



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

HALLER LAKE ADULT FAMILY HOME LLC
HALLER LAKE ADULT FAMILY HOME LLC
12018 Densmore Ave N
Seattle, WA 98133

RE: HALLER LAKE ADULT FAMILY HOME LLC License # 757492

Dear Provider:

This letter addresses Compliance Determination(s) 71354 (Completion Date 01/13/2026) and 69657 (Completion Date 12/11/2025).

The Department completed a follow-up inspection of your Adult Family Home on 01/13/2026 and found that you have corrected the violations listed in the Complaint report dated 12/11/2025. Your home is back in compliance as of 12/18/2025 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 388-76-10485-1, WAC 388-76-10485-3

The Department staff who did the on-site verification:
Ywen Dah Liou, AFH Complaint Investigator

If you have any questions, please contact me at (253)234-6033.

Sincerely,

Cecile Leano, Field Manager
Region 2, Unit E
Residential Care Services



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Statement of Deficiencies	License #: 757492	Compliance Determination # 69657
Plan of Correction	HALLER LAKE ADULT FAMILY HOME LLC	Completion Date
Page 1 of 4	Licensee: HALLER LAKE ADULT FAMILY HOME LLC	12/11/2025

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 an unannounced on-site complaint investigation on 12/04/2025 of:

HALLER LAKE ADULT FAMILY HOME LLC
12018 Densmore Ave N
Seattle, WA 98133

This document references the following complaint number(s): 203989

The following sample was selected for review during the unannounced on-site visit: 3 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Ywen Dah Liou, AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit E
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Residential Care Services

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

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

- (1) In locked storage;
- (3) Appropriately for each medication, such as if refrigeration is required for a medication and the medication is kept in refrigerator in locked storage.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to store prescribed and over-the-counter (OTC) medications for 1 of 6 residents (Resident 1) in locked and secured storage. This failure caused possible Resident 1's episode of low blood sugar and passing out, and was sent to the hospital when NR kept their insulin (a crucial hormone made by the pancreas that regulates blood sugar by helping cells absorb it for energy, storing the rest, and balancing fats and proteins) in their room.

Findings included...

Review of Resident 1's assessment dated 09/04/2025, showed Resident 1 can administer medication with AFH caregiver assistance. The assessment documented Resident 1 has limitations of medication administration related to medication management, including "does not record blood sugars and forgets

to take medications.” There was no documentation showing that Resident 1 was assessed as able to keep prescribed and OTC medications in their room.

Review of Resident 1’s Medication Log (ML) and prescription orders in September, October, November, and December 2025, showed Resident 1 prescribed medications included following: Acetaminophen 500 milligram (mg) tablet (for fever and pain relief), Insulin Lispro 100 unit/milliliter (ml) (a rapid-acting insulin used to manage blood sugar levels), and Lantus Solostar 100 unit/ml (a long-acting insulin used to manage high blood sugar levels), and Dextrose Glucose Oral 15 gram (g) (rapidly treat low blood sugar). There was no written order by any healthcare provider that Resident 1 was able to keep prescribed and OTC medications in their room.

Review of the AFH’s record titled “Instruction how to store Insulin” undated, showed the AFH stores unopened insulin in the fridge, keeps unopen insulin between 36 degrees Fahrenheit (F) to 45 degrees F. Opened insulin can stay at room temperature around 59 degrees F and 86 degrees F for approximately 28 days, but the AFH always checks expiration dates and manufacture guidelines.

Observation on 12/04/2025 at 1:30 PM, showed a bottle of Tylenol (a brand name of acetaminophen, used for fever and pain relief) and multiple same unidentified medicine tablets removed from their original container located on the bedside table in Resident 1’s room.

During an interview on 12/04/2025 at 1:35 PM, Resident 1 stated they purchased the bottle of Tylenol and the unidentified medicine tablets over the counter. Resident 1 stated that unidentified multiple medicine tablets were glucose tablets used for treatment of low blood sugar. Resident 1 stated that the bottle of Tylenol was Aspirin (fever and pain relief, inflammation reduction, and blood thinner) that their doctor prescribed it for pain relief.

During an interview on 12/04/2025 at 1:37 PM, Staff A, Provider, stated that they were unaware that Resident 1 had a bottle of Tylenol and unidentified medicine tablets in Resident 1's room.

During an interview on 12/04/2025 at 2:00 PM, Staff A stated that Resident 1 admitted to the AFH on [REDACTED] 2025 and brought multiple injectable insulin pens at the time of admission. Staff A stated that they asked Resident 1 to give the insulin pens to Staff A for appropriate and secure storage. Resident 1 refused to give their insulin pens to Staff A and said they wanted to keep the insulin pens in their room. Resident 1 kept the insulin pens from [REDACTED] /2025 through 12/01/2025.

Review of the AFH incident log dated 12/01/2025, showed that Resident 1 had an incident requiring Emergency Medical Services (EMS) and hospitalization. At approximately 9:30 AM on 12/01/2025, Resident 1 was screaming. Staff A responded and found Resident 1 with eyes wide open and sweating. Resident 1's blood sugar level was 31 milligrams per deciliter (mg/dL). Staff A provided orange juice to Resident 1 and contacted EMS. EMS transported Staff A to the local hospital after stabilizing Resident 1's blood sugar level.

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, HALLER LAKE ADULT FAMILY HOME LLC 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