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) 84000 (Completion Date 09/24/2026) and 80687 (Completion Date 08/16/2026).

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-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

(iii) Corridors, as well as common and outdoor areas accessible to residents.

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.

The Department staff who did the On Site verification:

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

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

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: 229111
Compliance Determination #: 80687
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 07/20/2026 through 08/16/2026
Complainant Contact Date(s): 07/15/2026

Allegation(s):

1. The facility was preventing the Named Resident (NR) from transferring to another facility.
2. The facility was holding the NR's debit card.
3. The NR had no social interaction in the facility affecting their quality of life.
4. The NR was not getting quality care from the facility.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 7 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident rooms Resident to resident interactions Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Collateral contacts
Record Reviews:	care plan assessments medical records progress notes EMAR Emails

Investigation Summary:

1. The Named Resident (NR) did not like to move to a different facility. The NR stated it was their son who wanted them to move to a facility closer to them. The

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NR stated they prefer to stay at the current facility. No failed practice identified.
2. The facility did not have the NR's debit card. The NR stated that their son took their debit card and did not return it to them. The NR was Power of Attorney for themselves. No failed practice identified.
3. The NR was offered activities that they did not like and preferred to stay in their apartment and watch TV. The staff continue to encourage the NR to socialize. No failed practice identified.
4. The facility failed to show proof that the NR and the sampled residents consistently had showers based on their assessed needs and the care plan. Failed practice was identified and a citation was issued. See Statement of Deficiency dated 08/16/2026.

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: 231434
Compliance Determination #: 80687
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 07/20/2026 through 08/16/2026
Complainant Contact Date(s): 07/16/2026

Allegation(s):
The NR had a fall and had to crawl out of their room to get assistance.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 7 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident rooms Resident care equipment Emergency Pull cords/Pagers
Interviews:	Identified resident Nursing staff Residents Family members ED collateral contacts
Record Reviews:	Incident investigation Facility policies progress notes Assessments Care plans emails

Investigation Summary:
The facility failed to ensure that their emergency pull cord system (a system for residents to summon staff for assistance) was functioning properly and communicating the alerts and calls to their staff pager system. The NR did not rely using the emergency pull cord in the wall of their bedside to summon for help because they believed it was not working. Failed practice was identified and a citation was issued. See Statement of Deficiency dated 08/16/2026.

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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: 229936
Compliance Determination #: 80687
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 07/20/2026 through 08/16/2026
Complainant Contact Date(s): 07/16/2026

Allegation(s):

1. The NR was not being fed properly, their nails not trimmed; hair was matted; had only minimal sponge bath, and they were not getting out of their bed.
2. The facility was not cooperating with the NR in moving to a skilled facility.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 7 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident rooms Resident care equipment Emergency Pull cords/Pager
Interviews:	Identified resident Nursing staff Residents Family members ED collateral contacts
Record Reviews:	Facility policies progress notes Assessments Care plans emails medical records

Investigation Summary:

1. The Named Resident (NR) did not need assistance with eating. The staff brings the NR's food in their room if they do not like to get out for their meals. The NR chose to stay in their room and watch TV. The staff encourages the NR to get out of their room for meals and socialize. The NR preferred their finger nails no to be cut.

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The facility failed to show proof that the NR and the sampled residents consistently had showers based on their assessed needs and the care plan. Failed practice was identified and a citation was issued. See Statement of Deficiency dated 08/12/2026.
2. The NR did not like to move out form the facility. The NR stated it was their son who wanted them to move to a skilled nursing facility closer to them.

Conclusion / Action:

- [x] 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 # 80687
Plan of Correction	Everett Heritage Court	Completion Date
Page 1 of 9	Licensee: Greenlake Management Everett, LLC	08/16/2026

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 07/20/2026 and 08/03/2026 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 229111, 231434, 229936

The following sample was selected for review during the unannounced on-site visit: 7 of 45 current residents and 0 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

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

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

Jim Sherman
Residential Care Services

08-17-2026
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)

8/26/24
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

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure that the emergency pull cord equipment (a communication system for residents to summon staff for assistance) was functional for 6 of 6 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 6 and Resident 7) rooms and in three of three common areas (the upper-level dining room, lower and upper-level living area). This failure resulted in Resident 2 not being able to summon for help immediately after a fall with injury. This failure placed residents at risk of harm and unmet care needs when unable to summon staff for assistance.

Findings included...

Review of the Departments' STARS (Secure Tracking and ReportingSystem) showed the facility was a Memory Care Certified since 07/01/2026.

Review of Assisted Living Facility Resident Characteristic Roster and Sample Selection received by the Department on 07/20/2026 during the unannounced visit showed 45 residents received care and services from the facility.

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In an email dated 07/28/2026, Staff A, Executive Director, stated that they used PalCare communication system (PalCare Communication System pull cords are completely wireless. They use Bluetooth and 900 MHz wireless backbones with battery power for quick installation without hardwiring.)

