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

LC Lynnwood Operator LLC
Quail Park of Lynnwood
4015 164th St SW
Lynnwood, WA 98087

RE: Quail Park of Lynnwood License # 2700

Dear Administrator:

This letter addresses Compliance Determination(s) 72939 (Completion Date 02/17/2026) and 69846 (Completion Date 01/12/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/17/2026 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-2210, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b

The Department staff who did the on-site verification:
Michelle Mcglon, 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 J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Quail Park of Lynnwood
Provider Type: Assisted Living Facility

License/Cert.#: 2700
Intake ID: 203224
Compliance Determination #: 69846
Region/Unit #: RCS Region 2 / Unit J
Investigator: Michelle Mcglon
Investigation Date(s): 12/09/2025 through 01/12/2026
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) had a significant weight loss while at the Assisted Living Facility (ALF).
2. The ALF were crushing the NR's medications without consent from the POA.
3. The ALF were charging the NR for care and services; they were not provided.
4. The ALF required 1:1 care giver for the NR at the family's expense.
5. The NR was physically aggressive with residents at the ALF.
6. The NR had lost items at the ALF.

Investigation Methods:

Sample:	Total residents: 120 Resident sample size: 1 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Executive Director
Record Reviews:	State reporting log Resident Records

Investigation Summary:

1. Interview and record review showed that the ALF monitored the NR's weight. Record review showed the NR ate meals and had less than one percent weight loss in the last 90 days. In an interview, staff reported that the NR did eat meals but occasionally refused. No failed practice identified.
2. Interview and record review showed the ALF failed to have a system in place to promote safe medications administration. In an interview, a licensed practical nurse stated that the medication technician would dispense and crush medication, that the nurse administered. Record review of the NR's medication administration record showed the ALF's nurses had not documented administering the NR's medications.

See Statement of Deficiency 388-78A-2210 (1)(a)(b)(2)(a)(b), dated 01/06/2026.
3. Interview and record review showed that the NR refused care and services provided by the ALF staff. In an interview, the HWC stated that the NR refused all care. Record review showed that the NR frequently refused care. Record review showed the ALF staff were reapproaching the NR to provide care and the resident continued to refuse. Record review of a physician's evaluation showed that the NR refused care, and the NR's family were provided with options to ensure the resident received care. No failed practice identified.
4. Interview and record review showed that due to the NR's physical aggression towards other residents. In an interview, the HWC stated that the NR required 1:1 care that the ALF could not provide. The NR no longer resides at the ALF. No failed practice identified.
5. Interview and record review showed the ALF staff separated NR from other residents with physical aggression. Interview and record review showed the ALF staff made all the appropriate notifications, including a call to law enforcement. The ALF staff put interventions in place to keep residents safe, including 1:1 caregiver for the NR. The NR has moved to a higher level of care. No failed practice identified.
6. Interview and record review, the Executive Director(ED) stated that she had not received any reports that the NR had missing items. The ED stated that the unit had a dedicated laundry staff that keeps all personal items separated. The ED stated that personal items of value, such as jewelry or phones, an incident report would be created and reported to the Department for investigation. The ED stated that linens and towels are replaced by the ALF, if reported missing. The ED stated that due to the residents' cognitive impairment, the ALF could not guarantee items would not be missing. The ED stated that family representatives were encouraged to label all of the residents' personal belongings and clothing with name and room number. No failed practice identified.

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
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2700	Compliance Determination # 69846
Plan of Correction	Quail Park of Lynnwood	Completion Date
Page 1 of 4	Licensee: LC Lynnwood Operator LLC	01/12/2026

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 12/19/2025 and 12/09/2025 of:

Quail Park of Lynnwood
4015 164th St SW
Lynnwood, WA 98087

This document references the following complaint number(s): 203224, 202646

The following sample was selected for review during the unannounced on-site visit: 1 of 120 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2700	Compliance Determination # 69846
Plan of Correction	Quail Park of Lynnwood	Completion Date
Page 2 of 4	Licensee: LC Lynnwood Operator LLC	01/12/2026

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.

