation policy
*Admission discharge policy and procedure
*Behavioral support plans
*Care plans
*Face sheets
*Incident investigations
*Characteristic roster
*Team chat conversations
*Disclosure of Services
*Drug and alcohol policy
*Email communication

*ADL documentation
*Behavior tracking
*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. Staff reported that they witnessed another staff pinning down a resident. The behavioral health staff stated that they were informed of an incident between that staff and resident. The executive director sent a communication to all staff about restraining residents. The facility did not report the abuse to the department, the executive director provide false information to the department during the investigation, the facility did not protect residents after the allegation was reported. Staff did not meet the training requirements. The administrator was unable to answer basic questions about processes and the facility did not have an identified job description of the administrators duties. Failed practice identified under Resident Rights 388-78A (3)(7) and RCW 70.129.120, Circumstances that may result in enforcement remedies 388-78A-3170 (1)(l)(2)(c), Reporting abuse and Neglect 388-78A-2630 (1)(a)(b), and Staff 388-78A-2450 (1)(a)(2)(a)(e)(5)(a).

2. The Alleged Victim was interviewed, and they denied having ever received a cold shower from staff. Other residents were interviewed, and no concerns were voiced about being showered in cold water. The Reporter was interviewed, and they reported that the allegation was based on second hand knowledge. The Reporter was unsure if facility management had been made aware of the allegation. Attempts were made to interview staff with first hand knowledge of the incident, though attempts were unsuccessful. Facility management was interviewed, and they stated they had no awareness of the allegation. Record review showed that the facility had a policy to guide staffs' response when allegations of abuse against residents occurred. The Alleged Victim was observed without signs of fear or distress. No failed facility practice.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 235820
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Allegation(s):

1. Staff required to use Google translator to communicate with non-English speaking resident.
2. Residents constantly sent to the hospital for medical issues.
3. Inadequate staffing.
4. Resident with only a mattress in their room has no mental stimulation.
5. Resident room smells like urine.
6. Resident constantly left nude in their room.
7. Heater in resident room has exposed wires.
8. Black mold on resident floor.
9. Staff blocking resident in room.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Alleged Victims Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Staff Management Alleged Victims' Representatives Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets

*Incident investigations
*Characteristic roster
*Team chat conversations
*Disclosure of Services
*Drug and alcohol policy
*Email communication
*ADL documentation
*Behavior tracking
*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. The Alleged Victim (AV) was a Spanish speaking resident that spoke very little English and was admitted without a solid plan to communicate with them. The facility staff were told to use online translator apps that were not effective in communicating with the resident. The facility did not have a translation policy created to implement. Failed practice identified under Required ALF Services 388-78A-2170 (3)(a)(b) and Policy and Procedure 388-78A-2600 (1)(a).

2. Attempts were made to contact the Reporter for clarification of their concerns, though attempts were unsuccessful. Residents and resident representatives were interviewed, and no concerns were voiced about unnecessary hospital visits. Interview with facility management showed that the facility had a plan to obtain medical care for residents following incidents with potential for injury when assessment by a facility nurse was unavailable. Staff were observed available to supervise resident safety and to respond to incidents when needed. No failed facility practice.

3. Staff, residents, and representatives stated that some staff slept on their shift. The department discovered staff sleeping during their shift. The staff were scheduled in excess of 16 hours due to short staffing and that resulted in staff sleeping on shift. Failed practice identified under Required ALF Services 388-78A-2170 (1), Implementation of the NSA 388-78A-2160, Licensee Responsibility 388-78A-2730 (1)(a)(b)(c), and Resident Rights 388-78A-2660 (1) and RCW 70.129.140.

4. The Alleged Victim (AV) and sampled residents did not have homelike environments. They did not have their pictures, personal items, or well maintained environments. Failed practice identified under Resident Rights 388-78A-2660 (1) and RCW 70.129.005, Maintenance and Housekeeping 388-78A-3090 (1).

5. The Alleged Victim's (AV) room had a very strong urine odor. The odor was present during multiple on-site visits. The staff stated that the resident urinated in inappropriate places frequently. Management said that they did not have a good plan to keep the urine smell under control. The administrator was unable to answer basic questions about the facility or protocols. Failed practice identified under Resident Rights 388-78A-2660 (1), Administrator Responsibilities 388-78A-2560(1), and RCW 70.129.005 and Maintenance and Housekeeping 388-78A-3090 (1).

6. Interview with the Alleged Victim's Representative showed that the resident preferred to be without clothing. The Alleged Victim was observed, and they disrobed repeatedly. The Alleged Victim was able to redress when they desired with minimal assistance from staff. The Alleged Victim had designated staff who were observed with a blanket when the resident was out of their room in order to provide for the resident's privacy in the event they disrobed in a common area. The Alleged Victim's Representative reported feeling safe with their loved one in the facility. No failed facility practice.

7. The Alleged Victim's (AV) room had an outlet plug that was uncovered and hole in the wall with exposed wires protruding out. Staff said the resident pulled them off the wall. Management said that the resident was destructive and they were unsure how or what to do to keep the room in safe working order. Failed practice identified under Resident Rights 388-78A-2660 (1) and RCW 70.129.005 and Maintenance and Housekeeping 388-78A-3090 (1).

8. The alleged victims room was observed and no mold was visible. Other sampled resident rooms were observed and no mold was visible. No failed practice identified.

9. Multiple unannounced facility visits were made, and the Alleged Victim was never observed to have been blocked in their room. Observations showed that when the Alleged Victim wished to leave their room, their designated staff ensured the resident was appropriately clothed then accompanied the resident where they wished to go. The Alleged Victim could not be interviewed as they were non-verbal. The Alleged Victim's Representative was interviewed, and they reported feeling safe with their loved one at the facility. They voiced no concerns related to staff restricting their loved one's movement. The Alleged Victim was observed, and no signs of distress were noted. No failed facility practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 236256
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Allegation(s):
No system for residents to summon staff in part of the building.

Investigation Methods:

Sample:
Total residents: 27
Resident sample size: 16
Closed records sample size: 1

Observations:
Alleged Victims
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Alleged Victims
Management
Staff
Residents
Resident Representatives

Record Reviews:
*Incident reports
*Abuse neglect and exploitation policy
*Admission discharge policy and procedure
*Behavioral support plans
*Care plans
*Face sheets
*Incident investigations
*Characteristic roster
*Team chat conversations
*Disclosure of Services
*Drug and alcohol policy
*Email communication
*ADL documentation
*Behavior tracking
*CARES assessments

*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

The facility did not have any call lights installed in the assisted living wing. Residents were moved into those rooms and were not provided with a pendant or a way to summons staff. Residents said they would like a pendant or a call light. Failed practice identified under Communication System 388-78A-2930 (1)(a)(ii).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 236361
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Allegation(s):

1. Staff working too many hours and not providing good care.
2. Inadequate supplies.
3. Resident not receiving enough care.
4. Resident fell, became injured, and was transported by staff in facility car.
5. Inadequate staffing.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Management Staff Residents Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets *Incident investigations *Characteristic roster *Team chat conversations *Disclosure of Services *Drug and alcohol policy *Email communication *ADL documentation

*Behavior tracking
*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. The staff were observed by the department to be there multiple shifts in a row without time off. The staff reported that they often were scheduled for at least 24 hours in a row. The schedule showed that staff were sometimes scheduled up to 72 hours in a row. The department observed staff sleeping on two different occasions. Staff, residents and representatives all stated they have seen staff sleeping while on shift. Failed practice identified Resident Rights 388-78A-2660 (1) and RCW 70.129.140 (1)(2)(a), Implementation of the NSA 388-78A-2160, Required ALF Services 388-78A-2170 (1), and Administrator Responsibilities 388-78A-2560 (1).

2. The Reporter was anonymous and provided no contact information so it could not be clarified which supplies were unavailable. Facility staff were interviewed, and they reported that while needed supplies were available, they had to go to a storage room to obtain them. A storage room was observed to be adequately stocked with personal care items. Interviewed residents and resident representatives voiced no concerns related to inadequate care supplies. No failed facility practice.

3. The Alleged Victim was observed. Their hair and clothes appeared clean, and no unmet needs were identified. The Alleged Victim could not be interviewed as they were non-verbal. The Alleged Victim's Representative was interviewed, and they denied concerns about their loved one's basic care needs being met. The AV had a behavioral support plan that identified activities and ways for staff to communicate. The residents room did not have any activities in it and the staff did not have the communication boards with them as outlined in the plan. The residents daily behavioral charting showed that they had a significant number of behaviors that staff had identified as being the result of boredom. Failed practice identified under Resident Rights 388-78A-2660 (1) and RCW 70.129.140 (1)(2)(a).

4. The alleged victim's (AV) careplan showed they were supposed to be accompanied anytime they went outside because they had advance alzheimers. The AV went outside unattended and tried to climb a fence. The AV fell, broke their hip and the facility transported them to the hospital in the facility car. The facility did not have a policy for facility transported residents. The executive director provided an investigation that did not have accurate information on it. Failed

practice identified under Implementation of the NSA 388-78A-2160, Policy and Procedure 388-78A-2600 (1)(b)(2)(o), and Circumstances that may result in enforcement remedies 388-78A-3170 (1)(l)(2)(c).

5. There were three residents that required 24 hour supervision. The department observe staff that were assigned to the residents sleeping on two different occasions. Resident, staff, and representatives reported that staff were observed sleeping on their shifts. Failed practice identified Resident Rights 388-78A-2660 (1) and RCW 70.129.140 (1)(2)(a), Implementation of the NSA 388-78A-2160, and Required ALF Services 388-78A-2170 (1).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 236311
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s): 08/25/2026, 09/03/2026

Allegation(s):

1. Medication not given as ordered.
2. Facility threatening to discharge a resident for breaking their [redacted]
3. Resident feels unsafe because a staff tried to enter their room when their door was locked.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Victim Management Staff Residents Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets *Incident investigations *Characteristic roster *Team chat conversations *Disclosure of Services *Drug and alcohol policy *Email communication

*ADL documentation
*Behavior tracking
*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. The Alleged Victim (AV) stated that the facility did not have their medication order correct and they were not getting their medications as ordered. The medication administration records showed they had missed multiple doses. The physician order showed the order in the facility medication system was wrong. The facility nurse stated that they order in their system was wrong and the resident had missed multiple doses. Failed practice identified under Medication Services 388-78A-2210 (2)(a).

2. The Alleged Victim was interviewed, and they reported that the facility wished to discharge them because they preferred a different provider than was stipulated by the resident's court ordered least restrictive alternative. This allegation falls outside of RCS jurisdiction.

3. The Alleged Victim was interviewed. They reported that the staff member knocked on their door prior to entering, and that when they asked the staff member to leave, the staff did as requested. The Alleged Victim reported that staff typically waited for a response after knocking before entering their room. Residents interviewed voiced no concerns about staff entering their rooms without permission. Staff observed knocked prior to entering a resident room. The Alleged Victim was observed, and no signs of fear or distress were noted. No failed facility practice.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 237257
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Allegation(s):

1. Unrepaired damage to resident apartment (BB hole in window and hole in bathroom wall).
2. Gum and ants on the floor of resident apartment.
3. Scar of unknown origin.
4. Black eye of unknown origin.
5. Resident possibly being yanked around as shirts are torn.
6. Resident possibly being restrained at table because table legs are broken.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Victim's Representative Alleged Victim Management Staff Residents Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets *Incident investigations *Characteristic roster

*Team chat conversations
*Disclosure of Services
*Drug and alcohol policy
*Email communication
*ADL documentation
*Behavior tracking
*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. The Alleged Victims (AV) room had damage in walls in the bathroom and there was a hole in the window. Sampled residents also had unrepaired damage in their room. Management acknowledged the damage and reported that it had been there for a while but they had not scheduled repairs at that time. Failed practice identified under Maintenance and Housekeeping 388-78A-3090 (1) and Licensee Responsibility 388-78A-2730 (1)(a)(b)(c).

2. The facility was inspected and observed on multiple occasions during the investigation, there were no signs of bugs anywhere or gum on the floors. Residents did not report any concerns about this. No failed practice identified.

3. The department observed the alleged victims head and did not see any new scars that would have indicated an unreported injury of such nature. The progress notes and assessments were reviewed and did not have any scars identified. No findings identified.

4. The Alleged Victims' (AV) representative reported that the AV had a black eye last Christmas and the facility said they did it to themselves. The representative said the injury seemed inconsistent to self-harm. The AVs records were reviewed and the nurse noted that the AV had a black eye with an unknown origin. The AVs record did not have an investigation and there was no monitoring of the injury. The facility did not report the black eye and did not follow their policy to investigate and report injuries of unknown origin. Failed practice identified under Reporting abuse and neglect 388-78A-2630 (1)(a)(b), Monitoring Residents Wellbeing 388-78A-2120 (3)(b), Policies and procedures 388-78A-2600 (1)(b)(2)(a), and Investigations 388-78A-2371 (2)(4).

5. The Alleged Victim (AV) was observed during multiple on-site visits during the investigation. Staff were not observed mishandling the resident. The residents

clothing was observed during the on-site visits and the department did not see torn shirts. Staff reported they are not to restrain or pull on residents. No failed practice identified.

6. The Alleged Victim (AV) was observed on multiple on-site visits during the investigation. The AV was freely moving about the facility on their own free will. STaff stated they go where the resident wants to go. Staff were unable to substantiate that the broken table was related to the Alleged Victim being restrained at the table. No failed facility practice.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 237926
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Allegation(s):
Resident-to-resident physical altercation.

Investigation Methods:

Sample:
Total residents: 27
Resident sample size: 16
Closed records sample size: 1

Observations:
Alleged Victim
Alleged Perpetrator
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Alleged Victim
Alleged Perpetrator
Management
Staff
Residents
Resident Representatives

Record Reviews:
*Incident reports
*Abuse neglect and exploitation policy
*Admission discharge policy and procedure
*Behavioral support plans
*Care plans
*Face sheets
*Incident investigations
*Characteristic roster
*Team chat conversations
*Disclosure of Services
*Drug and alcohol policy
*Email communication
*ADL documentation

*Behavior tracking
*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

The Alleged Victim (AV) reported that they Alleged Perpetrator (AP) hit and pushed them. The facility staff reported that they did witness the altercation. A police report and progress notes showed that there were two altercations. The facility did not report one of the altercations, they did not investigate one of the altercations and only did not do a thorough investigation of the second altercation. Police reports and progress notes show that the AP is impulsive, aggressive, and has attacked multiple staff and residents. The staff reported that the AP is difficult to redirect. Residents report that they are afraid of the AP. Failed practice identified under Investigations 388-78A-2371 (2)(4), Policies and Procedures 388-78A-2600 (1)(b), and Reporting Abuse and Neglect 388-78A-2630 (1)(a)(b).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 238079
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Allegation(s):

1. Injuries of unknown origin.
2. Staff sent inappropriate messages and pictures to another staff member.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Victim's Representative Management Staff Residents Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets *Incident investigations *Characteristic roster *Team chat conversations *Disclosure of Services *Drug and alcohol policy *Email communication *ADL documentation *Behavior tracking

*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. The Alleged Victim had bruises noted on the progress notes earlier in March. Staff reported that they saw the bruises but did not feel that the facility followed through with managing them. The residents record did not show that bruises were assessed, treated, or monitored. Failed practice identified under Monitoring Residents Wellbeing 388-78A-2120 (3)(b).

