STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Summer Hill Operations, LLC
Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

RE: Summer Hill Assisted Living License # 2676

Dear Administrator:

This letter addresses Compliance Determination(s) 82842 (Completion Date 09/02/2026) and 76445 (Completion Date 06/10/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/02/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660-1, WAC 388-78A-2660-4, WAC 388-78A-2660-6, WAC 388-78A-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2150-3, WAC 388-78A-2150

The Department staff who did the on-site verification:
Melissa Phillips, Long Term Care Surveyor

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

Sincerely,

Jamie Singer

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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Summer Hill Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2676
Compliance Determination #: 76445
Investigator: Teresa Pederson-Tuley
Investigation Date(s): 04/27/2026 through 06/10/2026
Complainant Contact Date(s):

Intake ID: 218913
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
The Identified Resident (IR) did not receive requested services.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Staff to resident interactions
Interviews:	Residents Nursing staff
Record Reviews:	Medical records Facility policies

Investigation Summary:
Review of the medical record showed the IR had discussed increasing services with the Executive Director and that the IR had moved out before the Negotiated Service Agreement (NSA) could be updated. Record review of the NSA showed no signature from the resident, their representative, authorized ALF representative or their Department Case Manager. Failed practice identified and a citation was issued at 388-78A-2150.

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: Summer Hill Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2676
Intake ID: 219852
Compliance Determination #: 76445
Region/Unit #: RCS Region 2 / Unit J
Investigator: Teresa Pederson-Tuley
Investigation Date(s): 04/27/2026 through 06/10/2026
Complainant Contact Date(s):

Allegation(s):

1. The Identified Resident (IR) did not have blood sugars checked as physician ordered and there was a used needle container in their room.
2. The staff did not unpack the IR boxes after moving in.
3. The IR is ordering their own meds and delivering them to the facility with a history suicidal ideation.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Staff to resident interactions
Interviews:	Nursing staff Residents
Record Reviews:	Medical records

Investigation Summary:

1. Record review of the Medication Administration Records and physician orders showed all physician recommendations had been followed. Staff interviews showed they had reviewed the orders with the IR on several occasions and they had stated they understood. Observation showed there was not a used needle container in the IR room but located on the medication cart. No failed practice identified.
2. Observation showed boxes had been unpacked. Staff interviews showed they had offered assistance to help unpack and the IR had not wanted assistance at the time they offered. Interview with IR showed she had unpacked the boxes and settled in. No failed practice identified.
3. Interview with the IR showed she had previously lived on her own, managed her medications and had clarified the process with staff. Care plan appropriate to care needs. Record review of the NSA showed no signature from the resident, their representative, authorized ALF representative or their Department Case Manager. Failed practice identified and a citation was issued at 388-78A-2150.

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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: Summer Hill Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2676
Compliance Determination #: 76445
Investigator: Teresa Pederson-Tuley
Investigation Date(s): 04/27/2026 through 06/10/2026
Complainant Contact Date(s):

Intake ID: 221878
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
The Identified Resident (IR) was prevented from using their power wheelchair on the 2nd and 3rd floor of the Assisted Living Facility (ALF)

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Residents Nursing staff Maintenance staff
Record Reviews:	Medical records Facility policies

Investigation Summary:
Observation showed signs had been placed on elevator doors, stating power wheelchairs were not allowed on the 2nd and 3rd floors of the building. Staff interviews showed residents in power wheelchairs were not allowed on the 2nd and 3rd floors and they were aware this violated their resident rights. IR interview showed the Regional Maintenance Director stated the power wheelchair would ruin the floors, that staff could transfer her to a manual wheelchair and push her up to those floors. IR stated she had the power wheelchair to remain independent with her mobility. Failed practice identified and a citation at 388-78A-2660 Resident Rights was issued.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

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☐ 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

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 04/27/2026 of:

Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

This document references the following complaint number(s): 218913, 219852, 221878

The following sample was selected for review during the unannounced on-site visit: 3 of 72 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Teresa Pederson-Tuley, Nursing Consultant Institutional

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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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.

Jessie Seigen
Residential Care Services

6/17/2026
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)

6/18/26
Date

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

(6) Reasonably accommodate residents consistent with applicable state and federal law;

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

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

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to comply with resident rights by reasonably accommodating one of three residents (Resident 1) and allowing freedom of movement in their power wheelchair on the 2nd or 3rd floor. This failure resulted in Resident 1 losing independence in visiting and attending activities in the ALF and place all residents using power wheelchairs at risk of a diminished quality of life.
Findings included...
Record review showed the ALF admitted Resident 1 on [redacted]/2024 with multiple disabling diagnosis.
Record review of the Negotiated Service Agreement (NSA), dated 05/01/2025, showed Resident 1 was cognitively intact, willing to socialize with other residents and was independent with mobility in her power wheelchair.
Observation, on 04/27/2026 at 1:00 PM, showed signs had been placed on the 1st, 2nd, and 3rd floor elevator doors stating that no power wheelchairs were allowed on floors two or three.
In an interview, on 04/27/2026 at 1:20 PM, Resident 1 stated she was told by Staff C (Regional Maintenance Director) that power wheelchairs were not allowed on the 2nd or 3rd floor of the ALF. Resident 1 stated Staff C said that power wheelchairs would ruin the floors. Resident 1 stated she was told the only way she could go to the 2nd and 3rd floor was if staff transferred her to a manual chair and pushed her around on those

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floors to attend activities. Resident 1 stated she was upset that she missed participating in activities and the reason she had a power wheelchair was to remain independent and not rely upon staff for transportation.
In an interview, on 04/27/2026 at 1:44 PM, Staff A (Executive Director) stated they knew signs restricting power wheelchairs were placed on the elevator doors and had been told by Staff C that residents with power wheelchairs were not allowed to use them on the 2nd and 3rd floors. Staff A confirmed that restricting residents in power wheelchairs their freedom of movement was a violation of residents rights.
In an interview, on 04/27/2026 at 1:50 PM, with Staff C stated he told staff and residents that no power wheelchairs were allowed on the 2nd and 3rd floors. That he had placed the signs on the elevator doors and told staff to load the residents into a manual chairs and push them to the 2nd and 3rd floors. Staff C confirmed he had no amendment from the Department to restrict movement and access of residents to any part of the ALF.

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, Summer Hill Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/25/26.

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

Administrator (or Representative) — Date 6/18/26.

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

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

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

(3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) was signed for 2 of 3 residents (Resident 2 and 3). This failure placed Resident 2 and 3 at risk of not having their needs met.
Findings included...
Record review showed the ALF admitted Resident 2 on [redacted]/2026 with multiple disabling diagnosis.

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Record review of the undated NSA showed no signature from the resident, their representative, authorized ALF representative, or their Department Case Manager.
Record review showed the ALF admitted Resident 3 on [redacted]/2026 with multiple disabling diagnosis.
Record review of the undated NSA showed no signature from the resident, their representative, authorized ALF representative, or their Department Case Manager.
In an interview, on 04/28/2026 at 9:53 AM, Collateral Contact 1 (Department Case Manager) stated they had not received a copy of the NSA to sign for Resident 2 or 3.
In an interview, on 04/27/2026 at 2:00 PM, Staff B (Health and Wellness Director) stated she could not find the signed copy of the NSA for Resident 2 or 3.

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, Summer Hill Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/25/26 .

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

Administrator (or Representative) — Date 6/18/26

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