Jessica Singer — Residential Care Services — 1/12/2026 — 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.

Marian Sayler — Administrator (or Representative) — 1/19/2026 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 facilty will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems that support and promote safe medication services, when the person dispensing and crushing medications for 1 of 1 sampled residents (Resident 1) was not the same as the person administering the medication, there was no nurse delegation in place for unlicensed staff to administer medications, and there was no licensed staff in the building as least one day a week. This resulted in Resident 1 not having qualified staff available to administer medications and placed him at risk of medication error when the five medication rights were not followed.

Findings included...

NOTE: Washington Administrative Code 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. (2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include: (b) Nurse delegation, if provided; (c) Initial and on-going assessments of the nursing needs of each resident; (3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to: (a) Chapter 18.79 RCW, Nursing care; (b) Chapter 18.88A RCW, Nursing assistants; (c) Chapter 246-840 WAC, Practical and registered nursing; (d) Chapter 246-841 WAC, Nursing assistants; and (e) Chapter 246-888 WAC, Medication assistance.

Record review of the ALF's undated policy, "Medication Services", showed the purpose was to provide safe assistance with medications to residents, to provide guidance to the staff for medication services, and to provide consistency in the style of medication delivery system. The policy showed the current Medication Administration Record must be present and read prior to assisting with medications. Prior to medication assistance, the five "rights" will be reviewed: the right resident, the right medication, the right dose, the right route, and the right time. Each medication must be given to the resident directly from the bubble pack, or medication container to ensure the five rights were being followed.

Record review of an Assessment, dated 11/11/2025, showed the ALF admitted Resident 1 on [redacted]20241 with multiple medical diagnoses, including [redacted]. Symptoms eventually grow severe enough to interfere with daily tasks). Record review showed that Resident 1 received medication administration.

Record review of a signed Physician's Order, dated 06/05/2025, showed the ALF staff were to administer Resident 1's medications crushed and in applesauce. Review of Resident 1's December 2025's Medication Administration Record (MAR) showed the resident had medications ordered to be given seven days a week.

Record review, from 06/05/2025 through 11/11/2025, showed Resident 1 did not have Nurse Delegation (ND) (when a registered nurse (RN) transfers responsibility for a specific skilled task to a competent, qualified team member, such as an unlicensed person, while the RN retains overall accountability for the resident's outcome) in place to allow nursing assistance or medication technicians (MT) to administer medications. An ND consent form was signed by Resident 1's representative, however no Registered Nurse Delegator completed an assessment, evaluation or delegation visit. Records showed Resident 1 had no ND in place to allow MT's to dispense, crush or administer

medication.

Record review of a Temporary Service Plan (TSP), dated 11/21/2025, showed only an ALF nurse would administer all medications to Resident 1 because there was no delegation in place and a physician's order to crush and administer them.

Review of the June through December 2025 MARS showed none of the medications documented as given were signed by Staff B(License Practical Nurse). The MARS showed only MTs had administered Resident 1's medications.

In an interview, on 12/19/2025 at 1:10 PM, Staff B when asked how they were administering Resident 1's crushed medications. Staff B stated that she had the MTs dispense, crush, and initial as administering Resident 1's medications, and then hand them off to her to administer. Staff B could not confirm she knew the medications she was administering to Resident 1 were the correct medication or dose and did not follow the five rights of medication administration.

In an interview, on 01/02/2026 at 9:00 AM, Staff A (Executive Director) stated the ALF only had a nurse in the building six days a week. Staff A stated that they knew Resident 1 had the known behavior of refusing medications if he was offered them. Staff A stated the ALF accepted Resident 1's refusals when they did not have staff qualified to administer medications. Staff A confirmed that ND was not in place for Resident 1. Staff A confirmed that the ALF was not in compliance with regulations in there medication management for Resident 1.

This deficiency was previously cited on 07/11/2025.

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, Quail Park of Lynnwood is or will be in compliance with this law and / or regulation on (Date) 2/2/2026

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

Marian Saula — Administrator (or Representative)

1/19/2026 — Date