2. This allegation falls outside of RCS jurisdiction.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 238548
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):

1. Staff allegedly taking away resident's personal belongings as punishment.
2. Suspected financial exploitation of a resident by family.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Victim Management Staff Residents Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets *Incident investigations *Characteristic roster *Team chat conversations *Disclosure of Services *Drug and alcohol policy *Email communication *ADL documentation *Behavior tracking

*CARES assessments
*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

1. The Alleged Victim (AV) and care givers reported that the facility had been taking away the residents personal belongings as punishment. The facility reported that they took items away due to self-harm. The facility did not have documentation to support why each item was taken away and they did not have a court order that allowed them to remove items from the AV. The residents behavioral support plan showed that interventions were not supposed to be punitive. Failed practice identified under Implementation of the NSA 388-78A-2160 and Resident Rights 388-78A-2660 (7).

2. The facility discussed the circumstances that surrounded the accusations and it was unfounded. There were other sampled residents that were potentially financially exploited that the facility was aware of. A police report showed that they contacted the facility after an [redacted] report was sent to them. The residents guardian suspected a family member was exploiting the resident. The CRU data base was reviewed and showed this was the second time there were concerns that the resident was financially exploited. The facility was made aware of the concerns by the police but did not follow their policy to report the allegations to CRU. Failed practice identified under Reporting abuse and neglect 388-78A-2630 (1)(a)(b) and Policies and Procedures 388-78A-2600 (1)(b).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 81737
Investigator: Carla Rose
Provider Type: Assisted Living Facility
Intake ID: 239173
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/10/2026 through 10/09/2026
Complainant Contact Date(s):

Allegation(s):
Medication error.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 16 Closed records sample size: 1
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Victim's Representative Management Staff Residents Resident Representatives
Record Reviews:	*Incident reports *Abuse neglect and exploitation policy *Admission discharge policy and procedure *Behavioral support plans *Care plans *Face sheets *Incident investigations *Characteristic roster *Team chat conversations *Disclosure of Services *Drug and alcohol policy *Email communication *ADL documentation *Behavior tracking *CARES assessments

*Progress notes
*Fall assessments
*After-visit summaries
*Court records
*Staff records
*Medication administration records
*Police records
*Life threatening emergency policy
*Nondisclosure of confidential information policy
*Service agreement
*Facility safety plans
*Nurse delegation records
*Staff roster
*Staff schedule
*Incident reporting and investigation policy and procedure
*Provider orders
*Medication management policy and procedure

Investigation Summary:

The facility nurse discovered that they had made a medication error. The nurse was unable to correct their medication administration record because they were unsure how to do it. The facility management team were consulted and they also were unsure how to correct the medication system. The nurse reported that they thought other residents had incorrect orders in their system as well but were unsure how to correct it. Failed practice identified under Staff 388-78A-2450 (1)(a).

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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

The department completed data collection for an unannounced on-site complaint investigation on 08/10/2026, 08/12/2026, 08/21/2026, 08/27/2026, 08/28/2026, 08/31/2026, 09/04/2026, 09/11/2026, 09/12/2026, 09/13/2026, 09/14/2026, 09/17/2026, 09/18/2026 and 09/20/2026 of:

Sycamore Glen at Quail Hollow
506 N Ehorn Lane
Chewelah, WA 99109

This document references the following complaint number(s): 234940, 234475, 235565, 235820, 236256, 236346, 236361, 236311, 237001, 237257, 237926, 238019, 238079, 238548, 238484, 238505, 239173

The following sample was selected for review during the unannounced on-site visit: 16 of 27 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Amy Wright, NCI Complain Investigator
Stephanie Jenks, Community Field Manager

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

RCW 70.129.005 Intent -- Basic rights. * CHANGE IN 2012 *** (SEE 2056-S.SL) *** The legislature recognizes that long-term care facilities are a critical part of the state's long-term care services system. It is the intent of the legislature that individuals who reside in long-term care facilities receive appropriate services, be treated with courtesy, and continue to enjoy their basic civil and legal rights. It is also the intent of the legislature that long-term care facility residents have the opportunity to exercise reasonable control over life decisions. The legislature finds that choice, participation, privacy, and the opportunity to engage in religious, political, civic, recreational, and other social activities foster a sense of self-worth and enhance the quality of life for long-term care residents. The legislature finds that the public interest would be best served by providing the same basic resident rights in all long-term care settings. Residents in nursing facilities are guaranteed certain rights by federal law and regulation, 42 U.S.C. 1396r and 42 C.F.R. part 483. It is the intent of the legislature to extend those basic rights to residents in veterans' homes, boarding homes, and adult family homes. The legislature intends that a facility should care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. A resident should have a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. [1994 c 214 1.] NOTES: Zoning -- 1994 c 214: "Nothing in this act shall affect the classifying of an adult family home for the purposes of zoning." [1994 c 214 30.]**

RCW 70.129.120 Restraints -- Physical or chemical. The resident has the right to be free from physical restraint or chemical restraint. This section does not require or prohibit facility staff from reviewing the judgment of the resident's physician in prescribing psychopharmacologic medications.

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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

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

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

(3) Not use restraints on any resident;

(7) Not allow any staff person to abuse or neglect any resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents were not restrained for 2 of 3 residents (Residents 1 and 2), that staff provided supervision for 2 of 3 residents (Residents 1 and 2), that residents had an environment that promoted dignity and quality of life for 2 of 15 residents (Residents 1 and 7), and that staff were not allowed to abuse 1 of 1 resident (Resident 14) who was subjected to punitive actions in response to their behavior. These failures resulted in Resident 2 being physically restrained and prevented from moving, the exits from Residents 1 and 2's room being obstructed by caregivers sleeping in front of their doors, limiting the residents' ability to freely exit their rooms, Resident's (1, 2, and 14) not receiving required care and supervision during nighttime hours while staff slept, and placed the residents at risk of a decreased quality of life.

Findings included…

<Restraints>

Per RCW 70.129.010, Physical restraint means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body.

Resident 2

Review of Resident 2’s negotiated care plan (the facility’s titled Negotiated Service Agreement, NSA) dated 08/13/2026, showed the resident was diagnosed with [redacted]

[redacted] and [redacted], and [redacted] The care plan showed that Resident 2 required “2:1” staff (two caregivers assigned to remain with the resident at all times) for 24-hour supervision. The NSA showed the resident was ambulatory with even gait (walking).

In an interview on 08/11/2026 at 1:32 PM, Staff N, Caregiver, stated that on 08/06/2026, they heard Resident 2 calling out their name from the resident’s room. Staff N stated that upon entering Resident 2’s room, they witnessed Staff O, Caregiver, lying on top of Resident 2, pinning the resident’s arms to their chest/stomach area.

Review of a group text sent by Staff A, Executive Director, to facility staff on 08/07/2026, showed that Staff A provided staff with the following important reminder on that day:

“It is unacceptable and illegal to restrain or yell at a resident. Engaging in either may result in unpaid suspension pending an investigation, immediate termination, and/or a state investigation that may result in you losing your ability to work with vulnerable adults or children for the rest of your life."

In an interview on 08/10/2026 at 10:35 AM, Staff J, Behavioral Support Specialist, was asked if any staff had recently gone hands on (inappropriate intervention in which staff place their hands on a resident to restrain them) with a resident. Staff J said they were notified late last week that Staff O, Caregiver, needed to be counseled because there had been an incident between Staff O and Resident 2. Staff J stated that they discussed that staff should never put their hands on residents out of frustration and that under no circumstances should staff restrain a resident. The department regulator asked what the details of the incident were, Staff J stated they were unsure, they were just told to talk to Staff O about caregiver burn out.

Observation on 08/11/2026 at 12:05 AM (night shift), showed the door to Resident 2’s room was locked. The department regulator knocked twice without any response from inside the room. The department regulator then asked Staff E, who was across the hall in Resident 1’s room, to unlock Resident 2's door. Staff E knocked twice on Resident 2’s door. The door unlocked from inside and was cracked an inch open. The department regulator attempted to open the door but was unable to because Staff F, HCA, was lying on the floor with a blanket and were positioned directly behind the door (blocking entrance or exit from the room). Resident 2 was observed in the room.

Resident 1

Review of Resident 1's NSA, dated 08/13/2026, showed the resident was diagnosed with [redacted], and that they required extensive support. The care plan showed that Resident 1 required "2:1" staff (an assignment with two care givers assigned to directly supervise the resident) to provide 24-hour a day supervision.

Observation on 08/11/2026 at 12:03 AM (night shift), showed Staff E, Home Care Aide (HCA), laid on the floor behind (blocking entrance or exit from the room) Resident 1's closed door. When the department regulator attempted to open the door, they had to wait for Staff E to shift out of the way before the door could be opened. Resident 1 was observed in the room.

In an interview on 08/12/2026 at 1:20 PM, Staff N stated that staff barricaded Resident 1's door and that they had pads which they laid down on in front of the resident's door.

<Lack of necessary supervision>

Resident 1

Review of Resident 1's NSA dated 08/13/2026, showed the resident required 2:1 staff for 24-hour supervision.

Observation on 08/11/2026 at 12:03 AM (night shift), showed Staff E, was lying on the floor behind (blocking entrance or exit from the room) Resident 1's closed door. When the department attempted to open the door, they had to attempt to open the door multiple times before Staff E opened the door. Observation showed that Staff C, Caregiver, was lying on a couch inside the room. Further observation showed that both Staff C and Staff E sat up but were not alert enough for the department to conduct a

thorough interview with them at that time. Resident 1 was observed in the room.

Observation on 09/11/2026 at 3:50 AM (night shift), showed Staff FF, Caregiver, and Staff GG, Caregiver were the 2:1 staff assigned to supervise Resident 1. Staff FF was observed was lying on the floor with their eyes closed in Resident 1's room. Staff GG was inside Resident 1's room, lying on the floor ten inches behind the door. Staff GG was snoring when the department regulator entered the room. Resident 1 was observed in the room.

Resident 2

Review of Resident 2's NSA, dated 08/13/2026, showed the resident required 2:1 staff for 24-hour supervision.

Observation on 08/11/2026 at 12:05 AM (night shift), showed the door to Resident 2's room was locked. The department regulator knocked twice without any response from inside the room. The department regulator then asked Staff E to unlock the door. Staff E knocked twice and then the door unlocked from inside and was cracked an inch open. Observation showed that once Staff F got up from the floor and allowed the department regulator to enter the room, Staff D, HCA, was lying on the couch asleep, covered up with a blanket with their back to the door. The department regulator called out Staff D's name three times and they did not respond. During this observation, Staff F was asked how long Staff D was sleeping, Staff F was unable to answer. Resident 2 was observed int he room.

Observation on 08/11/2026 at 12:50 AM (night shift) showed that when the department regulator went back to Resident 2's room, they discovered that Staff D was still sleeping. Staff D's name was called out again twice by Staff F and the department regulator before Staff D rolled over to face Staff D and woke up. Resident 2 was observed int he room.

In an interview on 08/11/2026 at 1:00 AM (night shift), Staff E confirmed that staff were not supposed to be asleep during their shift.

Resident 14

Review of Resident 14's NSA, dated 08/16/2026, showed that the resident was diagnosed with [redacted], and [redacted]
The NSA showed the resident required "1:1" staff for 24-hour supervision.

In an interview on 08/21/2026 at 2:40 PM, Staff CC, Caregiver, stated that they knew staff slept in Resident 14's room at night because they observed cushions laying on the ground. Staff CC further stated that they were new to the facility and had recently just finished training. When asked about the training process, Staff CC stated the facility had them do their training online while they were assigned as a 1:1 staff for Resident 14.

In an interview on 8/21/2026 at 3:00 PM, Resident 14 stated that staff slept on the floor inside their room in front of the inside of the doorway.

In an interview on 08/26/2026 at 10:22 AM, Collateral Contact 2 (Resident Representative), stated that there were times when they were at the facility and observed staff asleep on the couch in the resident's lounge.

In an interview on 08/11/2026 at 3:02 PM, Staff M, Administrator, stated that they agreed it was unsafe that staff were asleep during their assignment.

<Dignified environment/Quality of Life>

Resident 1

Review of Resident 1's NSA, dated 02/19/2026, showed they were diagnosed with [redacted], they were non-verbal, and they required extensive support.

Observations on 08/10/2026 at 09:29 AM, showed Resident 1’s room had the following:

- The bed did not have any sheets or blankets, the pillow did not have a pillowcase, and the pillow was covered with brown and pink stains on both sides.

- An outlet on the wall under the air conditioner unit was missing a cover plate and the wires were accessible behind the plug receptacle.

- There was a hole in the wall next to the bathroom with wires that protruded an inch out of the wall, with the ends of the wires exposed.

- A built-in cabinet near the bed was missing cabinet doors, the drawer was broken and parts of the drawer were missing. A wooden board, from the side of the drawer, was broken and left in the slider track with a sharp edge that protruded out.

- The kitchenette cabinets were missing doors and the trim that went around the countertop.

- There were deep gouges in the walls around the perimeter of the room.

- The room had a strong smell of urine that permeated out into the hallway.

- There were no pictures on the wall.

- The resident did not have access to any of their clothing from inside their room.

- The room had a bed, a couch, and two cushions on the floor. There were no activity supplies accessible from inside the room, nothing that provided any visual interest, and there was nothing to occupy the resident or provide any stimulation.

Observation on 08/28/2026 at 12:00 PM showed that the exterior window of Resident 1’s room had a white, torn and crooked vinyl window covering.

<Resident 7’s room>

Review of Resident 7's NSA, dated 08/14/2026, showed that the resident admitted to the facility on [redacted]/2026. Review of the NSA showed that Resident 7 had diagnoses that included [redacted]

Observation on 08/28/2026 at 2:34 PM, Resident 7’s room had the following:

- An unopened cardboard box containing a nightstand sat on the ground in the room. The shipping label of the box showed the furniture had been ordered for the resident by their guardian.

