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

09/24/2026

Greenlake Management Everett, LLC
Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

RE: Everett Heritage Court # 2612

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 83935 (Completion Date 09/24/2026) and 78164 (Completion Date 07/20/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/24/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

The Department staff who did the On Site verification:
Jodi Condyles, Nursing Consultant Institutional
Steven Kindle, Nursing Consultant Institutional

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

Sincerely,

Jamie Singer

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

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Everett Heritage Court
Provider Type: Assisted Living Facility

License/Cert.#: 2612
Intake ID: 225982
Compliance Determination #: 78164
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 05/29/2026 through 07/20/2026
Complainant Contact Date(s):

Allegation(s):

1. There were residents that had bruises. A female resident had a bruise on their face.
2. A resident fell on the floor and staff were trying to lift the resident instead of calling the Paramedics.
3. A female resident who does not speak English had big bruising on top of their hands.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 12 Closed records sample size: 5
Observations:	Identified resident Residents Resident to resident interactions Staff to resident interactions Resident care equipment Residents' skin
Interviews:	Identified resident Nursing staff Residents Family members collateral contacts
Record Reviews:	Facility policies Incident investigation Medical records care plans assessments progress notes eMARS emails

Investigation Summary:

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1. There were residents that had bruises. The facility had a documentation that showed how the sampled residents sustained the bruising. The facility failed to conduct an ongoing assessment and follow their policy when the Licensed Nurse failed to do a weekly assessment and document their finings in the residents progress notes until the skin issues were resolved. Failed practice identified and a citation was issued.
2. The facility had a policy to call the paramedics when based on staff assessment, they were unable to lift a resident. Interview with care staff showed they were aware and called the paramedics when a resident needed a lift from a fall. No failed practice identified.
3. The facility had identified in the care plan how staff would be able to communicate with the staff. Interview with the staff and family indicated the NR was able to speak and comprehend basic English. The NR had bruising that were healing. The facility failed to conduct an ongoing assessment and follow their policy when the Licensed Nurse failed to do a weekly assessment and document their finings in the residents progress notes until the skin issues were resolved. Failed practice identified and a citation was issued.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Everett Heritage Court
Provider Type: Assisted Living Facility

License/Cert.#: 2612
Intake ID: 223966
Compliance Determination #: 78164
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 05/29/2026 through 07/20/2026
Complainant Contact Date(s): 05/21/2026

Allegation(s):

1. There were five Named Residents who passed away with scabies. There were two residents on hospice who passed away and their death were not investigated.
2. There were 7-8 residents who had been diagnosed with [redacted] and were eventually treated but the facility have not changed the carpets and their shower practices which led to more residents having scabies indicators.
3. Facility staff and outside staff were reprimanded by the Licensed Nurse who reported the presence of scabies.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 12 Closed records sample size: 5
Observations:	Residents Identified resident Activities Dining Resident rooms laundry
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies care plans assessments progress notes emails eMARs lab results HH/hospice notes

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Investigation Summary:

1. The NR's passed away under hospice services. Interview with a sampled resident (SR) family showed they did not have any concerns as to the passing of the SR. The facility had documentation leading to the passing away of the NR's and showing how they monitored the NR's and coordinated with Hospice. Record showed the NR had skin issues. The facility failed to conduct an ongoing assessment and follow their policy when the Licensed Nurse failed to do a weekly assessment and document their finings in the residents progress notes until the skin issues were resolved. Failed practice identified and a citation was issued.
2. There were conflicting diagnosis issued by the facility Primary care physician stating that the skin issues were not scabies but they were cases dermatitis and were being treated. Outside providers diagnosed the cases as [redacted]. The facility continued their routine laundry and cleaning practices as well as providing showers with their residents. The NR's had skin issues that needed the weekly monitoring by the Licensed Nurse. The facility failed to conduct an ongoing assessment and follow their policy when the Licensed Nurse failed to do a weekly assessment and document their finings in the residents progress notes until the skin issues were resolved. Failed practice identified and a citation was issued.
3. Interview with the staff indicated they did not have concerns of reporting issues they feel it needed to be addressed. No failed practice identified.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Everett Heritage Court
Provider Type: Assisted Living Facility

License/Cert.#: 2612
Intake ID: 224436
Compliance Determination #: 78164
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 05/29/2026 through 07/20/2026
Complainant Contact Date(s): 05/21/2026

