STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
***20311 52nd Ave W, Suite 100, Lynnwood, WA 98036***

Elder Palcements, Inc
NORWAY HILL AFH
10127 NE 60th St
Kirkland, WA 98033

RE: NORWAY HILL AFH License # 612300

Dear Provider:

This letter addresses Compliance Determination(s) 69741 (Completion Date 12/08/2025) and 67445 (Completion Date 10/24/2025).

The Department completed a follow-up inspection of your Adult Family Home on 12/08/2025 and found that you have corrected the violations listed in the Full report dated 10/24/2025. Your home is back in compliance as of 11/30/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10430-2-c, WAC 388-76-10198-4, WAC 388-76-10146-2-e, WAC 388-76-10146-3, WAC 388-76-10146-3-a, WAC 388-76-10320-10, WAC 388-76-10320-10-a, WAC 388-76-10320-10-b

The Department staff who did the on-site verification:
Chrissy Exe, Long-Term Care Licensor

If you have any questions, please contact me at (206)914-5042.

Sincerely,

Renee' Bourque

Renee Bourque, Field Manager
Region 2, Unit I
Residential Care Services

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 #: 612300 | Compliance Determination #67445 |
|---|---|---|
| Plan of Correction | NORWAY HILL AFH | Completion Date |
| Page 1 of 7 | Licensee: Elder Palcements, Inc | 10/24/2025 |

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for the unannounced on-site full inspection on 10/20/2025 of:
NORWAY HILL AFH
16721 107TH PLACE NE
BOTHELL, WA 98011

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Chrissy Exe, Long-Term Care Licensor

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

| Statement of Deficiencies | License #: 612300 | Compliance Determination #:67445 |
|---|---|---|
| Plan of Correction | NORWAY HILL AFH | Completion Date |
| Page 2 of 7 | Licensee: Elder Placements, Inc | 10/24/2025 |

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.

Renee' Bourque — Residential Care Services

10/28/2025 — Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Ben Stevens — Provider (or Representative)

10.30.2025 — Date

**WAC 388-76-10430 Medication system.**

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(c) Medication log is kept current as required in WAC 388-76-10475 ;

**This requirement was not met as evidenced by:**

Based on record review, observation, and interview, the Adult Family Home (AFH) failed to ensure the medication logs (ML) were accurate and up-to-date for 2 of 2 sampled residents (Residents 1 and 2). This failure placed Residents 1 and 2 at risk of experiencing medication errors.

Findings included...

<Resident 1>

Record review of Resident 1's records showed the AFH admitted Resident 1 on [redacted]2023. Further review showed Resident 1 was prescribed multiple medications.

Record review of Resident 1's October 2025 ML showed an entry for cholecalciferol (vitamin D3, a dietary supplement) 25 micrograms (mcg) with instructions which read, "1 tab (tablet) PO (consumed orally) QD (once a day)." Further review showed an entry for calcium antacid (used to treat heartburn) 200 milligram (mg) PRN (taken as needed) with instructions which read, "1 tab PO QD."

Observation, on 10/20/2025 at 1:25 ML, of Resident 1's medication supply, showed a

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.

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Residential Care Services

10/28/2025
Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative)

Date

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Findings included...

<Resident 1>

Record review of Resident 1's records showed the AFH admitted Resident 1 on [redacted]/2023. Further review showed Resident 1 was prescribed multiple medications.

Record review of Resident 1's October 2025 ML showed an entry for cholecalciferol (vitamin D3, a dietary supplement) 25 micrograms (mcg) with instructions which read, "1 tab (tablet) PO (consumed orally) QD (once a day)." Further review showed an entry for calcium antacid (used to treat heartburn) 200 milligram (mg) PRN (taken as needed) with instructions which read, "1 tab PO QD."