- An opened cardboard box containing wall decorations and a laptop computer sat on the ground in the resident’s room. The shipping label on the box showed the items had been ordered for the resident by their guardian and had been delivered on 08/13/2026.

- Resident 7’s box spring and mattress were on the ground. A bed frame with no mattress, wide metal slats (entrapment hazard), and a broken headboard sat next to the mattress.

- Resident 7's walls had no decorations or personal items. The wall had a television mount with no television.

In an interview at 08/28/2026 at 2:34 PM, Staff T, Registered Nurse, was asked why Resident 7's personal decorations, furniture, and laptop remained in boxes, and were not set up, and why the resident's bed was on the ground. Staff T stated they did not know.

In an interview on 09/02/2026 at 11:18 AM, Collateral Contact 4 (CC4), Resident 7's Guardian, stated that they had also noticed on a recent visit that the personal items they purchased for the resident's room sat in a box on the resident's floor. CC4 stated they were told that maintenance would hang the pictures and put the furniture together. CC4 further stated the furniture, pictures, and laptop had been birthday presents for Resident 7. CC4 stated the laptop was for the resident to watch boxing matches. CC4 stated that Resident 7 loved to watch old boxing matches.

In an interview on 09/02/2026 at 12:36 PM, Staff A was asked if Resident 7's birthday gifts that were in boxes on the floor had been set up and put together. Staff A stated they had not. Staff A stated they knew that Resident 7 liked to watch boxing and that they would ensure the laptop was set up so that they could watch boxing on the laptop. Staff A stated that not all staff knew the resident liked watching boxing. When asked if the resident's care plan reflected the activity, Staff A stated that it did not. Staff A further stated they would talk to staff about being more attentive.

<Abuse Resident 14>

Per WAC 388-78A-2020, Abuse is defined as intentional, willful, or reckless action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult.

Review of Resident 14's NSA, dated 08/16/2026, showed that the resident was diagnosed with [redacted], and [redacted]
The NSA showed the resident required "1:1" staff for 24-hour supervision.

Review of Resident 14's Behavioral Support Plan (BSP, negotiated service agreement for behavioral support), dated 04/10/2026, showed that staff were to use non-punitive (not intended for punishment) interventions when addressing the resident's behaviors.

In an interview on 08/17/2026 at 1:05 PM, Staff AA, Caregiver, stated that Resident 14's personal items had been taken away. Staff AA stated that items taken away were clothing, furniture, toys, bathroom door, shower curtain, shower supplies and art supplies. The department regulator asked if these items were removed due to safety concerns for each item. Staff AA stated they were removed as punishment.

In an interview on 08/21/2026 at 2:40 PM, Staff CC stated they thought about talking to an Ombudsman as they felt that Staff J, Behavioral Support Specialist, took away Resident 14's personal items and limited the amount of time the resident had on their I Pad when the resident had behaviors.

In an interview on 08/21/2026 at 3:00 PM, Resident 14 stated that staff frequently took their phone away and recently took it away because they [the resident] called 911. Resident 14 stated they were told that if they worked with the counselor (Staff J) they would get their phone back. Resident 14 also stated that they were only allowed to use their I Pad during the evening hours, between dinner time and bedtime, but that if they did not eat all of their dinner or if they swallowed non-food items, they would not be allowed to use it at all. Resident 14 stated that they were no longer allowed to attend church in town due to an incident when they banged their head on a wall in town. Resident 14 further stated that Staff J was the staff who told them they could not go to church and took their personal items away. Resident 14 stated they requested to talk to the Ombudsman about these concerns and that staff would not allow them to.

In an interview on 08/21/2026 at 3:20 PM, Staff J stated that Resident 14 was only allowed to use their I Pad after dinner and before bedtime. Staff J stated that Resident 14's guardian wanted the I Pad use to be limited to evening time. Staff J was asked if the facility had a court order that allowed them to take personal items from Resident

14. Staff J stated they did not. Staff J stated that personal items were taken from Resident 14 when the resident self-harmed, laid in the middle of the highway, or eloped.

In an interview on 08/25/2026 at 2:12 PM, Collateral Contact 5 (CC5), Guardian of Resident 14, stated that they did not have a court order, prior to that day 08/25/2026, that allowed restrictions on Resident 14's access to their personal property.

In an interview on 08/28/2026 at 3:40 PM, Staff J stated that Resident 14 was not allowed access to their personal markers, art supplies, or showering items due to safety. When asked why the resident was not allowed access, Staff J stated that the resident's 1:1 staff had access and could supervise usage of the items. Staff J was notified that a pencil with a sharp tip was observed in the resident's room prior to this interview. Staff J was asked if the pencil was considered a safety issue. Staff J did not answer the question and then said, "Maybe [Resident 14] needs a different kind of care."

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, Sycamore Glen at Quail Hollow 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-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure care that was agreed upon in negotiated service agreements, was implemented for 6 of 7

residents (Resident 1, 2, 3, 7, 12, and 14). These failures resulted in a lack of personal hygiene care and overgrown toenails for Resident 3; unmonitored blood sugar and diabetes for Resident 7; a lack of supervision while outdoors that contributed to Resident 12 sustaining an injury requiring hospitalization; Residents 1, 2, and 14 not receiving continuous care and supervision when staff assigned to provide around-the-clock care slept while on duty; and Resident 14 having their personal belongings removed as punishment.

Findings included…

<Hygiene and foot care>

Review of Resident 3's Negotiated Care Plan (the facility's title Negotiated Service Agreement, NSA), dated 11/25/2025, showed the resident was diagnosed with [redacted], and [redacted]. The care plan showed that Resident 3 was to be bathed daily and as needed, and that they required extensive assistance from two care givers. The care plan showed Resident 3's foot care required extensive assistance from one person. Further review showed that when Resident 3 became resistant to care, different staff were to reapproach Resident 3 multiple times after the resident refused assistance.

Observation on 08/10/2026 at 9:45 AM, showed Resident 3 sat in a wheelchair outside of their room. Resident 3 was visibly disheveled, had greasy hair, food on their face and down their shirt, and was wearing socks without shoes. Staff B, Medication Technician, removed Resident 3's socks so their feet were visible to the department regulator. The tops and bottoms of Resident 3's feet were black with dirt, and they had thick black build-up between their toes. Resident 3's toenails were thick and extended beyond the ends of their toes.

In an interview on 08/10/2026 at 9:47 AM, Staff B stated that Resident 3 frequently refused showers. Staff B then stated that it often took three or four caregivers to get them to shower but once they agreed, they allowed staff to assist them in the shower.

In an interview on 08/10/2026 at 10:35 AM, Staff J, Behavioral Support Specialist, stated that Resident 3 frequently refused showers. Staff J then stated that care staff were to document Resident 3's behaviors, which included refusals, on the daily behavioral charting logs. Staff J further stated that Resident 3 preferred some staff over others and that staff were to reapproach them when they refused.

In an interview on 08/10/2026 at 10:45 AM, Staff A, Executive Director, stated that if care staff had concerns that a resident's care needs were not addressed, they were to report it to the nurse or to the medication technician. Staff A stated that diabetics were

seen by the podiatrist (doctor that specialized in foot care) and that all other residents were to have their nails trimmed by the caregivers. Staff A further stated they were unaware of any concerns about Resident 3's toenails and they were unsure when the resident last received nail care.

Review of Resident 3's July 2026 progress notes showed that on 07/02/2026, 07/10/2026, 07/17/2026, and 07/24/2026, Staff J documented weekly notes that showed staff were to provide gentle reminders and reapproach, when necessary, to encourage Resident 3 to shower.

Review of Resident 3's shower logs, dated 07/09/2026 through 08/10/2026, showed documentation that read, "Log: Fill out every time resident is changed/showered." The logs showed that Resident 3 was showered on 07/18/2026. Further review showed there were no other showers documented during that time period.

Review of Resident 3's Activities of Daily Living (grooming and hygiene) logs for 07/01/2026 through 08/10/2026, showed there were 12 days in July and four days in August without any documented attempts to shower the resident.

In an interview on 08/11/2026 at 12:15 AM (night shift), Staff K, Caregiver, stated that they did not feel comfortable trimming Resident 3's toenails because they were very thick. Staff K stated that they brought their concerns to management multiple times and requested that they have a podiatrist trim the resident's toenails. Staff K stated that management told them that only diabetics were referred to the podiatrist and care staff were to trim toenails for the other residents.

In an interview on 08/11/2026 at 1:10 AM (night shift), Staff B stated that they did not expect Resident 3's feet to be in the condition they were in when they removed the resident's socks earlier in the day for the department regulator to observe the resident's feet.

Observation on 08/27/2026 at 11:45 AM showed Resident 3 had greasy hair, their hands and fingers were stained yellow, and they had dried food caked into their beard.

Review of Resident 3's shower log on 08/28/2026, showed Resident 3 had not been bathed since 08/14/2026.

Observation on 08/28/2026 at 4:30 PM, while accompanied by Staff A and Staff M, Administrator, showed Resident 3 had food crusted into their beard which was matted. Observation of the residents' feet showed the socks they had on were dirty with a hole in the sock on the left foot. The resident's left foot toes were observed to be disfigured with one toe overlapping another. There was a buildup of thick black dirt in between the toes on both feet. Further observation showed both of Resident 3's feet were calloused

with peeling dry skin. In an interview at that time, Staff A and Staff M were asked if the resident had any medicated creams that could be applied to improve the condition of the resident's feet. Staff A and Staff M stated they did not know.

<Blood sugar monitoring>

Review of Resident 7's NSA, dated 08/14/2026, showed that the resident was diabetic (unable to control blood sugar levels). Further review of the NSA showed that staff were to monitor the resident's blood glucose levels (measurement of sugar in the blood).

In an interview on 8/24/2026 at 1:00 PM, Staff U, Licensed Practical Nurse, stated they did not monitor Resident 7's blood sugar. Staff U was asked how they knew if the resident's blood sugar was high or low. Staff U stated that they would check the resident's A1C (blood test that measures average blood sugar levels). Staff U was asked what the resident's A1C was, and they responded, "We haven't checked that yet."

Review of Resident 7's August 2026 medication records showed no documentation of staff monitoring the resident's blood sugar.

In an interview on 08/27/2026 at 4:38 PM, Staff T, Registered Nurse, stated that Resident 7's blood sugar had still not been checked.

In an interview on 08/28/2026 at 2:30 PM, Staff T stated that the facility had started checking Resident 7's blood sugar daily.

Review of Resident 7's September 2026 medication administration record showed the resident's blood sugar measurements had not been documented as taken on 09/01/2026, 09/02/2026, and 09/07/2026.

In an email sent to the department regulator, Staff A confirmed that Resident 7's blood sugars had not been taken on 09/01/2026, 09/02/2026, and 09/07/2026. Staff A stated they provided coaching around not capturing the blood sugar values.

<Outdoor supervision>

Review of Resident 12's NSA, dated 02/09/2026, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed that staff were to, "always supervise client outside of the facility as

client is often disoriented."

In an interview on 08/21/2026 at 10:45 AM, Staff M stated that Resident 12 had a fall that resulted in a fractured hip. Staff M stated that Resident 12 went to the emergency room, was transferred to a skilled nursing facility, and then passed away.

Review of Resident 12's undated Fall Risk Assessment (assessment tool used in healthcare to determine the level of risk for falls), showed the resident had a fall risk of 18 (six to 13 is a moderate fall risk, greater than 13 is a high fall risk).

Review of a progress note, dated 07/12/2026, showed that Staff S, Medication Technician, documented that on [redacted]/2026 around 5:00 PM, Resident 12 was found by a caregiver outside by the retaining wall near the smoking area, trying to climb the fence. The note showed that staff attempted to redirect the resident to get down, the resident jumped down, and fell which caused an injury.

In an interview on 09/01/2026 at 1:10 PM, Staff S stated that Resident 12 often wandered outside unsupervised and that they did not have enough staff to supervise the resident. Staff S confirmed that Resident 12 had wandered outside alone, and that they were found outside and had tried to climb a fence. Staff S then stated that management did not discuss the incident with them.

<24-hour supervision>

Resident 1

Review of Resident 1's NSA, dated 08/13/2026, showed the resident was diagnosed with [redacted], and that they required extensive support. The care plan showed that Resident 1 required "2:1" staff (an assignment with two care givers assigned to directly supervise the resident) to provide 24-hour a day supervision.

Observation on 08/11/2026 at 12:03 AM (night shift), showed Staff E, Home Care Aide (HCA), laying on the floor behind Resident 1's closed door. When the department regulator attempted to open the door, Staff E was observed to be lying directly behind the door on the floor and appeared to be asleep. Staff E then shifted out of the way for the department regulator to enter. Further observation showed that Staff C, Caregiver, was lying on the couch at the time the department regulator opened the door and also appeared to be asleep. The lights in the room were observed to be turned off. Both Staff C and Staff E sat up but were not alert enough for the department regulator to conduct a thorough interview with them at that time. Resident 1 was observed in room.

Observation on 09/11/2026 at 3:50 AM (night shift), showed Staff FF, Caregiver, and Staff GG, Caregiver were the 2:1 staff assigned to supervise Resident 1. Staff FF was lying on the floor in Resident 1's room and appeared to be asleep. Staff GG was inside Resident 1's room, lying on the floor ten inches behind the door. Staff GG was snoring when the department regulator entered the room. Resident 1 was observed in room.

Resident 2

Review of Resident 2's NSA, dated 08/13/2026, showed the resident was diagnosed with [redacted] and [redacted]. The care plan showed that Resident 2 required "2:1" staff to provide 24-hour supervision.

Observation on 08/11/2026 at 12:05 AM (night shift), showed the door to Resident 2's room was locked. The department regulator knocked twice without any response from inside the room. The department regulator then asked Staff E to unlock the door. Staff E knocked twice and then the door unlocked from inside and was cracked open an inch. The department regulator attempted to open the door but was unable to because Staff F, HCA, was lying on the floor with a blanket and appeared to be asleep. Staff D, HCA, was lying on the couch asleep, covered up with a blanket and their back to the door. The department regulator called out Staff D's name three times and they did not wake up. During this observation, Staff F was groggy and when asked how long Staff D was asleep, Staff F was unable to answer. Resident 2 was observed in room.

Observation on 08/11/2026 at 12:50 AM (night shift), showed that when the department regulator went back to Resident 2's room, they discovered that Staff D was still asleep. Staff D's name was called out again twice by Staff F and the department regulator before Staff D rolled over and woke up. Resident 2 was observed in room.

Resident 14

Review of Resident 14's NSA, dated 08/16/2026, showed the resident required "1:1" staff (one caregiver assigned to remain with the resident at all times) to provide 24-hour supervision.