Allegation(s):

1. The NR was not receiving adequate care. The staff were not assisting the NR to use the restroom.
2. The NR had dementia but does not have the degree of cognitive impairment. The NR should use ivermectin to treat their dementia.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 12 Closed records sample size: 5
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents collateral contacts Family members
Record Reviews:	Medical records Facility policies Staff patterns care plans assessments progress notes eMARS

Investigation Summary:

1. The facility followed the care plan. The NR was able to call for help when they need to. The NR uses a urinal and was at their bedside. The NR had skin issues that need monitoring by the facility Licensed Nurse. The facility failed to follow their

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policy when the Licensed Nurse failed to do a weekly assessment and document their finings in the residents progress notes until the skin issues were resolved. Failed practice identified and a citation was issued.
2. The NR had a diagnosis of [redacted] and was being followed up by their Primary Care Physician. No failed practice identified.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2612	Compliance Determination # 78164
Plan of Correction	Everett Heritage Court	Completion Date
Page 1 of 6	Licensee: Greenlake Management Everett, LLC	07/20/2026

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 05/29/2026 and 06/16/2026 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 225353, 224872, 225982, 223966, 224436

The following sample was selected for review during the unannounced on-site visit: 12 of 47 current residents and 5 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

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

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

Jim Sherman
Residential Care Services

07-21-2026
Date

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

Administrator (or Representative)

7/29/24
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure an ongoing assessment of skin issues for 6 of 7 residents (Residents 1, 2, 4, 5, 6, and 7 were completed by the Licensed Nurse (LN). This failure placed Resident 1, 2, 4, 5, 6, and 7 at risk for worsening skin issues and complications; and decreased quality of life.

Findings included...

Regulatory reference: WAC 388-78A- 2120 Monitoring residents' well-being.
If a resident had a departure from their customary range of functioning and have recurring conditions that had previously required intervention by others, the assisted living facility must:
(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
(2) Identify any changes in the resident's physical, emotional, and mental functioning.

Review of the facility policy titled "Skin Care Management" dated 02/15/2024 showed the facility would evaluate all residents for skin integrity and risk for skin breakdown upon admission, or readmission. All residents will receive care that promotes skin health

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and prevents breakdown. Any area of potential breakdown will be immediately reported and addressed by a Licensed Nurse. Wound care will only be performed by appropriate health care professionals. Additionally, the policy showed the Health Services Director is responsible for ensuring that appropriate interventions, follow-up, Service Plan updates and progress notes are completed. At least weekly assessment and documentation by the Health Services Director should occur until the problem is resolved.

Resident 1

Review of Resident 1's face sheet showed they were admitted to the facility on [redacted]/2026 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 1's assessment dated [redacted]/2026 showed Resident 1 had a wound or skin issue other than pressure or stasis ulcer (a shallow, slow-healing open sore, typically on the lower leg or ankle).

Review of Resident 1's Department of Social Health Services Assessment Details dated 05/18/2026 showed Resident 1 had chronically (a condition, disease, or problem that is persistent, long-lasting, or constantly recurring) dry skin and eczema on their legs.

During an observation on 05/29/2026 at 11:45 AM, Resident 1's lower legs and feet were observed to be dry and scaling. Additionally, it was observed that Resident 1's right big toenail was dark in color, curled, thick and a nail was observed to have overgrown and layered on top of the existing big toenail.

During an interview on 05/29/2026 at 05/29/2026 at 11:46 AM, Resident 1 stated their lower legs, and feet would itch at times.

Review of resident records did not show any ongoing assessment and documentation of findings was done by a Licensed Nurse regarding skin issues.

Resident 2

Review of Resident 2's face sheet showed they were admitted to the facility on [redacted]/2018 with multiple diagnoses including [redacted] and [redacted]. The face sheet showed Resident 2 takes Aspirin 18 milligrams (MG) (Aspirin is widely used in low daily doses to prevent blood clots, heart attacks, and strokes by keeping blood platelets from sticking together) daily by mouth as a preventative measure.

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Review of Resident 2's Assessment dated 05/13/2026 showed they have chronic, current and/or potential skin conditions such as dry skin.