Observation, on 10/20/2025 at 1:25 ML, of Resident 1's medication supply, showed a

bingo pack (pharmacy packaging that organizes a medication into multiple doses) for vitamin D3 25 mcg with instructions which read, "take 2 tablets by mouth once daily every morning." Further observation showed no calcium antacid in Resident 1's medication supply.

In an interview, on 10/20/2025 at 1:30 PM, Staff A, Entity Representative, stated that Resident 1's vitamin D3 prescription was increased from one tablet daily to two tablets daily on 9/10/2025. Observation showed Staff A corrected the entry for vitamin D3 on Resident 1's October 2025 ML. Staff A stated that the pharmacy stated that calcium antacid 200 mg is not commonly available over the counter. Staff A stated that they ordered the calcium antacid 200 mg from the pharmacy.

<Resident 2>

Record review of Resident 2's records showed the AFH admitted Resident 2 on [redacted]2025. Further review showed Resident 2 was prescribed multiple medications.

Record review of Resident 2's October 2025 ML showed an entry for melatonin (used to regulate sleep) 5 mg tablets with instructions which read, "1 tab PO QHS (at bedtime)."

Observation, on 10/20/2025 at 1:44 PM, of Resident 2's medication supply, showed a bingo pack of melatonin 3 mg tablets with instructions which read, "take 1 tablet by mouth at bedtime."

In an interview, on 10/20/2025 at 2:21 PM, Staff B, Caregiver, stated that the melatonin prescription was changed from 3 mg to 5 mg. Staff B said that the staff have been providing Resident 2 with one 3 mg tablet and one half of a 3 mg tablet. Staff B said that the melatonin 5 mg tablets have been ordered from the pharmacy.

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, NORWAY HILL AFH is or will be in compliance with this law and / or regulation on (Date) 10.29.2025.

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

Ben Sfuciue — Provider (or Representative)

10.30.2025 — Date

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In an interview, on 10/20/2025 at 1:30 PM, Staff A, Entity Representative, stated that Resident 1's vitamin D3 prescription was increased from one tablet daily to two tablets daily on 01/10/2025 . Observation showed Staff A corrected the entry for vitamin D3 on Resident 1's October 2025 ML. Staff A stated that the pharmacy stated that calcium antacid 200 mg is not commonly available over the counter. Staff A stated that they ordered the calcium antacid 200 mg from the pharmacy.

<Resident 2>

Record review of Resident 2's records showed the AFH admitted Resident 2 on [redacted]/2025. Further review showed Resident 2 was prescribed multiple medications.

Record review of Resident 2's October 2025 ML showed an entry for melatonin (used to regulate sleep) 5 mg tablets with instructions which read, "1 tab PO QHS (at bedtime)."

Observation, on 10/20/2025 at 1:44 PM, of Resident 2's medication supply, showed a bingo pack of melatonin 3 mg tablets with instructions which read, "take 1 tablet by mouth at bedtime."

In an interview, on 10/20/2025 at 2:21 PM, Staff B, Caregiver, stated that the melatonin prescription was changed from 3 mg to 5 mg. Staff B said that the staff have been providing Resident 2 with one 3 mg tablet and one half of a 3 mg tablet. Staff B said that the melatonin 5 mg tablets have been ordered from the pharmacy.

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, NORWAY HILL AFH 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.

_____ _____
Provider (or Representative) Date

**WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:**

(4) Criminal history disclosure and background check results as required.

**This requirement was not met as evidenced by:**

Based on record review and interview, the Adult Family Home (AFH) failed to ensure a national fingerprint background check was kept in the personnel records and readily available for 1 of 4 current staff (Staff B, caregiver). This failure delayed the verification of staff background screening and placed Residents 1, 2, 3, and 4 at risk of receiving care from someone with an unknown background.

Findings included...

Record review of the AFHs personnel records showed the AFH hired Staff B on 05/08/2019. Further review showed no evidence a national fingerprint background check had been completed for Staff B.