In an interview on 08/21/2026 at 2:40 PM, Staff CC, Caregiver, stated that they knew staff slept in Resident 14's room at night because they observed cushions laying on the ground. Staff CC further stated that they were new to the facility and had recently just finished training. When asked about the training process, Staff CC stated the facility had her do her training online while they were assigned as a one-on-one staff for Resident 14. Staff CC stated they did the training while the resident slept.

In an interview on 08/21/2026 at 3:00 PM, Resident 14 stated that the staff that were assigned to them at night, always slept on the floor in front of their door.

<Punitive treatment>

Review of Resident 14's NSA, dated 08/16/2026, showed that the resident was diagnosed with [redacted], and [redacted]. The NSA showed the resident required "1:1" staff for 24-hour supervision.

Review of Resident 14's Behavioral Support Plan (BSP, negotiated service agreement for behavioral support), dated 04/10/2026, showed that staff were to use non-punitive interventions (not intended for punishment) when addressing the resident's behaviors.

In an interview on 08/17/2026 at 1:05 PM, Staff AA, Caregiver, stated that they were frequently assigned to Resident 14 as their 1:1 assigned caregiver. Staff AA stated that there were multiple times in the past when Resident 14's personal items were taken away. Staff AA stated that items taken away included clothing, furniture, toys, bathroom door, shower curtain, shower supplies and art supplies. The department regulator asked if these items were removed due to safety concerns for each item. Staff AA stated they were removed as punishment. Staff AA further stated that they reported their concerns about removal of personal belongings as punishment to Staff J, Behavioral Support Specialist, but they were dismissed. Staff AA then went on to say that Resident 14's shower supplies and art supplies were still locked up. Staff AA stated that Staff J removed Resident 14's stuffed animals and gave them to Resident 14's representative to be donated. Staff AA stated that Staff J told them that Resident 14 could earn items back for good behavior. Staff AA then stated that it seemed as though Staff J felt the behavior was never good enough to earn belongings back. During the interview, Staff AA stated that Resident 14 had been restricted from going to church and on some shopping outings.

In an interview 08/21/2026 at 2:40 PM, Staff CC stated that Staff J had taken some of Resident 14's personal property from them. Staff CC stated that Staff J had taken the resident's cell phone and limited how often Resident 14 could use their personal I Pad. Staff CC further stated that taking these items was a consequence of self-harming behavior.

In an interview on 08/21/2026 at 3:00 PM, Resident 14 stated that some of their personal items had been taken by Staff J. Resident 14 stated that they were told if they worked with a counselor, they could get their phone back, which they reported had been a gift from their father for their 18th birthday. Staff 14 stated that they were only

allowed to use their personal I Pad from after dinner time until bedtime. Resident 14 stated that they would not be allowed to use their I Pad if they did not eat all of their dinner or if they swallowed non-food items. Resident 14 stated that after calling 911, their phone had been confiscated. Resident 14 stated that they were no longer allowed to attend church in town due to self-harming behavior out in the community.

In an interview on 08/28/2026 at 3:35 PM, Resident 14 stated they did not have access to their hygiene items, their markers, or their art supplies. Resident 14 stated that their guardian and Staff J had taken some of their personal items from their room.

In an interview on 08/28/2026 at 3:40 PM, Staff J stated that Resident 14 did not have markers or art supplies in their room anymore, since returning from a psychiatric inpatient stay. When asked about Resident 14's shower supplies, Staff J stated that the resident's 1:1 staff could access them. When asked if they, Staff J and Resident 14's guardian had taken some of the resident's personal belongings, Staff J said, "There is some truth to that." Staff J explained that they took the resident's belongings because the room was too small. Staff J was asked why this type of consequence was allowed, Staff J said, "It's the powers that be."

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, Sycamore Glen at Quail Hollow 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-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain resident rooms in a safe and sanitary conditions for 2 of 10 sampled resident rooms (Residents 1 and 2), that outdoor gathering areas were maintained in 2 of 2 memory care unit courtyards (Courtyards 1 and 2), and that 1 of 1 exterior grounds were maintained. These failures resulted in Resident 1 residing in a room with damaged walls and furniture, exposed electrical outlets and a soiled couch, and with Resident 2 residing in a room with

damaged walls and window, and placed the residents at risk of harm and decreased quality of life.

Findings included…

<Resident 1>

Review of Resident 1's Negotiated Care Plan (the facility's Negotiated Service Agreement, NSA) dated 02/19/2026, showed the resident was diagnosed with [redacted], and [redacted]. The NSA showed the resident required extensive support. The NSA documented that Resident 1 frequently urinated in inappropriate places and that staff were to clean up the urine after each incident.

Observation on 08/10/2026 at 9:29 AM, showed Resident 1's room had the following:

- An outlet on the wall under the air conditioner unit was missing a cover plate and the wires were accessible behind the plug receptacle.

- There was a hole in the wall next to the bathroom with wires that protruded an inch out of the wall, with the ends of the wires exposed.

- A built-in cabinet near the bed was missing cabinet doors and the drawer was broken with parts of the drawer missing. A wooden board, from the side of the drawer, was broken and left in the slider track.

- The kitchenette cabinets were missing doors and the trim that went around the countertop was missing.

- There were deep gouges in the walls around the perimeter of the room.

- The room had a strong smell of urine that permeated out into the hallway.

- The exterior side of the window was covered with a white, torn and crooked vinyl shade.

Observations throughout the day on 08/10/2026 showed the strong scent of urine from Resident 1's room was noticed halfway down the hall, several doors down from their

room.

Observations on 09/13/2026 at 11:00 AM showed that Resident 1's room had a strong scent of urine.

In an interview on 08/10/2026 at 12:45 PM, Staff L, Caregiver, acknowledged the damage and the smell of urine. Staff L stated that the resident had pulled a cord out of the wall that caused the outlet cover to come off. Staff L further stated that the smell of urine was due to the frequency of the resident urinating in inappropriate places in their room.

In an interview on 08/10/2026 at 1:45 PM, Staff A, Executive Director, stated that the wires protruded out of the wall because Resident 1 had pulled the thermostat off and they had not determined what they would use to replace it.

Observation on 08/11/2026 at 1:00 AM (night shift), showed Staff C, Caregiver, assigned to supervise Resident 1. Staff C was observed sitting on a chucks pad (an absorbent pad used as a protective barrier) on the couch in Resident 1's room. In an interview at that time, Staff C was asked why they sat on the chucks pad. Staff C stated they did so because Resident 1 urinated on the couch so often that they did not want to sit directly on the couch. Staff C further stated they would have preferred that the couch was made of material that could be cleaned instead of fabric.

In an interview on 08/12/2026 at 11:30 AM, Staff M, Administrator, acknowledged the strong scent of urine that came from Resident 1's room. Staff M stated that they were not aware if there was a plan to correct it. Staff M further stated that the damage had not been fixed because Resident 1 had a history of being destructive and they were "difficult to manage."

<Resident 2>

Review of Resident 2's NSA, dated 08/13/2026, showed the resident was diagnosed with [redacted] and [redacted] and [redacted] The care plan showed that Resident 2 required 2:1 staff (2 caregivers assigned to remain with the resident at all times) for 24-hour supervision to be provided.

In an interview on 08/18/2026 at 1:45 PM, Collateral Contact 1 (CC1), Resident 2's Representative, stated that last year they noticed a hole in the resident's bedroom window that resembled a BB shot (a small hole created by a round metal ball from an air gun). CC1 told the department that they brought the hole in the window to Staff A's attention last year, but it was not repaired. CC1 stated that there was a hole in the

bathroom wall that had not been repaired. CC1 further stated that they had requested that they paint over patched holes to match the rest of the walls because Resident 2 became fixated on the noticeable plaster on the wall.

Observation on 08/21/2026 at 1:45 PM, showed Resident 2's room had the following:

- Quarter inch hole that resembled a BB shot, in the far, left window.

- Four-inch hole in the bathroom wall. The hole was surrounded by plaster that had not been painted over.

- One side of the toilet paper holder was missing, and the bracket was left on the wall.

- Two towel bars were missing, and the sharp metal brackets were left on the walls.

In an interview on 08/21/2026 at 1:38 PM, Staff H, Home Care Aide, stated that the hole in the wall had been there for two months and that it had been patched before, but the resident pushed through the visible plaster on the wall. Staff H further stated that the metal brackets on the walls were from the toilet paper holder and towel bars that had been pulled off.

In an interview on 08/27/2026 at 2:10 PM, Staff A stated that the hole in Resident 2's bathroom wall was patched a few months ago but not painted. Staff A acknowledged that Resident 2 became fixated on previously repaired holes that were not painted to match the rest of the wall. Staff A further stated that they were aware of the missing towel bars and toilet paper holder.

<Exterior grounds>

Observation on 08/28/2026 at 12:00 PM showed the facility's front entrance patio contained rusted, broken and stained patio furniture. Observation showed that several metal patio chairs were missing their padded cover. Further observation showed the ground was littered with debris, and that the windowsills and furniture were covered with a thick layer of dust. Observation of the facility's exterior landscaping showed the following:

- Patches of dirt and dead grass.

- Weeds in garden beds and throughout grass.

- Areas of overgrown grass.

- Dead plants and flowers in garden beds.

Observation on 08/28/2026 at 2:15 PM, of Courtyard 1, showed the following:

- The patio furniture was covered in a thick layer of dust and dead plant debris.

- Some patio chairs were missing their cushions.

- The patio ground was covered in dead plant debris.

- Many of the plants in flowerpots were dead.

Observation on 08/28/2026 at 3:05 PM, of Courtyard 2, showed the following:

- Overgrown grass.

- Weeds covering grass areas.

- Dirty and dusty benches covered with bird droppings.

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, Sycamore Glen at Quail Hollow 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-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with their negotiated service agreement;

(2) The assisted living facility must:

(a) Develop and maintain written job descriptions for the administrator and each staff position and provide each staff person with a copy of their job description before or upon the start of employment;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience, and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure they had staff available who were trained on updating the facility's electronic medication administration record for 1 of 1 staff (Staff T) who gave the wrong amount of medication to 1 of 1 resident (Resident 1); that the administrator had a clear job description for 1 of 1 administrator (Staff M); that staff had received required training and certification for 2 of 7 sampled staff (Staff C and G). These failures contributed to the wrong dose of medication being given to Resident 1, precluded the facility administrator from fully carrying out the duties and responsibilities of their position, and placed residents at risk of harm from receiving care from untrained staff.

Findings included…

Assisted Living Rules and Regulations updates were filed 7/15/26, effective 8/15/26. This Washington Administration Code had not been updated electronically in the departments system and is available on the Washington State Legislature Website.

388-78A-2450 Staff.

(5) The assisted living facility must:
(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:
(A) Training required by chapter 388-112A WAC;
(C) Home care aide certification as required by this chapter and chapter 246-980 WAC;

<Medication management>

Review of Resident 1's Negotiated Care Plan (the facilities titled Negotiated Service

Agreement, NSA), dated 02/19/2026, showed the facility provided medication assistance to Resident 1. Further review showed the staff administering the resident's medications would follow the eight rights of medication administration (right resident, right medication, right dose, right route, right time, right documentation, right reason, and right response).

Review of an incident investigation for Resident 1, dated 08/31/2026, showed that Staff T, Registered Nurse, made a medication error that involved Resident 1 that day.

In an interview on 09/03/2026 at 11:00 AM, Staff T stated that they realized they had made a medication error after they notified the pharmacy that they needed a refill for Resident 1’s medication and the pharmacy told them they should have enough. Staff T stated that the order in the electronic medication administration record was confusing, so they accidentally gave Resident 1 three tablets of a sedating medication instead of one. Staff T stated that they recognized there were other unclear orders in the residents’ electronic medication administration records. Staff T stated they were unsure how to correct Resident 1’s medication order in the system. Staff T stated they were the only nurse currently working for the facility.

In an interview on 10/08/2026, Staff T stated their job description was not written down for them. Staff T stated when they started working at the facility, there were a lot of gaps and there was not a lot of time to decide what their duties were.

Review of a training record for Staff T showed that they did not received training on the electronic medication administration record until 10/09/2026.

<Administrator responsibilities>

In an interview on 08/21/2026 at 10:40 AM, Staff M, Administrator, was asked for a copy of an incident report for a resident that sustained an injury after a fall. Staff M stated they did not know where the investigation was located. Staff M was then asked about investigations related to an injury of unknown origin and a resident-to-resident assault. Staff M stated they did not know if the investigations were completed or documented. The department regulator then requested a list of employees that no longer worked at the facility. Staff M stated that they did not know how to access that list. The department regulator asked Staff M what they oversaw at the facility, Staff M stated that they mainly handled new admissions paperwork and interviewed and hired new employees.

In an interview on 08/21/2026 at 12:24 PM, Staff A, Executive Director, stated that they oversaw the day-to-day operations at the facility.

In an interview on 08/21/2026 at 3:20 PM, Staff T stated that Staff M did not know a lot

about resident behavioral issues.

Review of email sent to the department regulator on 08/24/2026 at 4:14 PM, showed Staff A wrote that they did not have a job description for the administrator role at the facility.

In an interview on 08/28/2026 at 12:15 PM, Staff A stated that the facility leadership needed to be trained. Staff A stated that they needed to work with Staff M the most.

In an interview on 10/08/2026 at 3:37 PM, Staff M stated that they did not know what all of the administrator duties were. Staff M asked the department regulator where they could find administrator responsibilities.

<Unqualified staff>

Resident 1

Review of Resident 1's NSA, dated 08/13/2026, showed the resident required two staff to supervise them 24 hours a day.

Observation on 08/11/2026 at 12:03 AM (night shift), showed Staff C was asleep on Resident 1’s couch, during their 2:1 (two caregivers assigned to provide 24-hour supervision) assignment.

Review of Staff C’s, Caregiver, personnel file showed they were hired on 07/01/2026. Further review showed they did not complete the five-hour orientation and safety training until 08/12/2026.

Review of the staff schedule for August 2026 showed Staff C was scheduled as a caregiver on 08/03/2026, 08/04/2026, 08/05/2026, 08/06/2026, 08/07/2026, 08/10/2026, and 08/11/2026.

Resident 2

Review of Resident 2's NSA, dated 08/16/2026, showed the resident required two staff to supervise them 24 hours a day.

Observation on 08/10/2026 at 10:10 AM, showed Staff G was asleep on the floor in Resident 2’s room during their 2:1 assignment.

Review of Staff G's, Caregiver, personnel file showed they were hired on 05/27/2025, further review showed they did not have a Home Care Aide certification (HCA).

Review of the staff schedule for August 2026, showed Staff G was scheduled as a caregiver for 27 days during the month of August.