During an observation on 05/29/2026 at 12:30 PM, Resident 2 had purplish discoloration on their arms, lower legs and knees that were consistent with rashes. The skin showed it was scabbed dry, scaly and appeared to be healing. Additionally, Resident 2 was observed with yellowish to greenish bruising on their left eye area.

Review of Resident 2's progress notes dated 05/11/2026 showed Resident 2 had a left swollen eye and bump on their eyebrow. The progress notes did not show any weekly assessments, and documentation was done by a Licensed Nurse of the skin issues after it was identified.

Resident 4

Review of Resident 4's face sheet showed they were admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted].

Review of Resident 4's Assessment dated 02/09/ 2026 showed they have chronic, current and/or potential skin conditions such as dry skin.

Review Resident 4's Service Plan dated 02/09/2026 showed Resident 4 had dermatitis (inflammation of the skin, characterized by itchy, red, and swollen areas).

During an interview on 05/29/2026 at 12:15 PM, Staff D, Medication Technician (MT), a non-licensed staff, stated that Resident 4 had rashes which looked -like bug bites and red spots on their torso (the central trunk of the human body, excluding the head, neck, and limbs) legs and arms.

Review of Resident 4's progress notes did not show any weekly assessment was done by a Licensed Nurse between February 2026 to 05/18/2026 regarding skin issues.

Resident 5

Review of Resident 5's face sheet showed they were admitted to the facility on [redacted]/2026 with multiple diagnoses including [redacted].

Review of Resident 5's Service Plan (SP) details dated 02/05/2026 showed they need

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assistance with their skin concerns. The SP did not show information about skin rashes.

Review of Resident 5's Electronic Medication Records for May 2026 showed Resident 5 was prescribed Cerave Daily Moisturizing External Lotion mixed with Triamcinolone Cream and Mupirocin External Ointment 2% for rashes.

During an observation on 05/29/2026 at 12:07 PM, Resident 5 was observed with greenish and yellowish discoloration and bruising on their face, and light purple discoloration on the bridge of their nose.

Review of Resident 5's progress notes dated 03/14/2026, 04/11/2026 and 04/17/2026 respectively showed that on 03/14/2026, a lamp fell and hit their head which caused bleeding on their forehead; On 04/11/2026, their left big toe was swollen and red; and on 04/17/2026, they had rashes on their body. The progress notes did not show a weekly assessment, and documentation was done by a Licensed Nurse regarding skin issues.

Resident 6

Review of Resident 6's face sheet showed they were admitted to the facility on [redacted]/2025 with multiple diagnoses including [redacted] and [redacted] and [redacted].

Review of Resident 6's Service Plan dated 03/28/2026 showed they had rashes under both their breast and groin areas.

Review of Resident 6's progress notes dated 02/08/2026 and 02/09/2026 showed they had swelling and redness on their left hip; and were hospitalized in the past due to cellulitis (a common, potentially serious bacterial skin infection caused by bacteria (usually strep or staph) entering through skin breaks).

Review of resident records did not show any ongoing assessments, and documentation was done by a Licensed Nurse about the rashes and cellulitis.

Resident 7

Review of Resident 7's face sheet showed they were admitted to the facility on [redacted]/2025 with multiple diagnoses including [redacted] and [redacted].

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Review of Resident 7's Assessment dated 12/03/2025 showed Resident 7 had dry skin, rashes, skin tear and ecchymosis (the medical term for a large bruise).

During an observation on 05/29/2026 at 1:20 PM, Resident 7 had reddish discoloration on their face, and there were purplish and pink discoloration consistent with rashes on their arms, chest and legs.

During an interview on 05/29/2026 at 1:30 PM, Staff G, MT stated that Resident 7 was admitted to the facility with skin condition such as dryness, bumps and rashes.

Review of Resident 7's progress notes dated 05/13/2026 showed they had a fall and a visible wound on their face The progress notes did not show a weekly assessment, and documentation was done by a Licensed Nurse regarding skin issues.

During an interview on 07/09/2026 at 1:03 PM, Staff B, Health and Wellness Director (Licensed Nurse), stated that they were not aware about their policy, that they were supposed to be doing a weekly assessment and documentation in their residents' progress notes regarding skin issues.

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, Everett Heritage Court is or will be in compliance with this law and / or regulation on (Date) 9/3/26 .

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

Administrator (or Representative) — Date 7/29/24

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