STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Golden Hearth Residence LLC

Golden Hearth Residence LLC
4431 S Shell St
Seattle, WA 98072

RE: Golden Hearth Residence LLC License # 2651

Dear Administrator:

This letter addresses Compliance Determination(s) 70477 (Completion Date 12/22/2025) and 66392 (Completion Date 10/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/22/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2130-3-a, WAC 388-78A-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-3010-8-e, WAC 388-78A-2468-1, WAC 388-78A-2483-1

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

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

Sincerely,

Jim Sherman

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for the unannounced on-site full inspection on 10/01/2025 and 10/02/2025 of:

Golden Hearth Residence LLC
15934 NE 139TH PLACE
WOODINVILLE, WA 98072

The following sample was selected for review during the unannounced on-site visit: 4 of 8 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2651	Compliance Determination # 66392
Plan of Correction	Golden Hearth Residence LLC	Completion Date
Page 2 of 8	Licensee: Golden Hearth Residence LLC	10/06/2025

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

10-09-2025
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.

Anteneh Moltot
Administrator (or Representative)

10/14/2025
Date

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to update the service plan for 2 of 8 sampled residents (Resident 2 and Resident 5). This failure placed Resident 2 and Resident 5 at risk for their care needs not being met.

Findings included...

Resident 2
Review of the facility's Characteristics Roster dated 10/01/2025, showed that the facility admitted Resident 2 in [redacted] 2021. The Characteristics Roster did not show that Resident 2 used medical devices.

Observations on 10/01/2025 at 1:32 PM, during the facility environmental tour showed a hospital bed with an alternating pressure relieving air mattress (an air mattress to prevent skin breakdown) in Resident 2's room. Observation showed an air pump located on the footboard of the bed.

Review of Resident 2's service plan dated 04/09/2025, did not show Resident 2 used an alternating pressure relieving air mattress and did not provide instructions for the caregivers to ensure the pump was turned on and the mattress was inflated.

Resident 5
Review of the facility's Characteristics Roster dated 10/01/2025, showed that the facility

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

10-09-2025
Date

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

Administrator (or Representative)

Date

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to update the service plan for 2 of 8 sampled residents (Resident 2 and Resident 5). This failure placed Resident 2 and Resident 5 at risk for their care needs not being met.

Findings included...

Resident 2
Review of the facility's Characteristics Roster dated 10/01/2025, showed that the facility admitted Resident 2 in [redacted] 2021. The Characteristics Roster did not show that Resident 2 used medical devices.

Observations on 10/01/2025 at 1:32 PM, during the facility environmental tour showed a hospital bed with an alternating pressure relieving air mattress (an air mattress to prevent skin breakdown) in Resident 2's room. Observation showed an air pump located on the footboard of the bed.

Review of Resident 2's service plan dated 04/09/2025, did not show Resident 2 used an alternating pressure relieving air mattress and did not provide instructions for the caregivers to ensure the pump was turned on and the mattress was inflated.

Resident 5
Review of the facility's Characteristics Roster dated 10/01/2025, showed that the facility

admitted Resident 5 in [redacted] 2022. The Characteristics Roster showed that Resident 5 received Hospice care services (end of life care). The Characteristics Roster did not show that Resident 5 used medical devices.

Observations on 10/01/2025 at 1:38 PM, during the facility environmental tour showed a hospital bed with an alternating pressure relieving air mattress in Resident 5's room. Observation showed an air pump located on the footboard of the bed.

Review of Resident 5's Hospice notes dated 09/10/2025 showed that the alternating pressure relieving air mattress was implemented on 08/28/2025.
Review of Resident 5's Hospice/facility service plan dated 09/10/2025, showed Resident 5 used an alternating pressure relieving air mattress. There were no instructions provided for the caregivers to ensure the pump was turned on and the mattress was inflated.

During an interview on 10/01/2025 at 1:45 AM, Staff A, Administrator/Caregiver stated that Hospice provided the alternating pressure relieving air mattress.