In an interview on 08/19/2026 at 10:00 AM, Staff A stated they were unsure which caregivers had completed their HCA certification or who had completed their five-hour orientation and safety training.

In an interview on 09/02/2026 at 11:19 AM, Staff U, Licensed Practical Nurse, stated that the training for staff was not adequate. Staff U stated that they discussed their concerns about the lack of training to management on multiple occasions.

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, Sycamore Glen at Quail Hollow 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-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report to the department bruises of unknown origin, allegations of abuse, financial exploitation, and resident to resident altercations for 4 of 15 residents (Resident 1, 2, 9, and 15). This failure precluded the department from having knowledge of such incidents to investigate and placed residents at risk of further harm.

Findings included…

In an interview on 08/07/2026 at 1:25 PM, Staff K, Caregiver, stated that Staff M, Administrator, told them that they do not call the state to report incidents, they handle everything in-house.

In an interview on 08/12/2026 at 1:20 PM, Staff N, Caregiver, stated that Staff M told staff not to report incidents to the state and that they would handle problems in-house instead.

In an interview on 08/21/2026 at 12:24 PM, Staff A, Executive Director, stated that they were recently informed by another state agency of allegations that Staff Q, Caregiver, may have sexually assaulted Resident 1.

<Allegations of abuse>

Resident 1

Review of a police report dated 08/13/2026, showed that the police responded to the facility after they received a state agency's report that Resident 1 may have been sexually assaulted. The report showed that the police spoke to Staff J, Behavioral Support Specialist, the day they responded.

Review of the Complaint Resolution Unit (CRU, state reporting system) database showed that the allegation of sexual abuse against Resident 1 was not reported by the facility.

Resident 2

<Bruises of unknown origin>

Review of the facility's December 2025 progress notes showed that Staff R, Director of

Nursing, wrote a note on 12/23/2025, documenting that Resident 2 had a black eye (right eye), but was unsure how it occurred Further review showed no documentation of any further assessment.

In an interview on 08/18/2026 at 1:45 PM, Collateral Contact 1 (CC1), Resident 2's Representative, stated that when they visited last Christmas (2025), Resident 2 had a black eye. CC1 stated that they took a photo of Resident 2 at that time. CC1 then forwarded the photo to the department regulator.

Observation of a photo provided by CC1 on 08/18/2026 at 2:46 PM, showed that Resident 2 had a large dark purple bruise under their right eye that went from one side of the eye to the other.

In an interview on 08/21/2026 at 10:45 AM, Staff J was asked if they recalled if Resident 2 had a black eye last winter. Staff J stated they did not. Staff J further stated that injuries of unknown origin would be reported and an investigation would be completed.

In review of the departments Complaint hotline database, the facility had not reported Resident 2's black eye.

<Restraints>

In an interview on 08/11/2026 at 1:32 PM, Staff N, Caregiver, stated that they heard Resident 2 calling out their name, and that upon entering the resident's room, they witnessed Staff O, Caregiver, lying on top of Resident 2 who was lying on their back on a couch with their arms pinned to their chest/stomach area. Staff N stated that they told Staff U, Licensed Practical Nurse, about the incident the following day, and Staff U told them they would look into it.

In an interview on 08/21/2026 at 12:24 PM, Staff A was asked if law enforcement had been notified of the allegations against Staff O, Staff A stated no and that and that they had not even thought to notify law enforcement.

In review of the departments Complaint hotline database, the facility had not reported that Resident 2 was pinned down physically by staff.

<Resident 9>

Review of a police report, dated 04/27/2026, showed that law enforcement contacted the facility about a report made by another state agency with concerns that Resident 9 had been financially exploited. The report showed that the officer discussed the

concerns with Staff J who told them that Resident 9 had a financial guardian who was appointed by the court. Further review showed that Staff J agreed to provide a bank record to the police department.

In an interview on 09/04/2026 at 11:30 AM, Staff A was asked about the report from police about Resident 9's financial exploitation. Staff A stated that it was a continuation of an investigation from last year. Staff A further stated that they assisted Resident 9 last year to obtain a financial guardian.

Review of a progress note, dated 04/22/2026, showed that Staff J wrote that the facility received a notification from another state agency that new debit card charges were discovered on Resident 9's account that did not belong to them and that the guardian had concerns that Resident 9 had been financially exploited again.

In review of the departments Complaint hotline database, the facility had not reported that there was an allegation Resident 9 may have been financially exploited a second time.

<Resident 15>

In an interview on 08/27/2026 at 12:38 PM, Resident 15 stated that Resident 4 hit them last week.

Review of a police report, dated 08/20/2026, showed that the police responded to a call after Resident 4 punched Resident 15.

Review of a progress note, dated 08/24/2026, showed another incident between Resident 4 and Resident 15. Staff BB, Care Coordinator, wrote that Resident 4 yelled in Resident 15's ear. The note showed that Resident 4 then pushed Resident 15 into the desk and pushed Resident 15 again in the hallway.

In an interview on 09/04/2026 at 12:28 PM, Staff BB was asked about the incident between Resident 4 and Resident 15. Staff BB stated that Resident 4 pushed Resident 15 multiple times on 08/24/2026 and they documented the incident in progress notes on the incident the same day.

Review of the CRU database showed one altercation was reported on 08/26/2026 and the facility noted that they were unsure what date the incident occurred on. Further review showed that the second altercation was not reported.

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, Sycamore Glen at Quail Hollow 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-2120 Monitoring residents' well-being. The assisted living facility must:

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to evaluate and take appropriate action for resident injuries sustained by 2 of 12 residents (Resident 1 and 2). These failures resulted in Resident 1 having bruises on their back and a fall that were not assessed or monitored and with Resident 2 having a black eye that was not assessed and monitored and placed the residents at risk of further harm.

Findings included…

<Resident 1>

Review of Resident 1's Negotiated Care Plan (the facility's titled Negotiated Service Agreement, NSA), dated 08/13/2026, showed the resident was diagnosed with [redacted] and [redacted]. The NSA showed the resident required extensive support. The care plan showed that Resident 1 required "2:1" staff (an assignment with two care givers assigned to directly supervise the resident) for 24-hour supervision to be provided.

Review of Resident 1's March 2026 progress notes showed a note on 03/02/2026 that documented that Resident 1 hit their head on a chair and had marks on their back. The progress notes showed a second note on 03/04/2026 that documented that Resident 1 had bruises on their back and coccyx (tailbone). Further review showed there were no

additional notes to indicate that an evaluation was conducted or that further monitoring had occurred.

Review of Resident 1's progress notes for April 2026, showed a note on 04/14/2026 that documented that Resident 1 slipped and fell while they got out of the shower. The note showed that Resident 1 had a mark on their tailbone and the nurse was notified. Further review of the notes showed there were no additional evaluations or monitoring completed.

In an interview on 08/28/2026 at 12:15 PM, Staff A, Executive Director, stated that progress notes should be reviewed by the nurse daily. Staff A further stated there was a gap in their process.

In an interview on 09/02/2026 at 11:19 AM, Staff U, Licensed Practical Nurse, stated that they were not notified that Resident 1 hit their head and had marks on their back in March 2026. Staff U further stated that they were not notified that Resident 1 fell in the shower in April 2026. Staff U stated that Staff R, Director of Nursing, may have been notified however they no longer worked there. Staff U stated that when an injury occurred, an assessment (evaluation) should have been done, an incident report completed, and the injury monitored.

In an interview on 09/04/2026 at 1:00 PM, Staff A confirmed that they did not have any additional information regarding Resident 1's bruises in March 2026 or fall in April 2026.

<Resident 2>

Review of Resident 2's NSA, dated 08/13/2026, showed the resident was diagnosed with [redacted] and [redacted], and

In an interview on 08/18/2026 at 1:45 PM, Collateral Contact 1 (CC1), Resident 2's Representative, stated that when they visited last Christmas (2025), Resident 2 had a black eye. CC1 stated that they took a photo of Resident 2 at that time. CC1 then forwarded the photo to the state regulator.

Observation of a photo that CC1 provided to the state regulator, showed Resident 2 had a large dark purple bruise under their right eye that went from one side of the eye to the other.

Review of Resident 2's December 2025 progress notes showed that on 12/23/2025, Staff R, Director of Nursing, documented that the resident had a black eye (right eye), but was unsure how it occurred. Further review showed no notes documenting that an evaluation had been conducted or that staff had monitored the residents' eye afterwards.

In an interview on 08/21/2026 at 10:45 AM, Staff M, Administrator, and Staff J, Behavioral Support Specialist, were asked if they recalled if Resident 2 had any injuries within the last year. Both Staff M and Staff J stated they did not.

Review of an email sent to the department, dated 08/24/2026 at 4:14 PM, showed that Staff A, Executive Director, confirmed that they did not have an investigation for Resident 2's black eye.

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, Sycamore Glen at Quail Hollow 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-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide a means for residents to summon staff in the new assisted living facility bedrooms for 2 of 2 residents (Resident 5 and 6) sampled in the new building. This failure resulted in the residents not having a way to call staff for help in the event of an emergency and placed them at risk of harm.

Findings included…

Observation on 08/10/2026 at 11:20 AM, showed Resident 5 in their room in the new wing of the assisted living facility. Observation showed the room did not have a call light installed. In an interview at that time, Resident 5 stated they would feel safer if they had a call light or pendant (device worn on the body to call for assistance) to call staff for help.

Observation on 08/10/2026 at 11:50 AM, showed Resident 6 used a walker for mobility throughout the facility and in their room. Resident 6 showed the department their room in the new wing of the assisted living facility. Observation showed the room did not have a call light. In an interview at that time, Resident 6 stated that they wanted a pendant in case they had to call staff for help.

In an interview on 08/10/2026 at 1:45 PM, Staff A, Executive Director, stated that they did not have call lights installed in the rooms of the new wing of the assisted living yet as they were on order. During this interview, Staff M, Administrator, said the call lights had been delivered but not yet installed.

In an interview on 08/21/2026 at 10:45 AM, Staff M confirmed that call lights were not installed in the new wing yet and that the residents did not have pendants.

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, Sycamore Glen at Quail Hollow 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-2420 Record retention.

(4) All active, inactive, and closed resident records must be available for review by department staff and other authorized persons.

This requirement was not met as evidenced by:

Based on interview and record review, the facility management failed to provide on-site department staff with the ability to access investigations upon request for 4 of 4 residents (Resident 1, 2, 10, and 11). This failure prevented the department and other

facility staff from having access to review investigations and placed residents at risk of harm.

Findings included…

In an interview on 08/21/2026 at 10:45 AM, the department asked Staff J, Behavioral Support Specialist, and Staff M, Administrator, for the investigation records for an incident that involved sexual abuse of Resident 10 against Resident 11, for allegations of abuse by staff against Resident 1 and Resident 2, and for a fall that Resident 12 had that resulted in a serious injury. Staff J and Staff M both stated that they did not have access to investigations because they were on Staff A's, Executive Director, computer who was not there that day.

In an interview by phone on 08/21/2026 at 12:24 PM, Staff A was asked how staff could access records that were on Staff A's computer. Staff A confirmed that staff did not have access to records on their computer and on-site staff were not able to provide the investigations that the department requested at that time.

Review of available resident records on 08/21/2026 at 12:25 PM, during the interview with Staff J and M, showed that they did not have access to investigations records for Resident 1, 2,10,11, and 12.

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, Sycamore Glen at Quail Hollow 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-2560 Administrator responsibilities. The licensee must ensure the administrator:

(1) Directs and supervises the overall twenty-four-hour-per-day operation of the assisted living facility;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that the

staff who carried the title of Administrator (Staff M) directed and supervised overall operations for 1 of 1 facilities (ALF Facility). This failure contributed to the lack of clarity of the role and responsibilities of the administrator and the repeated and uncorrected concerns of staff sleeping during their shift when residents required care, services and supervision.

Findings included…

<Administrators role>

Review of an email provided to department, dated 08/24/2026 at 4:14 PM, showed Staff A, Executive Director, wrote that they did not have a job description for the administrator role at the facility.

In an interview on 08/21/2026 at 10:45 AM, Staff M, Administrator, was asked what they oversaw at the facility. Staff M stated that they mainly handled new admissions paperwork and they interviewed and hired new employees.

In an interview on 08/21/2026 at 12:24 PM, Staff A stated that they oversaw the day-to-day operations at the facility. Staff A further stated that they were enrolled but had not completed the class that allowed them to be the administrator.

<Staff sleeping on night shift>

On 08/11/2026, the department regulator made the following observations:

-12:03 AM, Staff E, Caregiver, was sleeping on the floor inside of the door in Resident 1’s room. Staff C, Caregiver, was lying on the couch in Resident 1’s room. Staff E and C were not alert once they were woken up.

-12:05 AM, Staff F, Caregiver, was sleeping on the floor with a blanket in front of the inside of the door in Resident 2’s room after there were multiple attempts to know on the door since the door was locked. Staff D, HCA, was sleeping on the couch with a blanket. Staff F and Staff D were not alert or responsive.

In an interview on 08/11/2026 at 1:00 AM (night shift), Staff E confirmed that staff were not supposed to be asleep during their shift.

In an interview on 8/21/2026 at 3:00 PM, Resident 14 stated that staff slept on the floor inside their room and positioned themselves in the path of the doorway.

In an interview on 08/11/2026 at 3:02 PM, Staff M, was asked what safety plans were in place to ensure that staff were not sleeping during their shift. Staff M stated they were unsure and the department needed to speak with Staff A.

The department regulator received a written safety plan from Staff M via email on 08/12/2026. The safety plan (immediate, actionable response to identified concerns that have resulted in harm and placed residents risk for harm and a decreased quality of life) noted the following:

-“I [Staff A] am meeting with ownership [licensee] regarding hiring new leadership positions that would consist of a shift lead whose primary role would be monitoring staff assignments and ensuring all staff are awake and in the proper assignments. In the interim we will have current administrative and leadership staff scheduled to be in the [there] routinely every night to round on all staff and residents until the shift lead positions are filled and properly trained. I will be taking the first shift tonight. I plan to arrive onsite around 10pm. Tomorrow, 8/13/26, I will be meeting with all leadership/administrative staff and ha a schedule in place by end of business tomorrow.”

On 08/24/2026 at 2:00 PM, the department met via Microsoft Teams (video call) with Staff A, Executive Director, Staff M, Administrator, and Staff EE, Licensee, to discuss safety concerns found during an investigation. During this meeting the department informed all on the call, that the safety plan provided to the department previously, had not been implemented as evidenced by ongoing department observations and visits to the facility. At that time the facility was asked to provide a safety plan to the department for new and ongoing concerns by the end of business that day.