In an email, received by the Department on 10/21/2025 at 4:19 PM, Staff A, Entity Representative, provided a copy of the fingerprint background check appointment letter for Staff B. Review of this letter showed Staff B's fingerprint appointment was scheduled for 05/21/2019.

In an telephonic interview, on 10/23/2025 at 9:35 AM, Staff A stated that Staff B contacted the Background Check Unit and was informed the fingerprint check would be emailed to them on 10/23/2025.

In an email, received by the Department on 10/23/2025 at 4:19 PM, Staff A stated that Staff B did not receive any further contact from the Background Check Unit. Staff A stated that they would assist Staff B with completing the national fingerprint background check.

| Statement of Deficiencies | License #: 612300 | Compliance Determination #:67445 |
|---|---|---|
| Plan of Correction | NORWAY HILL AFH | Completion Date |
| Page 5 of 7 | Licensee: Elder Palcements, Inc | 10/24/2025 |

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, NORWAY HILL AFH is or will be in compliance with this law and / or regulation on (Date) 11.30.2025.

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

Ben Stevens — Provider (or Representative)

10.30.2025 — Date

**WAC 388-76-10146 Qualifications Training and home care aide certification.**

(2) The adult family home must ensure all adult family home caregivers, entity representatives, and resident managers hired on or after January 7, 2012, meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

(3) All persons listed in subsection (2) of this section, must obtain the home-care aide certification if required by this section or chapters 246-980 or 388-112A WAC.

(a) Until March 1, 2016, a provisional home-care aide certification may be issued by the department of health to a long-term care worker who is limited English proficient.

**This requirement was not met as evidenced by:**

Based on record review and interview, the Adult Family Home (AFH) failed to ensure home care aide (HCA) certification was obtained within one year of employment for 1 of 2 sampled staff (Staff B, Caregiver). The AFH also failed to ensure Staff B completed 12 hours of continuing education (CE) by their most recent birthday. These failures placed Residents 1, 2, 3, and 4 at risk of receiving care from someone who was not fully qualified.

Findings included...

<HCA certification>

Record review of the AFH's personnel records showed the AFH hired Staff B on 05/09/2019. Further review showed Staff B had a nursing assistant registration (NAR) certificate with an expiration date of 06/20/2026. There was no evidence that Staff B had HCA certification.

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, NORWAY HILL AFH 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.

_____ _____
Provider (or Representative) Date

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**This requirement was not met as evidenced by:**

Based on record review and interview, the Adult Family Home (AFH) failed to ensure home care aide (HCA) certification was obtained within one year of employment for 1 of 2 sampled staff (Staff B, Caregiver). The AFH also failed to ensure Staff B completed 12 hours of continuing education (CE) by their most recent birthday. These failures placed Residents 1, 2, 3, and 4 at risk of receiving care from someone who was not fully qualified.

Findings included…

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Record review of the AFH's personnel records showed the AFH hired Staff B on 05/08/2019. Further review showed Staff B had a nursing assistant registration (NAR) certificate with an expiration date of 06/20/2026. There was no evidence that Staff B had HCA certification.

| Statement of Deficiencies | License #: 612300 | Compliance Determination #:67445 |
|---|---|---|
| Plan of Correction | NORWAY HILL AFH | Completion Date |
| Page 6 of 7 | Licensee: Elder Palcements, Inc | 10/24/2025 |

In an interview, on 10/20/2025 at 3:59 PM, Staff A, Entity Representative, stated that they were not sure if Staff B had obtained HCA certification. At 4:07 PM, Staff B stated that they have not yet taken the HCA examination.

In an email, received by the Department on 10/21/2025 at 2:42 PM, Staff A provided a screenshot of an email to Staff B regarding certified nursing assistant (CNA) courses. Review of the email, dated 08/22/2025, shows Staff B was registered for CNA classes.

In an email, received by the Department on 10/21/2025 at 2:53 PM, Staff A stated that Staff B is currently participating in the CNA classes. Staff A stated that Staff B has not yet been scheduled for the CNA examination.