During an interview on 10/01/2025 at 2:00 PM, Staff C, Registered Nurse and Manager, stated that Hospice provided the medical equipment. Staff C stated that there were no instructions provided to show the caregivers what to do to ensure the medical devices functioned correctly.

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, Golden Hearth Residence LLC is or will be in compliance with this law and / or regulation on (Date)___ 11/20/2025

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

[signature] 10/14/2025

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:

admitted Resident 5 in [redacted] 2022. The Characteristics Roster showed that Resident 5 received Hospice care services (end of life care). The Characteristics Roster did not show that Resident 5 used medical devices.

Observations on 10/01/2025 at 1:38 PM, during the facility environmental tour showed a hospital bed with an alternating pressure relieving air mattress in Resident 5's room. Observation showed an air pump located on the footboard of the bed.

Review of Resident 5's Hospice notes dated 09/10/2025 showed that the alternating pressure relieving air mattress was implemented on 08/28/2025.
Review of Resident 5's Hospice/facility service plan dated 09/10/2025, showed Resident 5 used an alternating pressure relieving air mattress. There were no instructions provided for the caregivers to ensure the pump was turned on and the mattress was inflated.

During an interview on 10/01/2025 at 1:45 AM, Staff A, Administrator/Caregiver stated that Hospice provided the alternating pressure relieving air mattress.

During an interview on 10/01/2025 at 2:00 PM, Staff C, Registered Nurse and Manager, stated that Hospice provided the medical equipment. Staff C stated that there were no instructions provided to show the caregivers what to do to ensure the medical devices functioned correctly.

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, Golden Hearth Residence LLC 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:

WAC 246-840-930 Criteria for delegation.
(18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.

Based on observation, interview, and record review, the Assisted Living Facility failed to reevaluate and document at least every 90 days nurse delegation (ND) services for 1 of 1 sampled resident (Resident 3). This failure placed Resident 3 at risk for unsafe medication administration.

Findings included...

Review of the facility's undated Disclosure of Services showed the facility used nursing assistants to administer drops, oral, and topical medications under the delegation of a Registered Nurse.

RESIDENT 3
Review of the facility's Characteristics Roster dated 10/01/2025, showed that the facility admitted Resident 3 in [redacted] 2022. The Characteristics Roster showed that Resident 3 received Hospice care services (end of life care). The Characteristics Roster showed that Resident 3 received nurse delegation services.

Review of Resident 3's "Nurse Delegation: Nursing Visit" dated 06/07/2025 showed that Resident 3 received oral medications, pain gel and patches. The Nurse delegation form showed Resident 3 was unable to self-administer medications due to impaired cognitive function related to a debilitating disease. Review of the Nurse Delegation Nursing visit showed that the next 90 day reevaluation return visit was due on 09/07/2025.

Observation on 10/02/2025 at 11:00 AM, showed that Resident 3 required the caregivers to hand feed them for nourishment and administer medications.

During an interview on 10/01/2025 at 1:00 PM, Staff C, Registered Nurse Delegator/Manager, stated that they lived on-site and were present most of the time in the facility, which allowed them to consistently observe delegated staff. Staff C stated that the return nursing delegation visit for reevaluation of delegated staff was overdue.

Statement of Deficiencies	License #: 2651	Compliance Determination # 66392
Plan of Correction	Golden Hearth Residence LLC	Completion Date
Page 5 of 6	Licensee: Golden Hearth Residence LLC	10/08/2025

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, Golden Hearth Residence LLC is or will be in compliance with this law and / or regulation on (Date) 11/10/2025 .

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

Administrator (or Representative) [signature] Date 10/15/2025

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide a lockable storage area for 6 of 8 sampled residents, (Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, and Resident 8). This failure violated Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, and Resident 8, rights to have a lockable storage area for their personal belongings.

Findings included...

Review of the facility's Assisted Living Resident Characteristics Roster dated 10/01/2025 showed a total of eight residents resided at the facility.

Observation on 10/01/2025 between 1:00 PM and 3:00 PM showed that six of eight occupied rooms provided no lockable storage space for resident use. Observation of rooms for Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 12 showed no lockable storage space in each room for their personal items.