The department regulator received a written safety plan from Staff M via email on 08/24/2026. The safety plan noted the following:

-Leadership will make unannounced visits at different times during night shift to ensure staff are awake.

-Leadership directed to deny staff to work more than 16 hours consecutively.

-Medication Technician will make rounds for all 1:1 and 2:1 residents to ensure staff are awake.

On 09/11/2026 at 3:50 AM, the department regulator made the following observations:

- 3:50 AM, Staff FF were observed lying on the floor with their eyes closed in Resident 1's room. Staff GG was inside Resident 1's room, lying on the floor on the inside of the door. Staff GG was snoring when the department regulator entered the room.

In an interview with the facility licensee (Staff EE), Staff A, and Staff DD on 09/17/2026 at 11:41 AM, Staff EE stated they were at the facility frequently and routinely. Staff EE stated that they along with Staff HH were aware and involved with what was currently being investigated by the department. Staff EE stated they were aware that facility staff had been found to be sleeping on more than one occasion. Staff EE was asked about leadership staff checking on staff at night to ensure staff were not sleeping. Staff EE stated that an agency (contracted) medication technician was responsible for fulfilling this duty.

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, Sycamore Glen at Quail Hollow 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-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(o) Regarding the safe operation of any assisted living facility vehicles used to transport residents, and the qualifications of the drivers;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow their reporting policy when allegations of abuse, financial exploitation, and bruises of

unknown origin were discovered for 4 of 15 residents (Resident 1, 2, 9, and 15) and failed to develop a policy for facility vehicles transporting residents and communicating with non-English speaking residents for 2 of 2 policies (Transportation and Translation). These failures contributed to the department not receiving allegations of abuse by the facility, increased challenge for non-English speaking residents to communicate with staff and placed facility transported residents at a safety risk.

Findings included…

<Reporting and investigation policy>

Review of the facility policy, titled, “Incident Reporting and Investigation,” dated 11/2009, showed that the facility was to report and investigate pertinent incidents as required.

<Resident 2>

In an interview on 08/21/2026 at 12:24 PM, Staff A, Executive Director, stated that they were recently informed by another state agency of allegations that Staff Q, Caregiver, may have sexually assaulted Resident 1 and kicked Resident 2.

Review of the Complaint Resolution Unit (CRU, state reporting system) database showed that the allegations of sexual abuse against Resident 1 and the allegation that Resident 2 was kicked, were not reported by the facility.

In an interview on 08/18/2026 at 1:45 PM, Collateral Contact 1 (CC1), Resident 2’s Representative, stated that when they visited last Christmas (2025), Resident 2 had a black eye. CC1 stated that they took a photo of Resident 2 at that time. CC1 then forwarded the photo to the state regulator.

Observation of a photo provided by Collateral Contact 1, Resident 1’s representative, showed Resident 2 had a large dark purple bruise under their right eye that went from one side of the eye to the other.

Review of December 2025 progress notes showed that Staff R, Director of Nursing, wrote a note on 12/23/2025, that documented that Resident 2 had a black eye (right eye), but was unsure how it occurred.

Review of Resident 2’s facility file showed there was no investigation of their black eye.

Review of intakes reported to the state CRU database showed that Resident 2's black eye was not reported.

In an interview on 08/11/2026 at 1:32 PM, Staff N, Caregiver, stated that on 08/06/2026, they heard Resident 2 calling out their name from the resident's room. Staff N stated that upon entering Resident 2's room, they witnessed Staff O, Caregiver, lying on top of Resident 2 and pinning the resident's arms to their chest/stomach area. Staff N stated they heard Staff O speaking aggressively and in a raised voice to Resident 2.

Review of a group text sent by Staff A to facility staff on 08/07/2026 showed that Staff A provided staff with the following important reminder on that day:

"It is unacceptable and illegal to restrain or yell at a resident. Engaging in either may result in unpaid suspension pending an investigation, immediate termination, and/or a state investigation that may result in you losing your ability to work with vulnerable adults or children for the rest of your life."

Review of the CRU database showed that the allegation that Resident 2 was pinned down was not reported by the facility.

<Resident 9>

Review of a police report, dated 04/27/2026, showed that law enforcement contacted the facility with new reports of allegations that Resident 9 had recently been financially exploited.

Review of the CRU database showed that the allegations that Resident 9 had been financially exploited in April 2026 were not reported to the department by the facility.

<Resident 15>

Review of a police report, dated 08/20/2026, showed that the police responded to a call of an alleged altercation between Resident 4 and Resident 15.

Review of the CRU database showed that the allegation that Resident 4 hit Resident 15 were not reported to the department by the facility.

In an interview on 08/27/2026 at 1:03 PM, Staff A stated that they had sent all the investigations they had for Resident 4 (which did not include one for the altercation between Resident 4 and Resident 15). Staff A stated they realized they had dropped the

ball with some investigations.

<Transportation>

In an interview on 08/27/2026 at 10:45 AM, Staff M, Administrator, stated that the facility had a vehicle and there were staff that had been approved to transport residents.

Review of an investigation, dated 07/13/2026, showed that Resident 12 was transported to the hospital in a facility vehicle after they had a fall.

Review of an email sent to the department dated 08/24/2026, and sent by Staff A, showed that they confirmed the facility did not have a transportation policy.

<Translation>

Review of a Negotiated Service Agreement (NSA) for Resident 7, dated 09/02/2026, showed that the resident had dementia (a condition that causes a decline in memory, thinking, and reasoning severe enough to interfere with daily life) and they required extensive assistance with communication. The NSA showed that Resident 7's primary language was Spanish, they had disorganized speech, and they mumbled and spoke softly. Further review showed that they had paranoia and often refused their food and medications because they feared they were being poisoned.

In an interview on 08/12/2026 at 10:23 AM, Staff A stated that they had just two Spanish-speaking staff. Staff A stated that if a staff member was unable to clarify one of Resident 7's questions, they would use a translator. Staff A stated that staff were using an application called Duolingo to communicate with Resident 7 (when researched, was found to be a way to learn a language, not a translation service).

In an interview on 08/21/2026 at 2:23 PM, Staff V, Medication Technician, stated that they used [an online translation application] to communicate with Resident 7 as they (Staff V) did not speak Spanish. Staff V stated that they typed into the application what they wanted to say to Resident 7 then the application would verbalize it in Spanish. Staff V stated that the application would not listen to Resident 7 and translate the resident's statements into English. Staff A stated that there had been times when Resident 7 was trying to communicate something to them though they (Staff V) had been unable to understand what the resident was trying to say.

Review of an email sent to the department, dated 09/10/2026, and sent by Staff A, showed that the facility did not have a policy that addressed non-English speaking residents.

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, Sycamore Glen at Quail Hollow 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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident who required medication assistance received their medication as ordered for 1 of 2 residents (Resident 5). This failed practice resulted in increased pain and discomfort and a decreased quality of life for Resident 5.

Findings included…

Review of Resident 5's Negotiated Care Plan (the facility's titled Negotiated Service Agreement, NSA), dated 07/14/2026, showed that the resident required assistance with medication management. Review of the NSA showed that Resident 5 had a history of headaches.

In an interview on 08/25/2026 at 9:12 AM, Resident 5 stated that they missed multiple doses of their topiramate (a medication used to treat migraine headaches) during the first week they were at the facility.

Review of a physician order sheet for Resident 5, dated 08/24/2026, showed that the resident had an order for topiramate to be taken by mouth three times daily in the morning, at noon, and at bedtime. The order sheet showed that the topiramate order was started on 07/14/2026.

Review of a Medication Administration Record (MAR) for Resident 5, dated July 2026, showed that the resident was supposed to receive topiramate by mouth three times daily. Further review of the MAR showed the following:

-On 07/14/2026, Resident 5 did not receive their midday dose of topiramate.

-On 07/16/2026, Resident 5 did not receive their morning dose of topiramate.

-On 07/17/2026 and 07/18/2026, Resident 5 did not receive their morning doses of topiramate, though they received doses at midday and doses at 7:00 PM and 8:00 PM on both days.

-On 07/19/2026 through 07/23/2026, Resident 5 did not receive their morning doses of topiramate.

-On 07/24/2026 and 07/25/2026, Resident 5 did not receive their morning doses of topiramate, though they received doses at midday and doses at 7:00 PM and 8:00 PM on both days.

-On 07/26/2026, Resident 5 did not receive their morning dose of topiramate.

In an interview on 09/02/2026 at 11:01 AM, Staff U, Licensed Practical Nurse, stated that Resident 5’s medication orders had been hard to follow, and they were not sure why the resident’s topiramate had not been given as ordered.

In an interview on 09/03/2026 at 12:19 pm, Resident 5 stated that they had migraines and were miserable every day that they had not received three doses of topiramate.

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, Sycamore Glen at Quail Hollow 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-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(2) Necessary and contraindicated medications;

(6) Level of personal care needs;

(7) Activities and service preferences; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to include required information in the resident's preadmission assessment and in a manner that could be read by others, for 1 of 1 resident (Resident 7). This failed practice placed the resident at risk for inadequate care, unmet needs, and decreased quality of life.

Findings included...

Review of hospital progress notes for Resident 7, dated 07/09/2026, showed that a representative from the assisted living facility would be there the following day to interview the patient and to determine if they were an appropriate candidate for the facility.

Review of an initial assessment/care plan for Resident 7, dated 07/10/2026, showed the following:

-It failed to identify necessary or contraindicated medications for the resident.

-It identified that the resident required assistance with medication management, though

under the section “resident strengths/what resident prefers to do independently,” was illegible handwriting.

-It identified that the resident required assistance with mobility, though next to the section “level of care required,” was illegible handwriting. The section “resident strengths/what resident prefers to do independently,” was blank.

-It identified that the resident required assistance with bed mobility and transfers, though next to the section “level of care required,” was illegible handwriting. The section “resident strengths/what resident prefers to do independently,” was blank.

-It identified that the resident required assistance with dietary intake, though it did not identify what level of assistance was required. Under the section “resident strengths/what resident prefers to do independently,” was illegible handwriting.

-It identified that the resident required assistance with dressing though it did not identify what level of assistance was required. Under the section “resident strengths/what resident prefers to do independently,” was illegible handwriting.

-It identified that the resident required assistance with toileting, though next to the section “level of care required,” was illegible handwriting.

-It identified that the resident required assistance with personal hygiene though it did not identify.

what level of assistance was required. The section “resident strengths/what resident prefers to do independently,” was blank.

-It identified that the resident required assistance with bathing though it did not identify what level of assistance was required. The section “resident strengths/what resident prefers to do independently,” was blank.

-It identified that the resident required assistance with body care (foot, skin, nail) though it did not identify what level of assistance was required. Under the section “resident strengths/what resident prefers to do independently,” was illegible handwriting.

-The activities section of the initial assessment was blank, and it failed to identify anything about the resident’s choice in activities or preferences.

In an interview on 08/26/2026 at 12:15 PM, Staff A, Executive Director, stated that they had completed Resident 7's preadmission assessment. Staff A stated that the preadmission assessment, dated 07/10/2026, was the only information accessible for staff to use as a care guide for the first few days after the resident admitted.

In an interview on 08/27/2026 at 11:36 AM, and when asked to read the handwritten portions of Resident 7's initial assessment/care plan, Staff T, Registered Nurse, stated that it was very hard to read and that they could not read parts of it.

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, Sycamore Glen at Quail Hollow 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-2320 Intermittent nursing services systems.

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a system that ensured safe nurse delegated insulin administration for 1 of 1 resident (Resident 7). This failed practice placed Resident 7 at risk for unmet diabetic care and management and a decreased quality of life.

Findings included…

Per WAC 246-840-930 Criteria for delegation, before delegating a nursing task, a nurse delegator shall decide if a task is appropriate to delegate based on the following:

(3) Assess the patient's nursing care needs and determine whether the patient's

condition is stable and predictable.

(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.

(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least every two weeks for the first four weeks.

Review of a Negotiated Service Agreement (NSA) for Resident 7, dated 08/14/2026, showed that the resident had type II diabetes (a chronic condition where sugar builds up in the blood because the body cannot use insulin properly or make enough of it). The NSA showed that Resident 7 had a long-term history of insulin (injected medication used to lower sugar in the blood) use and history of past noncompliance. The NSA showed that Resident 7 required assistance with medication administration, including injections (nurse delegated task). Review of the NSA showed that Resident 7 had a strong belief that they were being poisoned by their medications and they frequently refused them. Further review of the NSA showed that Resident 7's primary language was Spanish.

Review of a Medication Administration Record (MAR) for Resident 7, dated August 2025, showed that the resident admitted to the facility on [redacted]/2026. Review of the MAR showed that Resident 7 refused their insulin seven times during their first 22 days of admission to the facility. Further review of the MAR showed that there were no orders for monitoring Resident 7's blood sugars.

<Stable and predictable>

Review of a hospital progress note for Resident 7, dated [redacted]2026, showed that the resident's A1C (a blood test that measures a person's average blood sugar level over the previous two to three months) was elevated at 7.7 (a normal A1C level is below 5.7) The progress notes showed that the elevated A1C was likely due to multiple refused insulin doses.

In an interview on 08/27/2026 at 1:52 PM, Staff U, Licensed Practical Nurse, stated that the facility was warned by the hospital that Resident 7 refused their medications at times.

In an interview on 09/02/2026 at 3:02 PM, Staff T, Registered Nurse, stated that Resident 7 intermittently refused their insulin. When asked if they felt that a resident who frequently refused their insulin would be considered stable and predictable, Staff T stated that it would depend on their baseline and if their blood sugars were stable. When asked if Resident 7's blood sugars had been stable at the hospital prior to being admitted to the facility, Staff T stated that they did not think they had record of that.

Staff T stated they did not know what Resident 7's A1C was.

<Language consideration>

In an interview on 08/12/2026 at 10:23 AM, Staff A, Executive Director, stated that Resident 7 feared they were being poisoned during medication administration. Staff A stated there were just two Spanish-speaking staff working at the facility.

In an interview on 08/21/2026 at 10:48 AM, Staff J, Behavioral Support Specialist, stated that they were planning to discuss the use of a translator service with Resident 7's guardian the following week. Staff J stated that Resident 7 could speak some English though it was a "hit or miss." Staff J stated that an interpreter was used for Resident 7's care plan.

In an interview on 08/21/2026 at 2:23 PM, Staff V, Medication Technician, stated that they used an online translation service to communicate with Resident 7 because they (Staff V) did not speak Spanish. Staff V stated there had been times when Resident 7 was trying to communicate something with them though they were unable to understand what the resident was trying to say. Staff V stated that the online translation service was ineffective for translating what Resident 7 said into English. Staff V stated that Resident 7 was more accepting of their medications when they could communicate with staff. Staff V stated that Resident 7 had refused their medications from them about three times.