<CE>

Record review of Staff B's records showed four CE certificates between June 2024 and June 2025. The total amount of CE credits for these certificates was 6 hours. There was no further evidence that Staff B had obtained 6 additional CE credits between June 2024 and June 2025.

In an interview, on 10/20/2025 at 4:06 PM, Staff A stated that they would look for additional CE certificates for Staff B.

In emails, received by the Department on 10/21/2025, Staff A provided CE certificates for Staff B. Record review of these certificates showed Staff B completed a 10-hour CE course on 03/13/2024. Review of the other certificates showed Staff B completed a 1.5-hour CE course and a 4-hour CE course on 10/21/2025.

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, NORWAY HILL AFH is or will be in compliance with this law and / or regulation on (Date) 11.30.2025.

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

Ben Stelcine — Provider (or Representative)

10.30.2025 — Date

**WAC 388-76-10320 Resident record Content. The adult family home must ensure that each resident record contains, at a minimum, the following information:**

In an interview, on 10/20/2025 at 3:59 PM, Staff A, Entity Representative, stated that they were not sure if Staff B had obtained HCA certification. At 4:07 PM, Staff B stated that they have not yet taken the HCA examination.

In an email, received by the Department on 10/21/2025 at 2:42 PM, Staff A provided a screenshot of an email to Staff B regarding certified nursing assistant (CNA) courses. Review of the email, dated 08/22/2025, shows Staff B was registered for CNA classes.

In an email, received by the Department on 10/21/2025 at 2:53 PM, Staff A stated that Staff B is currently participating in the CNA classes. Staff A stated that Staff B has not yet been scheduled for the CNA examination.

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Record review of Staff B's records showed four CE certificates between June 2024 and June 2025. The total amount of CE credits for these certificates was 6 hours. There was no further evidence that Staff B had obtained 6 additional CE credits between June 2024 and June 2025.

In an interview, on 10/20/2025 at 4:06 PM, Staff A stated that they would look for additional CE certificates for Staff B.

In emails, received by the Department on 10/21/2025, Staff A provided CE certificates for Staff B. Record review of these certificates showed Staff B completed a 10-hour CE course on 03/13/2024. Review of the other certificates showed Staff B completed a 1.5-hour CE course and a 4-hour CE course on 10/21/2025.

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, NORWAY HILL AFH 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.

_____ _____
Provider (or Representative) Date

**WAC 388-76-10320 Resident record Content. The adult family home must ensure that each resident record contains, at a minimum, the following information:**

| Statement of Deficiencies | License #: 612300 | Compliance Determination # 67445 |
|---|---|---|
| Plan of Correction | NORWAY HILL AFH | Completion Date |
| Page 7 of 7 | Licensee: Elder Palcements, Inc | 10/24/2025 |

(10) A current inventory of the resident's personal belongings dated and signed by:

(a) The resident, and

(b) The adult family home.

**This requirement was not met as evidenced by:**

Based on record review and interview, the Adult Family Home (AFH) failed to ensure an Inventory of Personal Belongings (IPB) form was completed for 1 of 2 sampled residents (Resident 1). This failure placed Resident 1 at risk of experiencing lost, stolen, or misplaced property.

Findings included...

Record review of Resident 1's records showed the AFH admitted Resident 1 on [redacted]/2023. Further review showed no IPB form in Resident 1's records.

In an interview, on 10/20/2025 at 11:10 AM, Staff A, Entity Representative, stated that an IPB form was created for Resident 1 at the time of their admission. Staff A stated that they would look for the IPB form.

In an email, received by the Department on 10/21/2025 at 12:01 PM, Staff A stated that they were unable to locate Resident 1's IPB form. Staff A stated that they would create a new IPB form and have Resident 1's representative to review, sign, and date the form.