During an interview on 10/01/2025 at 1:34 PM, Staff A, Administrator/Caregiver, stated that they were not aware that all the resident rooms were required to be equipped with a lockable storage area. Staff A stated that residents and their families were encouraged to remove all valuables.

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, Golden Hearth Residence LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

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Based on observation and interview, the facility failed to provide a lockable storage area for 6 of 8 sampled residents, (Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, and Resident 8). This failure violated Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, and Resident 8, rights to have a lockable storage area for their personal belongings.

Findings included...

Review of the facility's Assisted Living Resident Characteristics Roster dated 10/01/2025 showed a total of eight residents resided at the facility.

Observation on 10/01/2025 between 1:00 PM and 3:00 PM showed that six of eight occupied rooms provided no lockable storage space for resident use. Observation of rooms for Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, and Resident 12 showed no lockable storage space in each room for their personal items.

During an interview on 10/01/2025 at 1:34 PM, Staff A, Administrator/Caregiver, stated that they were not aware that all the resident rooms were required to be equipped with a lockable storage area. Staff A stated that residents and their families were encouraged to remove all valuables.

Statement of Deficiencies	License #: 2651	Compliance Determination # 66392
Plan of Correction	Golden Hearth Residence LLC	Completion Date
Page 6 of 8	Licensee: Golden Hearth Residence LLC	10/08/2025

During an interview on 10/01/2025 at 2:00 PM, Staff C, Registered Nurse and Manager, stated that residents were allowed to have their valuables locked up in the facility's safe.

Plan/Attestation Statement

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

Administrator (or Representative) 10/15/25 Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit the Washington state name and date of birth background inquiry (BGI) for 2 of 4 sampled staff (Staff C and Staff D) within one business day after their start date. This failure placed all eight residents as risk for abuse and neglect from caregivers and staff persons with unknown backgrounds.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that eight residents received assisted living services.

STAFF C

Review of the facility's undated employee roster showed that the facility hired Staff C, Registered Nurse/Manager on 11/14/2022. Review of Staff C's employee records showed that the facility completed the Washington state name and date of birth BGI on 03/25/2025, 862 days after hire.

During an interview on 10/01/2025 at 2:00 PM, Staff C, Registered Nurse and Manager, stated that residents were allowed to have their valuables locked up in the facility's safe.

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, Golden Hearth Residence LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

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Based on interview and record review, the facility failed to submit the Washington state name and date of birth background inquiry (BGI) for 2 of 4 sampled staff (Staff C and Staff D) within one business day after their start date. This failure placed all eight residents as risk for abuse and neglect from caregivers and staff persons with unknown backgrounds.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that eight residents received assisted living services.

STAFF C
Review of the facility's undated employee roster showed that the facility hired Staff C, Registered Nurse/Manager on 11/14/2022. Review of Staff C's employee records showed that the facility completed the Washington state name and date of birth BGI on 03/25/2025, 862 days after hire.

STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Certified Nursing Assistant (CNA) on 10/11/2023. Review of Staff D's employee records showed that the facility completed the Washington state name and date of birth BGI on 10/21/2023, 10 days after hire.

During an interview on 10/02/2025 at 2:30 PM, Staff C stated that they completed background checks for Staff C. Staff C stated that they were unable to locate Staff C's initial Washington state name and date of birth BGI result document. Staff C stated that they completed Staff D's Washington state name and date of birth BGI late.

Review of the Department's Background Check Central Unit's (BCCU) email titled "Background Inquiry", dated 10/07/2025, showed no records that the facility completed an initial Washington state name and date of birth BGI for Staff C when Staff C was hired.

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, Golden Hearth Residence LLC is or will be in compliance with this law and / or regulation on (Date) 11/20/2025.

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

Administrator (or Representative) [signature] Date 10/15/2025

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

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 2 sampled staff (Staff D), with documented negative results from a previous two-step skin test, completed one Tuberculosis (TB) test within three days of hire. This failure placed all eight residents at risk of contracting tuberculosis, a contagious respiratory illness.

