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

07/22/2026

Lynnwood ALC LLC
Cottages of Lynnwood
18625 60th Ave W
Lynnwood, WA 98037

RE: Cottages of Lynnwood # 2764

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 80901 (Completion Date 07/22/2026) and 77342 (Completion Date 05/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/22/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

(b) Together for each resident and physically separated from other residents' medications;

(c) Separate from food or toxic chemicals;

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

(e) In environments recommended on the medication label.

The Department staff who did the On Site verification:

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

Hayley Pinkham, ALF Licensor

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

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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

Statement of Deficiencies	License #: 2764	Compliance Determination #77342
Plan of Correction	Cottages of Lynnwood	Completion Date
Page 1 of 3	Licensee: Lynnwood ALC LLC	05/28/2026

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 follow-up on 05/13/2026 of:
Cottages of Lynnwood
18625 60th Ave W
Lynnwood, WA 98037

This document references the following SOD dated: 05/28/2026

The following sample was selected for review during the unannounced on-site visit: 2 of 34 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

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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Statement of Deficiencies	License #: 2764	Compliance Determination # 77342
Plan of Correction	Cottages of Lynnwood	Completion Date
Page 2 of 3	Licensee: Lynnwood ALC LLC	05/28/2026

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.

Jamie Singer
Residential Care Services

06/08/2026
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.

Mari Harrell
Administrator (or Representative)

6/12/2026
Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

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(c) Separate from food or toxic chemicals;

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

(e) In environments recommended on the medication label.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to maintain safe storage of medications in 1 of 4 cottages (Fir Cottage). This placed 11 residents, in a cottage designated to memory care, at risk of harm from access to pharmaceuticals.

Findings included...

Review of the facility's undated Resident Characteristics Roster showed 11 residents resided in Fir Cottage. The roster showed all 11 of the residents had cognitive impairment and behavioral or psychosocial issues.

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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.

Jamie Singer
Residential Care Services

06/08/2026
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)

Date

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Statement of Deficiencies	License # 2764	Compliance Determination # 77342
Plan of Correction	Cottages of Lynnwood	Completion Date
Page 3 of 3	Licensee: Lynnwood ALC LLC	05/28/2026

Findings included...

Observation: on 05/13/2026 at 2:39 PM, the entrance to Fir Cottage and its common room area showed residents freely moving about the ALF via wheelchairs or independent ambulation. Observation showed the ALF maintained one locking medication cart for storage of residents' prescribed medications. The medication cart was housed in an alcove off the main common area. At 3:11 PM, the medication cart was left unsupervised and observed to be unlocked. Observation showed the cart contained multiple prescription drug storage drawers full of medications.

In interview, on 05/13/2026 at 3:13 PM, Staff B (Medication Technician) confirmed the medication cart was left unlocked and unsupervised. Staff B stated she should have ensured it was locked. Staff B stated, "we work with people that have memory loss, so it's possible they [the residents] can get into anything".

In interview, on 05/27/2026 at 2:21 PM, Staff A (Administrator) stated "absolutely" the medication cart should be locked when someone is not always standing by it. Staff A stated, "anybody could get in there".

This deficiency is uncorrected previously cited on 03/24/2026 and in accord with the global settlement, dated 09/22/2025, this is a recurring citation previously cited on 03/14/2026 and 05/06/2025.

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, Cottages of Lynnwood is or will be in compliance with this law and / or regulation on (Date) 7/12/2026

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

Administrator (or Representative) — Date: 6/12/2026

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

Findings included...

Observation, on 05/13/2026 at 2:39 PM, the entrance to Fir Cottage and its common room area showed residents freely moving about the ALF via wheelchairs or independent ambulation. Observation showed the ALF maintained one locking medication cart for storage of residents' prescribed medications. The medication cart was housed in an alcove off the main common area. At 3:11 PM, the medication cart was left unsupervised and observed to be unlocked. Observation showed the cart contained multiple prescription drug storage drawers full of medications.

In interview, on 05/13/2026 at 3:13 PM, Staff B (Medication Technician) confirmed the medication cart was left unlocked and unsupervised. Staff B stated she should have ensured it was locked. Staff B stated, "we work with people that have memory loss, so it's possible they [the residents] can get into anything".

In interview, on 05/27/2026 at 2:21 PM, Staff A (Administrator) stated "absolutely" the medication cart should be locked when someone is not always standing by it. Staff A stated, "anybody could get in there".

This deficiency is uncorrected previously cited on 03/24/2026 and in accord with the global settlement, dated 09/22/2025, this is a recurring citation previously cited on 03/14/2025 and 05/06/2025.

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_____ _____

Administrator (or Representative) Date

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Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Lynnwood
Provider Type: Assisted Living Facility
License/Cert.#: 2764
Compliance Determination #: 73835
Intake ID: 214796
Investigator: Hayley Pinkham
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 03/04/2026 through 03/24/2026
Complainant Contact Date(s): 03/24/2026

Allegation(s):

1) The Assisted Living Facility (ALF) did not notify the Named Residents' (NR) family members (FM) in a timely manner of the NRs' severe illness prior to hospitalization.
2) An ALF staff member (SM) texted the FM a message asking if the NR is "still yelling for help," while the NR was in the hospital.
3) The FM discovered the NR was missing "valuable items" from the NRs apartment.