On 08/21/2026 at 2:39 PM, a department employee attempted to communicate with Resident 7 via a telephonic translation service arranged by the department. The translator was unable to hear Resident 7 due to their low volume of speaking, so the resident could not be interviewed.

In an interview on 08/25/2026 at 9:57 AM, Collateral Contact 4 (CC4), Resident Representative, stated that it was really hard to use [an online translation service] with Resident 7 because the resident mumbled. CC4 stated that Resident 7 had delusions that made them think staff were trying to poison them.

In an interview on 08/27/2026 at 11:51 AM, Staff W, Medication Technician, stated that Resident 7 refused their medication that morning because they thought Staff W was trying to poison them.

<Supervise and evaluate>

In an interview on 09/02/2026 at 3:02 PM, when asked how often a nurse delegator was supposed to supervise a delegated staff who administered a resident's insulin, Staff T

stated, “every 90 days.” When told that it was required every two weeks for four weeks, Staff T stated that they had supervised the delegated staff more frequently than the required 90 days though they had not documented it.

Review of Resident 7’s nurse delegation records showed no documentation that supervisory visits occurred.

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, Sycamore Glen at Quail Hollow 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-2371 Investigations. The assisted living facility must:

(2) Determine the circumstances of the event;

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to determine the circumstances on incidents for 6 of 6 residents (Resident 1, 2, 4, 10, 11, and 15) and failed to protect resident during an investigation of allegations for 2 of 2 residents (Resident 1 and 2) regarding alleged abuse by 2 of 2 staff (Staff O and Q). These failures resulted in allegations of staff to resident abuse and resident to resident altercations not being investigated to determine the circumstances of the allegations, residents not being protected during investigations, and placed the residents at risk for further abuse by staff and fellow residents.

Findings included...

<Determine the circumstances of the event: Staff O and Resident 2>

In an interview on 08/11/2026 at 1:32 PM, Staff N, Caregiver, stated that on 08/06/2026, they heard Resident 2 calling out their name from the resident’s room. Staff N stated that upon entering Resident 2’s room, they witnessed Staff O, Caregiver, lying on top of

Resident 2, pinning the resident's arms to their chest/stomach area.

In an interview on 08/12/2026 at 10:23 AM, Staff A, Executive Director, stated that they heard about an incident the Thursday or Friday prior in which a staff member may have been in Resident 2's face and may have been yelling. Staff A stated that the staff member involved was Staff O. Staff A stated that they had not been able to speak with anyone that witnessed the incident. Staff A stated they had not been able to interface with Staff P, Caregiver, the staff who had been working with Staff O at the time of the incident. Staff A stated that they were going to investigate the incident, but they had not done that yet because what was described to them could have been a normal interaction with Resident 2.

In an interview on 08/27/2026 at 2:26 PM, Staff A stated that all the investigations they had done, had been sent to the department. Staff A acknowledged that some of the investigations that had been requested by the department were missing.

Facility provided investigations were reviewed and no investigation determining the circumstances of events was found related to the alleged abuse of Resident 2 by Staff O. There was no documentation provided that the residents were protected during the investigation.

<Determine the circumstances of the event: Staff Q and Resident 1>

In an interview on 08/21/2026 at 12:24 PM, Staff A stated that they had been informed by another state agency of an allegation that Staff Q, Caregiver, may have sexually assaulted Resident 1. The department asked Staff A if the facility had completed an internal investigation into the allegations against Staff Q. Staff A stated that they had started the investigation, but they were unable to provide names of who they spoke to. Staff A then stated they were unsure where to start with the investigation. When the department requested a copy of the investigation thus far; the facility was unable to provide it. There was no documentation provided that the residents were protected during the investigation.

<Determine the circumstances of the event: Staff Q and Resident 2>

In an interview on 08/21/2026 at 12:24 PM, Staff A stated that they had been informed by another state agency of an allegation that Staff Q, Caregiver, may have kicked Resident 2. The department asked Staff A if the facility had completed an internal investigation into the allegation against Staff Q. Staff A stated that they had started the investigation, but they were unable to provide names of who they spoke to. When the department requested a copy of the investigation thus far; the facility was unable to provide it. There was no documentation provided that the residents were protected during the investigation.

<Determine the circumstances of the event: Resident 10 and Resident 11>

Review of an undated facility investigation, with incident date documented as 08/11/2026, showed that a staff member reported that they witnessed Resident 10 fondle Resident 11's breast. Review of the investigation showed that the staff documenting the investigation, Staff J, Behavioral Support Specialist, was unable to make a determination about what happened. Review of the investigation showed that no witness interviews were documented. There was no documentation provided that the residents were protected during the investigation.

<Determine the circumstances of the event: Resident 4 and Resident 15>

Review of a police report, dated 08/20/2026, showed that the police responded to a call after Resident 4 punched Resident 15.

Review of a progress note, dated 08/24/2026, showed another incident between Resident 4 and Resident 15. Staff BB, Care Coordinator, wrote that Resident 4 yelled in Resident 15's ear and then pushed Resident 15 into the desk. Resident 4 then pushed Resident 15 in the hallway.

In an interview on 09/04/2026 at 12:28 PM, Staff BB was asked about the incident between Resident 4 and Resident 15. Staff BB stated that Resident 4 pushed Resident 15 multiple times on 08/24/2026 and they documented the incident in progress notes the same day.

Review of Resident 4 and Resident 15's facility file, showed no record of an investigation into the altercation between the two residents on 08/20/2026.

Review of an undated facility investigation, with incident date documented as 08/25/2026, and written by Staff J showed that Staff M, Administrator, had interviewed staff in relation to an incident between Resident 4 and Resident 15. Review of the investigation showed that Staff J documented that it had been difficult to assess the actual "occurrence of the event," because Resident 4 had autism (a condition that affects how a person communicates, interacts with others, and experiences the world). Staff J documented that the incident occurred at an unknown time and unknown location. There was no documentation in the investigation to show that either one of the residents had been asked why the altercation occurred. There was no documentation provided that the residents were protected during the investigation.

In an interview on 08/27/2026 at 12:44 PM, and when asked if they had interviewed any staff in relation to the incident between Resident 4 and Resident 5 on 08/24/2026, Staff M stated they had not. Staff M stated they had been unsure what time of the day the

incident had occurred. Staff M was unsure what day the incident occurred. Staff M stated they had been unsure which staff had been working at the time of the incident.

<Determine the circumstances of the event: Resident 2 black eye>

Review of Resident 2's progress notes for December 2025 showed that Staff R, Director of Nursing, documented on 12/23/2026 that the resident, "has a black eye (right eye), but unsure how this occurred."

Review of Resident 2's facility file showed it did not contain an investigation to determine the circumstances of or evaluate the effects of their black eye. There was no documentation provided that the residents were protected during the investigation.

<Determine the circumstances of the event: Resident 1 arm bruises>

Review of an incident report for Resident 1, dated 08/25/2026, showed that the resident was found to have had two small bruises on their upper, inner right arm. The incident report showed that origin of the bruises was unknown. There was no documentation to show that staff interviews had occurred.

Review of facility provided investigations showed no investigation for Resident 1's bruises from 08/25/2026. There was no documentation provided that the residents were protected during the investigation.

<Resident protection during investigation, Staff O>

In an interview on 08/10/2026 at 10:35 AM, Staff J was asked if any staff had recently gone hands on (inappropriate intervention in which staff place their hands on a resident to restrain them), Staff J said they had been notified late last week that Staff O, Caregiver, needed to be counseled because there had been an incident between Staff O and Resident 2. The department asked what the details of the incident were, Staff J stated they were unsure, they were just told to talk to Staff O about caregiver burn out and what to do when staff became frustrated with a resident.

In an interview on 08/11/2026 at 1:32 PM, Staff N stated that on 08/06/2026, they heard Resident 2 calling Staff N's name from the resident's room. Staff N stated that upon entering Resident 2's room, they witnessed Staff O lying on top of Resident 2 who was lying on their back on a couch with their arms pinned to their chest/stomach area. Staff N stated that Staff O was speaking aggressively and in a raised voice to Resident 2.

In an interview on 08/12/2026 at 10:23 AM, Staff A stated that they heard about an

incident the week prior in which a staff member may have been in Resident 2's face and they may have been yelling. Staff A stated that they pulled the staff member, Staff O, from working with Resident 2 and immediately moved Staff O to the memory care.

Review of the August 2026 staff schedule provided to the department on 08/12/2026, showed that Staff O was assigned as a caregiver for Resident 2 on 08/07/2026, and was assigned in the memory care unit on 08/10/2026 and 08/12/2026. There was no documentation provided that the residents were protected during the investigation.

<Resident protection during investigation, Staff Q>

In an interview on 08/21/2026 at 12:24 PM, Staff A stated that they had been informed by [redacted] of allegations that Staff Q may have sexually assaulted Resident 1 and kicked Resident 2. The department asked Staff A if the facility had completed an internal investigation into the allegations against Staff Q. Staff A stated that they started investigations, but they were unable to provide names of who they spoke to. When asked if Staff Q had been removed from the schedule, Staff A stated they were not. The department asked Staff A when [redacted] informed them of the allegations, Staff A said, "it's been more than days." Staff A stated that Staff Q was still on the schedule because [redacted] had determined everything was okay. Staff A stated they were unsure if Staff Q was still working with Resident 1 and Resident 2.

Review of an email that Staff A sent to the department on 08/12/2026 at 5:24 PM, showed that Staff A referenced "2 [redacted] investigators here today."

Review of the August 2026 staff schedule provided in the above referenced email on 09/01/2026, showed that Staff Q was scheduled every day in August except for 08/10/2026, 08/17/2026, 08/24/2026, and 08/31/2026. There was no documentation provided that the residents were protected during the investigation.

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, Sycamore Glen at Quail Hollow 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-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify a health care provider of a resident's frequent medication refusals and failed to evaluate the significance of the resident not getting their medication for 1 of 1 resident (Resident 7). This failed practice resulted in the resident not being assessed by a health care provider for signs and symptoms of missed diabetes medication and placed them at increased risk for adverse health effects.

Findings included…

Review of a facility policy, titled, "Medication Management Procedure," last revised in December 2025, showed that consistent medication refusals should be evaluated, and the prescriber should be notified.

Review of a hospital progress note for Resident 7, dated 07/09/2026, showed that prior to the resident's admission to the assisted living facility, they were admitted to a hospital for nearly ten months. Review of the progress note showed that Resident 7 had Parkinson's Disease (a progressive brain disorder that causes problems with movement, balance, and other body functions) as well as psychiatric behavioral issues that included delusions (a firm, fixed, and false belief that a person holds onto despite clear evidence or rational proof that contradicts it), visual and auditory hallucinations (a false sensory perception that happens without any actual external stimulus), paranoia (an intense, irrational state of mind where a person firmly believes that others are trying to harm, deceive, or exploit them), and episodes of severe anxiety with agitation. The progress note showed that Resident 7's care was complicated by their frequent refusal of medications. Further review of the progress note showed that a representative from the assisted living facility would be at the hospital the following day to interview Resident 7 and to determine if they were an appropriate candidate for the facility.

Review of Resident 7's initial facility assessment and care plan, dated 07/10/2026, showed that the resident required assistance with medication management.

Review of a Negotiated Service Agreement (NSA) for Resident 7, dated 08/14/2026,

showed that the resident admitted to the assisted living facility on [redacted]/2026. Review of the NSA showed that Resident 7 had diagnoses including [redacted] and [redacted]. Review of the NSA showed that Resident 7 required assistance with medication management. Further review of the NSA showed that staff were to notify the facility nurse when medications were refused.

Review of a Medication Administration Record (MAR) for Resident 7, dated August 2026, showed the following:

-Resident 7 refused their insulin glargine (a long-acting prescription insulin used to control blood sugar levels in people with diabetes) seven times between their date of admission and 08/25/2026.

-Resident 7 refused their memantine (a prescription medication used to treat moderate to severe dementia) seven times between their date of admission and 08/26/2026.

-Resident 7 refused their quetiapine (an antipsychotic medication) 18 times between their date of admission and 08/26/2026.

-Resident 7 refused their carbidopa/levodopa (a prescription medication used to treat the motor symptoms of Parkinson's Disease) 39 times between their admission date and 08/26/2026.

-There was no documentation on the MAR to show that a health care provider was notified of the resident's medication refusals.

Review of a progress note for Resident 7, dated 08/09/2026 at 2:30 PM, showed that the resident refused every one of their medications from 7:00 AM to 3:00 PM that day because they were afraid of being poisoned. There was no documentation to show that a physician or nurse was notified of Resident 7's medication refusals.

Review of a progress note for Resident 7, dated 08/10/2026 at 6:00 AM, showed that the resident continued to refuse their medications throughout the evening prior and 2:00 AM that day. There was no documentation to show that a physician or nurse was notified of Resident 7's medication refusals.

Review of a progress note for Resident 7, dated 08/11/2026 at 9:00 PM, showed that the resident refused their medications multiple times. Further review of the progress note showed there was no documentation to show that the physician or nurse was notified of

Resident 7's medication refusals.

In an interview on 08/27/2026 at 11:51 AM, when asked what staff were supposed to do when a resident refused their medication, Staff W, Medication Technician, stated that they were supposed to attempt three times and if the resident still refused, then staff were supposed to notify the nurse. Staff W stated that they were supposed to document the refusal. When asked if anything else was supposed to be done, Staff W, stated, "no."

In an interview on 08/27/2026 at 1:52 PM, Staff U, Licensed Practical Nurse, stated that when a resident refused their medications, staff were to reapproach or try another staff member. Staff U stated that staff were supposed to mark the medication as refused and after three refusals, the physician should be notified. Staff U stated they were unsure if staff had been educated on the refusal process. Staff U stated that they usually tried to be the one to notify the physician of medication refusals. When asked how many times staff had notified them that Resident 7 had refused their medications, Staff U said, "about twice." Staff U stated that Resident 7 just needed to get some trust. Staff U stated that the facility was warned about Resident 7's medication refusals by the hospital where the resident came from.

Review of a physician after-visit summary for Resident 7, dated 08/26/2026, showed that a physician was made aware of the resident's non-compliance with their medication, approximately three weeks after their admission to the facility and after 71 missed doses of medication.

In an interview on 09/01/2026 at 9:04 AM, Staff U was asked if either they (Staff U) or Staff T, Registered Nurse, had evaluated the significance of Resident 7's medication non-compliance, Staff U stated that Staff T had not worked at the facility at that time and that they (Staff U) had not been, "assigned in nursing school to evaluate or assess."

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, Sycamore Glen at Quail Hollow 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-2730 Licensee's responsibilities.