Non – functional emergency pull cord equipment in resident rooms

Resident 1

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

Record Review of Resident 1's care plan (CP) dated 04/30/2026 showed they did not have any communication impairment. The CP showed Resident 1 was capable of effectively communicating and could express their needs to the staff.

During an interview on 07/20/2026 at 1:49 PM, Resident 1 stated that their emergency pull cord installed in their apartment was not functioning and they must yell to call for assistance from the staff. Resident 1 stated that they had attempted to activate their emergency pull cord multiple times, but no staff members responded to their calls for help.

On 07/20/2026 at 1:52 PM the Department, along with Staff E, Caregiver, conducted testing and observation of the emergency pull cord equipment in Resident 1's room. Observation showed the emergency pull cord equipment was located on the wall near the head of their bed in the sleeping area. Upon activation of the emergency pull cord, the indicator lights on the device flickered briefly three times then stopped.

Resident 2

Record review of Resident 2's face sheet showed they were admitted to the facility on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

Record Review of Resident 2's CP dated 05/11/2026 showed they did not have any communication impairment. The CP showed they were able to communicate effectively and expressed their needs to the staff. The CP showed Resident 2 required cues and

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prompts for ambulation, mobility, and escorts. The CP showed Resident 1 uses a walker (for mobility) and has an unsteady gait.

Record review of an incident report dated 07/04/2026 showed Resident 2 had a fall while reaching over the deck in their apartment, that resulted in a loss of balance and subsequent fall.

Review of Resident 2's progress notes dated 07/04/2026 showed Resident 2 was sent to the hospital following the fall. The notes showed Resident 2 returned on the same day with a diagnosis of a [redacted].

During an interview on 07/20/2026 at 2:35 PM, Resident 2 stated that they stepped on their 4-wheeled walker while trying to reach for their (window) curtain that resulted in a fall. Resident 2 stated that they crawled to the hallway and yelled for assistance. Resident 2 stated that they activated their emergency pull cord by pulling the string but believed it did not function as no one arrived to assist them. Resident 2 stated that their emergency pull cord had not been operational for an extended period.

On 07/20/2026 at 2:38 PM the Department, along with Staff F, MT, conducted testing and observation of the emergency pull cord equipment in Resident 2's room. Observation showed the emergency pull cord was located on the wall of their room. Upon activation of the emergency pull cord, there were no beep (audible) sounds and the indicator light in the device flickered briefly three times before it stopped.

During an observation and interview on 07/20/2026 at 3:20 PM, Staff C, Medication Technician (MT) stated that the (wireless) pagers (that were to receive notification of pull cord activation) were held and managed by the MTs. Staff C stated that when residents activated the emergency pull cords by pulling the strings or cords, an alert notification would be sent to the pagers. Staff C did not have a pager in their possession. Staff C found the wireless pager designated for the lower level in the staff break room. Staff C observed that the pager's battery was dead and was non-functional.

Resident 3

Record review of Resident 3's face sheet showed they were admitted to the facility on [redacted]2025 with multiple diagnoses including [redacted]

Record review of Resident 3's assessment dated 04/29/2026 showed they have an emergency response enabling device called an emergency pull cord.

Resident 4

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Record review of Resident 4's face sheet showed they were admitted to the facility on [redacted]/2025 with multiple diagnoses including [redacted].

Record review of Resident 4's assessment dated 03/28/2026 showed they have an emergency response enabling device called an emergency pull cord.

Resident 6

Record review of Resident 6's face sheet showed they were admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted].

Record review of Resident 6's assessment dated 05/23/2026 showed they have an emergency response enabling device called a Personalized emergency pull cord.

Resident 7

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

Record review of Resident 7's assessment dated 12/03/2025 showed they have an emergency response enabling device called an emergency pull cord.

On 07/20/2026 at 3:24 PM, the Department, along with Staff C, MT, conducted testing and observation regarding the emergency pull cord equipment for Resident 3 and Resident 4 which were installed on the wall of their room near the head of their beds. The observation showed the emergency pull cord equipment did not show any blinking lights or beeping (audible) sounds when the pull cord was activated. When staff C located the pagers, there was no evidence of transmission to show the pull cords were recently activated in Resident 3 and Resident 4's rooms and that the signal was communicated to the staff pagers.

Common Areas non- functional emergency pull cord equipment

On 07/20/2026 at 3:26 PM the Department, along with Staff I, MT, conducted testing and observation regarding the emergency pull cord equipment at the upper-level dining room and living area. Observation showed the emergency pull cord equipment which was attached to the walls of the common areas did not activate any lights or beeping sounds on the device.

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During an interview on 07/20/2026 at 2:42 PM and 3:29 PM, Staff I, MT stated that they did not have their pager on their person, and the emergency pull cord equipment was not working. When Staff I located their pagers, there were no notifications transmitted to the pager when the emergency pull cords in common areas were activated.