Investigation Methods:

Sample:	Total residents: 27 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members
Record Reviews:	Medical records Hospital records

Investigation Summary:

1) The NR no longer resides at the ALF. Interview and observation with sampled residents showed no voiced concerns with care services and/or safety. Interview and record review showed the NR was at their baseline medical condition prior to requiring emergency transfer to the hospital. Interview and record review showed the FM were notified of the NR's need for emergency services. No findings of deficient practice.
2) Interview showed that the text message was in reference to the NR's known behavior after consuming meals and was not sent with willful ill intent. No findings of deficient practice.
3) Interview and record review showed the ALF staff were notified of the missing "valuable items" when it was reported, and staff conducted an immediate room and

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cottage search for reported missing items. Interview showed the ALF staff requested specific descriptions of the missing items from the FM, and the facility had not received the information at the time of the investigation. Observation showed there is an available locking cabinet in the NRs' bathroom. Interview showed there was no inventory provided for the missing items. No findings of deficient practice.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

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

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The department completed data collection for an unannounced on-site complaint investigation on 03/04/2026 of:

Cottages of Lynnwood
18625 60th Ave W
Lynnwood, WA 98037

This document references the following complaint number(s): 214796

The following sample was selected for review during the unannounced on-site visit: 3 of 27 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

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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Statement of Deficiencies	License #: 2764	Compliance Determination # 73835
Plan of Correction	Cottages of Lynnwood	Completion Date
Page 2 of 3	Licensee: Lynnwood ALC LLC	03/24/2026

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.

Jamie Singer
Residential Care Services

04/03/2026
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)

4/6/26
Date

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(e) In environments recommended on the medication label.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure medications were securely stored in 1 of 4 cottages (Fir Cottage). This failure placed 10 residents with cognitive loss at risk for serious health complications if un-locked medications were to be ingested.

Findings included...

Record review of an undated Resident Characteristic Roster, showed that the Fir Cottage neighborhood had 10 residents identified with cognitive diagnoses.

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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.

Jamie Singer
Residential Care Services

04/03/2026
Date

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Administrator (or Representative)

Date

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Record review of an undated Resident Characteristic Roster, showed that the Fir Cottage neighborhood had 10 residents identified with cognitive diagnoses.

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Statement of Deficiencies	License #: 2764	Compliance Determination # 73835
Plan of Correction	Cottages of Lynnwood	Completion Date
Page 3 of 3	Licensee: Lynnwood ALC LLC	03/24/2026

An observation, on 03/04/2026 at 1:38 PM, with Staff B (Medication Technician) showed a cabinet located above a medication cart in a resident used hallway of Fir Cottage was unlocked and contained several medication cards. The medication cards, that were accessible to residents, contained the following medications: Haldol (a psychotropic medication-used to treat psychotic disorders), quetiapine (a psychotropic medication-used to treat psychotic behaviors) amlodipine (a calcium channel blocker-used to treat high blood pressure) gabapentin (an anticonvulsant-used to treat partial seizures and nerve pain), Lexapro (an antidepressant-used to treat major depressive disorder and generalized anxiety), Narcan nasal spray (emergency treatment designed to rapidly reverse known or suspected opioid overdoses) and several various containers of over the counter medications. Also found in the unlocked cabinet was a used sharps container (a specialized, puncture-resistant, red plastic container-used to safely store used needles, syringes, lancets, and other sharps).

In an interview, on 03/04/2026 at 1:38 PM, Staff B stated, "why is it unlocked, it was supposed to be locked." Staff B confirmed that resident medications should always be locked up, in the medication cart or a cabinet.

In an interview, on 03/03/2026 at 1:48 PM, Staff A (Executive Director) stated the cabinets should be locked and Staff A confirmed that unlocked medications were not safe.

In accord with the global settlement with Pacifica Senior Living Lynnwood #2371, dated 09/22/2025, this is a recurring citation previously cited on 03/14/2025 and 05/06/2025.

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, Cottages of Lynnwood is or will be in compliance with this law and / or regulation on (Date)__ 5/8/2026 __. 5/8/2026

SB confirmed amended POC date with Provider on 4/8/2026.

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

Aloha Cartwright — Administrator (or Representative)

4/6/26 — Date

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In an interview, on 03/04/2026 at 1:38 PM, Staff B stated, “why is it unlocked, it was supposed to be locked.” Staff B confirmed that resident medications should always be locked up, in the medication cart or a cabinet.

In an interview, on 03/03/2025 at 1:48 PM, Staff A (Executive Director) stated the cabinets should be locked and Staff A confirmed that unlocked medications were not safe.

In accord with the global settlement with Pacifica Senior Living Lynnwood #2371, dated 09/22/2025, this is a recurring citation previously cited on 03/14/2025 and 05/06/2025.

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