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

(a) The operation of the assisted living facility;

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

(c) The care and services provided to the assisted living facility residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the licensees (Staff EE, Staff HH and Staff II) failed to maintain operations, ensure cares and services were implemented, records were accessible, reporting suspected/alleged abuse was investigated and reported to the department, policies and procedures were developed and implemented, staff sleeping during shift was addressed, and that the environment was maintained in a safe manner, for 1 of 1 facilities (ALF Facility) impacting 9 of 9 residents (Resident 1, 2, 4, 9, 10, 11, 12, 14 and 15). These failures resulted in immediate health and safety risks for residents, decreased quality of life and placed residents at risk for harm.

Findings included…

Review of the state database showed that the facility had three licensees (owners). The database showed that Staff EE, Licensee, Staff HH, Licensee, and Staff II, Licensee, were listed as licensees, and they shared equal ownership of the facility.

On 08/11/2026 at 12:03 AM, 12:05 AM and 09/11/2026 at 3:50 AM, observations of Staff E, Staff C, Staff FF, Staff GG, Staff D, Staff F showed staff sleeping, unresponsive, or not alert while scheduled to provide 24-hour supervision to Residents 1, 2 and 14. Residents 1, 2, and 14 were observed in their rooms during observations of staff sleeping, being unresponsive and not alert.

Observation of Resident 1’s room at 9:29 AM, showed missing outlet cover plate and exposed wiring, broken and missing furniture, strong smell of urine.

On 08/10/2026 at 1:45 PM, Staff A, Executive Director, acknowledged the exposed wiring and stated that they had determined not to fix it.

On 08/11/2026 at 1:00 AM, Staff C, Caregiver, stated they sat on chuck pads (an absorbent pad used as a protective barrier) in Resident 1’s room because they did not want to sit directly on the couch due to Resident 1 urinates on the couch. Staff C stated that the fabric couch is not made of cleanable material.

Review of an email sent to the department by Staff A, on 08/12/2026 at 5:24 PM, showed the following safety plan (immediate, actionable response to identified concerns that have resulted in harm and placed residents risk for harm and a decreased quality of life) that was provided to the department upon request due to sleeping staff observed by a department licensor on 08/11/2026:

-Regarding sleeping staff- “I am [Staff A] meeting with ownership [licensee] regarding hiring new leadership positions that would consist of a shift lead whose primary role would be monitoring staff assignments and ensuring all staff are awake and in the proper assignments. In the interim we will have current administrative and leadership staff scheduled to be in the [there] routinely every night to round on all staff and residents until the shift lead positions are filled and properly trained. I [Staff A] will be taking the first shift tonight. I [Staff A] plan to arrive onsite around 10pm. Tomorrow, 8/13/26, I [Staff A] will be meeting with all leadership/administrative staff and ha a schedule in place by end of business tomorrow."

-Regarding [Resident 1’s] environment: “I [Staff A] am currently researching other enzyme cleaners that target urine and are safe for human skin due to the frequency that [Resident 1’s] room requires cleaning due to urination we want a product that is not going to irritate [Resident 1’s] skin as [Resident 1] often likes to sit or kneel on the ground. We are looking for a distributer for weighted non-porous furniture, like what we discussed on the phone today. We will be ordering at least a couch and possibly a chair in this material. Once I [Staff A] have the order details and delivery options I will forward them to you [department regulator].”

<Access to Records>

In an interview on 08/21/2026 at 10:45 AM, the department asked Staff J, Behavioral Support Specialist, and Staff M, Administrator, for the investigation records for an incident that involved sexual abuse of Resident 10 against Resident 11, for allegations of abuse by staff against Resident 1 and Resident 2, and for a fall that Resident 12 had that resulted in a serious injury. Staff J and Staff M both stated that they did not have access to investigations because they were on Staff A’s, Executive Director, computer who was not there that day.

In an interview by phone on 08/21/2026 at 12:24 PM, Staff A was asked how staff could access records that were on Staff A’s computer. Staff A confirmed that staff did not have access to records on their computer and on-site staff were not able to provide the investigations that the department requested at that time.

Review of available resident records on 08/21/2026 at 12:25 PM, during the interview with Staff J and M, showed that they did not have access to investigations records for Resident 1, 2,10,11, and 12.

<Reporting / Policies and procedures>

<Resident 4>

Review of Resident 4's NSA, dated 08/24/2026, showed the resident was diagnosed with [redacted] and [redacted]. The NSA showed the following resident behaviors: Assaultive, loud, throws items, wanders, caused disruptions, rapid mood swings, and aggressive.
Review of local law enforcement reports for 2026 showed law enforcement was contacted because of Resident 4's assaultive behavior on the following dates:

- 02/21/2026, sat on another resident and punched them multiple times.

- 02/23/2026, attacked staff members and placed one in a headlock.

- 02/25/2026, pulled another residents' hair and placed staff in a headlock.

- 02/27/2026, tried to pull a hoody off another resident and hit them in their head.

- 08/20/2026, struck another resident.

Review of Resident 4's facility file from January 2026 to August 2026, showed the resident had multiple impulsive behaviors that included aggression towards staff and other residents. The file showed Resident 4's aggressive behaviors were frequent and consistent throughout this time period and intermittently required law enforcement intervention for everyone's safety.

Review of a police report, dated 08/20/2026, showed that the police responded to a call after Resident 4 punched Resident 15.

Review of a progress notes, dated 08/24/2026, showed Resident 4 yelled at and physically pushed Resident 15 two times. The facility records showed no documentation of an full investigation between Resident 4 and 15 at that time.

In an interview on 08/27/2026 at 12:50 PM, Staff Z, Caregiver, was asked if they had been instructed to monitor Resident 4. Staff Z stated that staff were not specifically assigned to monitor Resident 4 except at mealtimes. Staff Z further stated that Resident 4 had been food aggressive, so they were instructed to redirect them back to

their room during meals.

In an interview on 09/17/2026 at 11:41 AM, Staff EE was asked if they were aware of Resident 4's assaults and aggressive behavior. Staff EE stated, "I know when police are called. I am assuming I know the reason for the call." Staff EE was asked why Resident 4 had not been on one-on-one monitoring and supervision prior to the initiation of the investigation. Staff EE stated that the facility was not paid by the state to provide that kind of supervision for Resident 4. Near the end of the interview, Staff EE stated, "We need to find [Resident 4] a new home."

Review of a police report, dated 08/20/2026, showed that the police responded to a call of an alleged altercation between Resident 4 and Resident 15.

Review of the CRU database showed that the allegation that Resident 4 hit Resident 15 were not reported to the department by the facility.

<Resident 1 and 2>

In an interview on 08/21/2026 at 12:24 PM, Staff A, Executive Director, stated that they were recently informed by another state agency of allegations that Staff Q, Caregiver, may have sexually assaulted Resident 1 and kicked Resident 2.

Review of the Complaint Resolution Unit (CRU, state reporting database) database showed that the allegations of sexual abuse against Resident 1 and the allegation that Resident 2 was kicked, were not reported by the facility.

<Resident 9>

Review of a police report, dated 04/27/2026, showed that law enforcement contacted the facility with new reports of allegations that Resident 9 had recently been financially exploited.

Review of the CRU database showed that the allegations that Resident 9 had been financially exploited in April 2026 were not reported to the department by the facility.

In an interview on 08/27/2026 at 1:03 PM, Staff A stated that they had sent all the investigations they had for Resident 4 (which did not include one for the altercation between Resident 4 and Resident 15). Staff A stated they realized they had dropped the ball with some investigations.

On 08/24/2026 at 2:00 PM, the department met via Microsoft Teams (video call) with Staff A, Executive Director, Staff M, Administrator, and Staff EE, Licensee, to discuss safety concerns found during an investigation. During this meeting the department informed all on the call, that the safety plan provided to the department previously, had not been implemented as evidenced by ongoing department observations and visits to the facility. At that time the facility was asked to provide an additional safety plan to the department for new and ongoing concerns by the end of business that day.

Review of an email sent to the department by Staff A on 08/24/2026 showed the following safety plan response from the facility:

-Staff sleeping on shift when assigned as one staff member to one resident or two staff members to one resident. Residents [1, 2, and 14].

- A designated member from leadership will make surprise visits during night shift who will check on staff. A medication technician will check on staff assigned on one to one and two to one assignments to ensure staff are awake. Working with owner to add a management role who will be scheduled to work on nights.

- Resident 4 will be monitored by staff when in common spaces.

- Ordering new weighted non-porous furniture for the resident [Resident 1]. Have a large vinyl wall/ceiling cling that will be installed.

- We hired a contractor to work on [Resident 1's] room. We are working with ownership on a plan for maintenance person that can be onsite more frequently.

-We replaced items that were reported damaged in [Resident 2's] room.

<Staff sleeping>

The following observations were made by the department after receiving two facility safety plans regarding sleeping staff.

-On 09/11/2026 at 3:45 AM (night shift), Staff I, Caregiver, was asleep in a chair in the hallway near Resident 1's room.

-On 09/11/2026 at 3:50 AM (night shift), the department observed that Staff FF, Caregiver, and Staff GG, Caregiver, were assigned to supervise Resident 1. Staff FF was lying on the floor in Resident 1's room and was asleep. Staff GG was observed inside Resident 1's room, lying on the floor ten inches behind the door. Staff GG was snoring when the department entered the room. Resident 1 was observed in their room.

Observation on 09/11/2026 at 3:53 AM (night shift), showed Staff B, Medication Technician, was at the facility in the medication room.

In an interview on 09/13/2026 at 10:45 AM, Staff DD, Nurse Consultant, stated that they were aware that the department regulators observed staff sleeping on 09/11/2026.

<Resident environment >

<Resident 1>

The following observations were made by the department after receiving two facility safety plans regarding [Resident 1's] room:

Observation on 09/11/2026 at 6:00 AM, showed there was strong urine odor outside the door of Resident 1's temporary room.

Observation on 09/12/2026 at 6:10 PM, showed there was strong urine odor inside Resident 1's temporary room.

Observation on 09/13/2026 at 11:00 AM showed that Resident 1 was in a temporary room. The room smelled of urine and the absorbent, fabric couch from their previous room had been moved into the temporary room. The temporary room had a hole in the wall in the bathroom where the toilet paper holder had been pushed through the wall. There was a hole behind the bathroom door where the door stopper was pushed through the wall.

Observation on 09/17/2026 at 1:14 PM showed that staff had just moved Resident 1 back into their permanent room that day. The observation showed that the walls in Resident 1's permanent room still had not been painted. The observation showed that the absorbent, fabric couch that had been moved from Resident 1's permanent room to the temporary room had been moved back into the resident's permanent room. There were two absorbent pads (used to protect someone sitting on soiled furniture) noted on

top of the couch cushions. There was no cover on the toilet tank in Resident 1's bathroom.

Observation on 09/19/2026 at 4:54 PM of Resident1's room showed the resident's fabric couch was still in their room. Observation showed the room was void of personal affects other than the clothing Resident 1 was wearing. There was no bedding on the mattress.

In an interview on 09/17/2026 at 11:41 AM, Staff EE stated they were aware of urine odor in Resident 1's room. Staff EE said that it was an "on-going challenge."

<Resident 2>

In an interview on 08/27/2026 at 2:10 PM, the department regulator asked about the hole in Resident 2's bathroom wall. Staff A reported that they planned to have the hole patched.

The following observation were made by the department after receiving two facility safety plans regarding [Resident 2's] room:

-On 09/13/2026 at 10:55 AM the four-inch hole was still in the wall in the bathroom, the towel rack and hooks were still missing parts, and the brackets were the only pieces attached to the wall.

-On 09/17/2026 at 1:26 PM showed that there was still a four-inch hole in Resident 2's bathroom wall.

-On 09/18/2026 at 11:08 10 rug pieces overlapping each other. All were spotted with multiple marks of dark residue. The was uneven and buckling padding under the rug pieces causing a trip hazard.

In an interview on 09/11/2026 at 4:38 PM, Staff A stated that Staff HH, Licensee, was the facility's maintenance person. Staff A stated that it "varies" how often they come to the facility. Staff A stated that Staff HH was involved with the facility and was aware of the current concerns. Staff A further stated that Staff HH and Staff EE were "aware of just as much as I am." Staff A stated they took direction from both Staff HH and Staff EE.

In an interview on 08/27/2026 at 1:45 PM, Collateral Contact 6 (CC6), Law Enforcement, stated that the facility had been a problem for local law enforcement for about three to four years. CC6 stated the police are constantly inundated with calls to respond to the

facility due to aggressive behaviors, sexual assaults, and self harm. CC6 said, "They expect us to solve their problems." CC6 stated that the facility could not handle their own residents. CC6 further stated that the facility was just in it for the money.

In an interview on 09/13/2026 at 7:13 PM, Staff K, Caregiver, stated in an interview on 09/13/2026 at 7:13 PM, Staff K, Caregiver, stated that Staff EE and Staff J, Behavioral Support Specialist, have been asking caregivers what they are telling state workers. Staff K said they wanted to know what the state workers were asking. Staff K stated that Resident 1's care had been better since "the state arrived." Staff K stated they were not reimbursed by Staff EE after purchasing activity supplies for residents. Staff K stated that the facility is admitting residents who they should not admit and that Resident 7 had too many medical needs for this facility to handle. Staff K stated that Staff EE was aware what happens in the facility, is the one in charge and tells the administrative staff what to do.

In an interview with on 09/17/2026 at 11:22 AM, Staff BB, Care Coordinator, stated that Staff EE was usually at the facility Monday through Friday. Staff BB stated that Staff EE ran the facility along with Staff A and Staff M.

In an interview with the facility licensee (Staff EE), Staff A, and Staff DD on 09/17/2026 at 11:41 AM, Staff EE stated they were at the facility frequently and routinely. Staff EE stated that they along with Staff HH were aware and involved with what was currently being investigated by the department. Staff EE stated they were aware that facility staff had been found to be sleeping on more than one occasion. Staff EE was asked about staff working 24-hour shifts and if that could have been a reason staff were sleeping. Staff EE stated that, "None of us in leadership were monitoring that people were working 24-hour shifts." Staff EE was asked about leadership staff checking on staff at night to ensure staff were not sleeping. Staff EE stated that an agency (contracted) medication technician was responsible for fulfilling this duty.

Refer to WAC 388-78A-2600 Policies and procedures.
Refer to WAC 388-78-3090 Maintenance and housekeeping.
Refer to WAC 388-78A-2660 Residents rights.
Refer to WAC 388-78A-2630 Reporting abuse and neglect
Refer to WAC 388-78A-2420 Record retention

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, Sycamore Glen at Quail Hollow 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