Findings included...

STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Certified Nursing Assistant (CNA) on 10/11/2023. Review of Staff D's employee records showed that the facility completed the Washington state name and date of birth BGI on 10/21/2023, 10 days after hire.

During an interview on 10/02/2025 at 2:30 PM, Staff C stated that they completed background checks for Staff C. Staff C stated that they were unable to locate Staff C's initial Washington state name and date of birth BGI result document. Staff C stated that they completed Staff D's Washington state name and date of birth BGI late.

Review of the Department's Background Check Central Unit's (BCCU) email titled "Background Inquiry", dated 10/07/2025, showed no records that the facility completed an initial Washington state name and date of birth BGI for Staff C when Staff C was hired.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

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(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 2 sampled staff (Staff D), with documented negative results from a previous two-step skin test, completed one Tuberculosis (TB) test within three days of hire. This failure placed all eight residents at risk of contracting tuberculosis, a contagious respiratory illness.

Findings included...

Statement of Deficiencies	License #. 2651	Compliance Determination # 66392
Plan of Correction	Golden Hearth Residence LLC	Completion Date
Page 8 of 8	Licensee: Golden Hearth Residence LLC	10/08/2025

NOTE: Washington Administrative Code (WAC) 388-78A-2480, Tuberculosis-Testing-Required, (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that eight residents received assisted living services.

Review of the facility's undated employee roster showed the facility hired Staff D, Certified Nursing Assistant (CNA), on 10/11/2023. Review of Staff D's employee records showed documentation of the previous negative results of two-step skin tests. The records showed Staff D's initial step skin test was completed on 09/27/2023 and Staff D's second step skin test was completed on 10/06/2023, five days before being hired. The records showed no documentation that Staff D completed a one-step TB test within three days of hire, as required.

During an interview on 10/02/2025 at 11:50 AM, Staff C, Registered Nurse/Manager, stated that they were unfamiliar with the TB testing requirements. Staff C stated that Staff D completed their two-step TB skin tests on 10/06/2023. Staff C stated that they were unaware Staff D's TB tests did not meet the state's TB testing requirement. Staff C stated that Staff D did not complete a TB test after hire.

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, Golden Hearth Residence LLC is or will be in compliance with this law and / or regulation on (Date) 11/20/2025.

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

Administrator (or Representative) 10/15/25 Date

NOTE: Washington Administrative Code (WAC) 388-78A-2480, Tuberculosis-Testing-Required, (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that eight residents received assisted living services.

Review of the facility's undated employee roster showed the facility hired Staff D, Certified Nursing Assistant (CNA), on 10/11/2023. Review of Staff D's employee records showed documentation of the previous negative results of two-step skin tests. The records showed Staff D's initial step skin test was completed on 09/27/2023 and Staff D's second step skin test was completed on 10/06/2023, five days before being hired. The records showed no documentation that Staff D completed a one-step TB test within three days of hire, as required.

During an interview on 10/02/2025 at 11:50 AM, Staff C, Registered Nurse/Manager, stated that they were unfamiliar with the TB testing requirements. Staff C stated that Staff D completed their two-step TB skin tests on 10/06/2023. Staff C stated that they were unaware Staff D's TB tests did not meet the state's TB testing requirement. Staff C stated that Staff D did not complete a TB test after hire.

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, Golden Hearth Residence LLC 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 _____

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Golden Hearth Residence LLC
Golden Hearth Residence LLC
4431 S Shell St
Seattle, WA 98072

RE: Golden Hearth Residence LLC # 2651

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/08/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

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

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

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

The Assisted Living Facility failed to develop the notice of facility's policy on accepting Medicaid as a payment source in a type font at least 14 points and on a page separate from other documents. On 10/02/2025, during the Department's full inspection, the facility developed a new facility's Medicaid notice to meet the requirements.

This deficiency was corrected by the exit conference.

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

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

Email: RCSIDR@dshs.wa.gov; or

Fax: (360) 725-3225

If You Have Any Questions:

- Please contact me at (206)305-3489.

Sincerely,

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

Enclosure