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, NORWAY HILL AFH is or will be in compliance with this law and / or regulation on (Date) 11.30.2025.

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

Ben Sheline — Provider (or Representative)

10.30.2025 — Date

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Findings included…

Record review of Resident 1's records showed the AFH admitted Resident 1 on [redacted]/2023. Further review showed no IPB form in Resident 1's records.

In an interview, on 10/20/2025 at 11:10 AM, Staff A, Entity Representative, stated that an IPB form was created for Resident 1 at the time of their admission. Staff A stated that they would look for the IPB form.

In an email, received by the Department on 10/21/2025 at 12:01 PM, Staff A stated that they were unable to locate Resident 1's IPB form. Staff A stated that they would create a new IPB form and have Resident 1's representative to review, sign, and date the form.

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, NORWAY HILL AFH 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.

_____ _____

Provider (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
***20311 52nd Ave W, Suite 100, Lynnwood, WA 98036***

10/28/2025

Elder Palcements, Inc
NORWAY HILL AFH
10127 NE 60th St
Kirkland, WA 98033

RE: NORWAY HILL AFH # 612300

Dear Provider:

The Department completed a full inspection of your Adult Family Home on 10/24/2025 and found that your home does not meet the Adult Family Home Licensing 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 the home 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:

Renee Bourque, Field Manager
Residential Care Services
Region 2, Unit I
Preferred methods:

eFax: (206) 971-6791
Email: rcsregion2email@dshs.wa.gov
Optional method:
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• 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 388-76-10810 Fire extinguishers.**

(2) The home must ensure fire extinguishers are:

(a) Mounted or securely fastened in a stationary position at a minimum of four inches from the floor and a maximum of sixty inches from the floor;

(b) Inspected and serviced annually;

The Adult Family Home (AFH) failed to ensure the fire extinguisher on the lower level of the home was inspected at least annually. This deficiency was corrected on site at the time of inspection by Staff A, Entity Representative, who mounted a new fire extinguisher on the lower level of the home.

**WAC 388-76-10750 Safety and maintenance. The adult family home must:**

(7) Keep all toxic substances and hazardous materials in locked storage and in their original containers;

The Adult Family Home (AFH) failed to ensure all toxic substances were kept in locked storage. Cleaning supplies were observed in a cupboard utilizing a child lock to secure it. This deficiency was corrected on site at the time of inspection by Staff B, Caregiver, who moved the cleaning supplies to a locked storage area.

**WAC 388-76-10805 Automatic smoke alarms.**

(4) Each smoke alarm must be kept in working condition at all times.

The Adult Family Home (AFH) failed to ensure the smoke detector in bedroom C was in working condition. This deficiency was corrected on site at the time of inspection by Staff A, Entity Representative, who fixed the smoke detector.

**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:**

• Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
• Ask questions and provide written information to help clarify or dispute the deficiencies.

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

**If You Have Any Questions:**

• Please contact me at (206)914-5042.

Sincerely,

Renee' Bourque

Renee Bourque, Field Manager
Region 2, Unit I
Residential Care Services

Enclosure

**Plan**
**(Plan of Correction)**

**You Must:**

Return the plan, on the enclosed report, within 10 calendar days after you receive this letter.

Include the following in your plan for each deficiency:
• The date you have or will correct each deficiency; and
• Provide a signature and date certifying that you have or will take corrective measures to correct each cited deficiency.

Send your plan to:
Renee Bourque, Field Manager
Residential Care Services
Region 2, Unit I
Preferred methods:
eFax: (206) 971-6791
Email: rcsregion2email@dshs.wa.gov
Optional method:
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

**INFORMAL DISPUTE RESOLUTION [RCW 70.128]**

**You May:**

Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an **'IDR Request Form'** for **each** citation or enforcement you plan to dispute. You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

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**Provider Process for Choosing a Panel or Traditional IDR:**

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a **Panel IDR**, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDRs** the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

Send your supporting documents to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225