STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

MADISON AVENUE LIMITED PARTNERSHIP
MADISON AVENUE RETIREMENT CENTER
285 MADISON AVE S
BAINBRIDGE ISLAND, WA 98110

RE: MADISON AVENUE RETIREMENT CENTER License # 922

Dear Administrator:

This letter addresses Compliance Determination(s) 78588 (Completion Date 06/05/2026) and 72741 (Completion Date 04/08/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/05/2026 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-2310-2, WAC 388-78A-2310-2-f

The Department staff who did the on-site verification:
Shelley Neeleman, ALF Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: MADISON AVENUE RETIREMENT CENTER
License/Cert.#: 922
Compliance Determination #: 72741
Investigator: Shelley Neeleman
Investigation Date(s): 02/10/2026 through 04/08/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 211449
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

Unqualified Personnel:
1) The facility did not provide nurse delegation services to residents in their Memory Care Unit.
2) The facility used “Med Techs” to administer medications without properly being delegated by an RN.
3) The facility was told that nurse delegation was not required for their memory care unit.

Investigation Methods:

Sample:
Total residents: 32
Resident sample size: 3
Closed records sample size:

Observations:
General environment
Residents
Resident Rooms
Staff
Staffing levels
Resident to Resident interactions
Staff to Resident interactions

Interviews:
Staff
Residents

Record Reviews:
Resident Characteristic Roster
Face Sheets
Service Plans
Charting Notes
Nurse Delegation Client List
Bainbridge Senior Living Nurse Delegation Policy and Procedure (no date provided)
Nurse Delegation: Consent for Delegation Process
Nurse Delegation: Nursing Visit
Nurse Delegation: Instruction for Nursing Task
Physicians Orders
Email from Executive Director, dated 03/24/2026 at 12:04 p.

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Investigation Summary:

1) Based on interviews and record review, the facility does not have a Memory Care Unit, and currently has three residents receiving Nurse Delegation services.
Unable to substantiate the allegation or identify failed practice.
2) The Executive Director (ED) stated that Resident 1 (R1) had a stroke (a lack of blood supply to the brain) and was unable to self-administer medications. The ED stated that R1 requested medications in applesauce and that staff spooned the medications into R1's mouth. The ED stated that Resident 2 (R2) was physically able to take medications received by staff, but has requested that staff put the medications in applesauce and spoon the medications into R2's mouth.
The Resident Care Coordinator (RCC) stated that all residents were aware of the medications received. The RCC stated that R1 required staff to put the medications in applesauce and then spoon the medications into their mouth.
R1 stated that staff placed their medications in applesauce, and then put the medications on a spoon and into R1's mouth.
Based on observations, interviews and record review, R1 was found to be unable to self-administer their medications and did not receive nurse delegation services.
The facility failed to meet the regulatory requirements outlined in WAC 388-78A-2310(2)(f) – Intermittent nursing services. Citation issued.
3) Based on interviews and record review, there was no indication that facility staff received misinformation related to nurse delegation services.
Unable to substantiate the allegation or identify failed practice on the part of the facility.

Conclusion / Action:

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

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PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 922	Compliance Determination # 72741
Plan of Correction	MADISON AVENUE RETIREMENT CENTER	Completion Date
Page 1 of 4	Licensee: MADISON AVENUE LIMITED PARTNERSHIP	04/08/2026

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 02/10/2026 and 04/08/2026 of:

MADISON AVENUE RETIREMENT CENTER
285 MADISON AVENUE SOUTH
BAINBRIDGE ISLAND, WA 98110

This document references the following complaint number(s): 211449

The following sample was selected for review during the unannounced on-site visit: 3 of 32 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Shelley Neeleman, ALF Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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.

Laurie Anderson
Residential Care Services

04/14/2026
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.

Kri Denoon
Administrator (or Representative)

4/20/26
Date

WAC 388-78A-2310 Intermittent nursing services.

(2) The assisted living facility may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facilty may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law.

(f) Nurse delegation consistent with chapter 18.79 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 2 sampled residents (Resident 1 [R1] and Resident 2 [R2]) received medication administration assistance from delegated staff. This failure placed R1 and R2 at risk of receiving care and services from untrained staff.

Findings included...

Review of RCW 18.79.260(3)(a)(i)(ii)(iii)(iv) Registered nurse—Activities allowed—Delegation of tasks, (Effective until June 30, 2027.), showed "(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient. (a) The delegating nurse shall: (i) Determine the competency of the individual to perform the tasks; (ii) Evaluate the appropriateness of the delegation; (iii) Supervise the actions of the person performing the delegated task; and (iv) Delegate only those tasks that are within the registered nurse's scope of practice".

Review of WAC 246-945-714(1)(d) Medication assistance by nonpractitioners, showed "(1) An individual may receive medication assistance from nonpractitioners. Medication assistance only includes: (d) Using an enabler, except if a nonpractitioner uses the individual's hand as an enabler, the nonpractitioner may only steady or guide an individual's hand while the individual administers a medication to themselves and may

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Residential Care Services _____ 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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not engage in “hand-over-hand” administration.”

Review of WAC 246-945-718(3) Medication assistance—Restrictions, showed “(3) If an individual is not able to administer a medication to themselves independently or with assistance, then the medication must be administered to the individual by a person legally authorized to do so.”

Record review of the facility’s undated policy titled, “Bainbridge Senior Living Nurse Delegation Policy and Procedure”, showed that the facility shall adhere to the Department of Health Nurse Delegation Law. Procedures were developed and designed to meet state requirements and were to be individualized to the resident requiring/requesting assistance. These Job Tasks/Procedures were written to meet Best Practices and industry Standards of Care. These direction/instructions were then to be individualized based on physician orders, resident needs and preferences.

Record review of email dated 03/24/2026 at 12:04 p.m., from Staff A, Executive Director, showed that there were currently two residents who took medications with applesauce. The email showed that R1 was aware they received their medications in applesauce and that staff spooned the medications into R1’s mouth due to left arm weakness following a stroke (a lack of blood supply to the brain). The email showed that R2 was aware they received their medications in applesauce and that staff spooned the medications into R2’s mouth. The email showed that R2 requested staff assistance to take their medications, although R2 was able to take medications independently.

Record review of the facility’s nurse delegation records showed no documentation that any staff were delegated to provide medication administration for R1 and R2.

During an interview on 03/30/2026 at 2:22 p.m., R1 stated that staff put the pills in applesauce and then put the pills into R1’s mouth.

During an interview on 03/30/2026 at 3:04 p.m., Staff B (Resident Care Coordinator) stated that R1 required staff to put medications in R1’s mouth with applesauce. Staff B stated that R1 did not receive nurse delegation services.

During an interview on 04/02/2026 at 1:18 p.m., Staff A stated that R1 was unable to self-administer medications and requested that medications be administered in applesauce.

During an interview on 04/02/2026 at 1:18 p.m., Staff A stated that R2 was able to independently take medications, but requested that staff put medications in applesauce and spoon it into their mouth.

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Statement of Deficiencies	License #: 922	Compliance Determination # 72741
Plan of Correction	MADISON AVENUE RETIREMENT CENTER	Completion Date
Page 4 of 4	Licensee: MADISON AVENUE LIMITED PARTNERSHIP	04/08/2026

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, MADISON AVENUE RETIREMENT CENTER is or will be in compliance with this law and / or regulation on (Date) 4/20/26 .

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

Kri Duncan
Administrator (or Representative)

4/20/26
Date

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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, MADISON AVENUE RETIREMENT CENTER 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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