During an interview on 08/11/2026 at 1:24 PM, Staff J, Maintenance, stated that they would check mechanically if the emergency pull cords were working. Staff J stated they do not check it with pagers. Staff J stated that the issue with the emergency pull cord equipment not communicating or triggering notification with the pagers were IT (information technology) issues which they do not do. Staff J stated that when the emergency pull cord equipment was activated, the pagers should vibrate, indicating it was transmitting the signal.

On 08/11/2026 at 1:29 PM and 1:31 PM, the Department, along with Staff J, conducted testing and observation regarding the emergency pull cord equipment in Resident 6 and Resident 7's room, and of the lower-level living area, respectively. Observation showed that when the emergency pull cord equipment was activated, the pager did not vibrate to show that the pager received the signal of the pull cord equipment activation.

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) 9/17/26 .

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

Administrator (or Representative) — Date 8/26/26

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 interview and record review, the facility failed to ensure to follow and implement the care plan for 3 of 3 sampled residents (Resident 1, Resident 5 and Resident 6) who required shower (bathing) staff assistance. This failure resulted in unmet care needs and a potentially diminished quality of life for Resident 1, Resident 5

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and Resident 6.

Findings included...

Resident 1

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

Record Review of Resident 1's care plan (CP) dated 04/30/2026 showed Resident 1 preferred to take showers. The CP showed they required hands-on and extensive assistance from the staff with bathing. The CP showed Resident 1 was to receive 1-2 baths weekly and would utilize a handheld shower device during bathing.

Review of the facility's shower logs showed Resident 1 was scheduled to shower in the mornings on Sundays and Thursdays. The shower log for Resident 1 showed:

a. From 05/03 to 05/09, there was no documentation showing that they had showers.

b. 05/10 to 06/16, it was documented that they refused their shower on Sunday and it was documented that they had shower for the Thursday.

c. 05/24 to 05/30, it was documented that they had a shower on a Sunday and there was no record that they had a shower on a Thursday.

d. 05/31 to 06/06, it was documented that they had a shower on a Sunday and there was no record that they had a shower on a Thursday.

e. 06/21 to 06/27, it was documented that they had a shower on a Sunday and there was no record that they had a shower on a Thursday.

f. 06/28 to 07/18, it was documented that they had a shower on a Sunday and there was no record that they had a shower on a Thursday.

g. 07/19 to 07/25, there was no record that showed they had a shower.

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During an interview on 07/20/ 2026, at 1:49 PM, Resident 1 stated that they had received a sponge bath with staff assistance. Resident 1 stated that they had not received showers since they moved in and had consistently received sponge baths from the staff. Resident 1 stated that they had not requested a shower from the staff, as the staff always provided sponge baths during their visits and did not offer them the option of a shower.

Resident 5

Record review of Resident 5's face sheet showed they were admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted].

Record review of Resident 5's care plan (CP) dated 04/17/2026 showed Resident 5 preferred to take showers. The CP showed they required hands-on and extensive assistance from the staff with bathing. The CP showed Resident 5 was to receive 1-2 baths weekly and would utilize a handheld shower device during bathing.

Record review of the facility's shower logs showed Resident 5 was to receive showers on Monday and Thursday mornings. The shower log for Resident 5 showed from 05/03/2026 to 05/09/2026; 05/24/2026 to 06/06/2026; and 06/21/2026 to 07/25/2026 no showers or refusal were documented.

During an interview on 07/20/2026 at 2:50 PM and at 3:08 PM, Resident 5 stated that they had taken a shower three to four days ago. Resident 5 stated that they were scheduled to shower this morning (07/20/2026) but no staff asked them about a shower. Resident 5 stated that they were unable to shower independently and required assistance.

Resident 6

Record review of Resident 6's face sheet showed they were admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted].

Record review of Resident 6's CP dated 05/23/2026 showed they required total assistance with bathing. The CP showed Resident 5 preferred shower bath 1 - 2 x per week.

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Record review of the facility's shower logs showed Resident 6 was to receive showers on Tuesday and Saturday mornings. The shower log for Resident 6 showed from 05/03/2026 to 05/09/2026; 05/24/2026 to 06/06/2026; and from 06/28/2026 to 07/025/2026 no showers or refusal to shower were documented.

During an interview on 07/20/2026 at 2:59 PM, Staff G, Caregiver, stated that they follow a schedule when providing showers to residents. Staff G stated that if a resident refuses a shower, they attempt to encourage them again. Staff G also stated that they ask their colleagues to see if the resident might agree to a shower. Staff G stated that if a resident continues to refuse, they will report the situation to the Medication Technician. Staff G stated that they would document in the shower log whether showers were completed or declined. Staff G stated that Resident 5 was scheduled for a shower on 07/20/2026 but refused. Additionally, Staff G recalled giving a bath to Resident 6, explaining that they could only provide a bed bath because they were alone while the other staff members were occupied.

During an interview on 07/20/2026 at 3:10 PM, Staff H, Caregiver, who was assigned on the lower level, stated that they were unaware of which resident was scheduled for an evening shower.

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) 9/17/26 .

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

Administrator (or Representative) — Date 8/26/26

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