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

THE SUMMIT AT FIRST HILL

THE SUMMIT AT FIRST HILL
1200 UNIVERSITY ST SUITE 100
SEATTLE, WA 98101

RE: THE SUMMIT AT FIRST HILL License # 1435

Dear Administrator:

This letter addresses Compliance Determination(s) 70353 (Completion Date 12/18/2025) and 68439 (Completion Date 11/25/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/18/2025 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-2100-2-a, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2170-1, WAC 388-78A-2090-2-b, WAC 388-78A-2090-2-c, WAC 388-78A-2090-3

The Department staff who did the on-site verification:
Alma Duran, Licensor
Keiko Kitano, 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

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

Statement of Deficiencies	License #: 1435	Compliance Determination # 68439
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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 the unannounced on-site full inspection on 11/04/2025 and 11/06/2025 of:
THE SUMMIT AT FIRST HILL
1200 UNIVERSITY ST SUITE 100
SEATTLE, WA 98101

The following sample was selected for review during the unannounced on-site visit: 10 of 61 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Keiko Kitano, Licensor
Alma Duran, Licensor

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

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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.

Jeanie Singer
Residential Care Services

11/26/2025
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)

12.5.25
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must: 12.5.25

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure on-going Assessments were updated to include the required topics for 2 of 3 sampled residents (Residents 6 and 7). This placed Residents 6 and 7 at risk of not having their care needs properly addressed and compromised health conditions.

Findings included..

NOTE: Washington Administrative Code (WAC) 388-78A-2090 - Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (1) Individual's recent medical history, including, but not limited to: (2) Currently necessary and contraindicated medications and treatments for the individual, including: (a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her; (6) Significant known behaviors or symptoms of the

individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility. (8) Individual's level of personal care needs, including: (a) Ability to perform activities of daily living; (b) Medication management ability, including: (i) The individual's ability to obtain and appropriately use over-the-counter medications; and

RESIDENT 6
Records review showed that the ALF admitted Resident 6 on [redacted]/2018 with multiple medical diagnoses. Record review of Resident 6's Assessment, dated 07/15/2024, showed Resident 6 had a private caregiver (PCG) to help with showers twice a week, and required family assistance with medication management.

Observation and interview, on 11/06/2025 at 10:15 AM, Resident 6 was in her apartment and able to communicate well. When questioned about medication, Resident 6 showed a medication organizer, and stated that she managed her own medications, ordered by mail, and placed them in a medication organizer (mediset) every week. Resident 6 stated that she did not require assistance from her family or PCG. Resident 6 stated that she "only" needed assistance to pull her pants up due to shoulder and hip pain.

Resident 6's Assessment, dated 07/15/2024, had not been updated to showed Resident 6 was assessed as safely managing her own medications and no long required PCG to help with showers twice a week.

In a telephone interview, on 11/14/2025 at 10:30 AM, Staff G (Director of Assisted Living) stated that Resident 6 never had a PCG. Staff G acknowledged that Resident 6's care needs had to be re-assessed to address current needs.

RESIDENT 7
Review of the ALF's undated Fall policy and procedures, showed a Fall Risk Assessment needed to be completed annually to determine residents' risk factors such as cause or what contributed to the fall, to address the factors for the fall to treat current issues and help prevent future falls.

Record review showed the ALF admitted Resident 7 on [redacted]/2022 with multiple disabling diagnoses including [redacted].

Review of the Progress Notes, showed Resident 7 had multiple falls dated: 08/14/2025, 09/16/2025, 09/17/2025, 09/18/2025, 09/22/2025, 09/24/2025, and 10/12/2025.

Review of Resident 7's Assessment, dated 10/23/2025, showed Resident 7 had history of falls speaking to only three fall incidents in the year. The Assessment did not include residents' risk factors such as cause or what contributed to the falls, address the factors for the falls or treat current issues to help prevent future falls.

In an interview, on 11/06/2025 at 2:50 PM, Staff G acknowledged the need for Residents 6 and 7 to be reassessed to update their current needs.

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, THE SUMMIT AT FIRST HILL is or will be in compliance with this law and / or regulation on (Date) 12.5.25 .
(correct) 11.6.25)

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

Administrator (or Representative) [signature] Date 12.5.25

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

[signature] 12.5.25

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) was updated to reflect the current health status and care and service needs for 1 of 5 sampled residents (Residents 7). This placed Resident 7 at risk of having their health adversely affected by not receiving needed care and services.

Findings included...

Record review showed the ALF admitted Resident 7 on [redacted]/2022 with multiple

disabling diagnoses including [redacted].

Review of a Progress Notes, showed Resident 7 had non-injury fall incidents dated: 08/14/ 2025, 09/16/2025, 09/17/2025, 09/18/2025, 09/22/2025, 09/24/2025 and 10/12/2025.

Review of the Service Plan Report (equivalent to an NSA), dated 08/26/2025, showed Resident 7 was at risk for fall however there were no interventions or directives to caregivers on how prevent future falls.

Observation and interview, on 11/06/2025 at 1:45 PM, showed Resident 7 seated in his apartment watching TV. Resident 7 was observed with dressing on both legs. Resident 7 stated that he recently visited a wound clinic for treatment.

Review of the SPR showed Resident 7 had consistent bilateral lower extremity wounds followed by the wound care clinic. However the SPR did not include information on how and when to contact the wound clinic and what wound care interventions were required by the ALF.

In interview, on 11/06/2025 at 2:50 PM, Staff G (Director of Assisted Living (AL) acknowledged that the SPRs for Resident 7 needed to be updated to properly address their care needs.

Plan/Attestation Statement

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(corrected 11.6.25

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

Administrator (or Representative) [signature] Date 12.5.25

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

[signature] 12.5.25

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure proper and safe installation of side bed rails (SBR) for 1 of 3 sampled residents (Resident 8). This failure placed Resident 8 at risk for serious bodily harm, including death from entrapment from a bed mobility device.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards,

Review of the United States Food and Drug Administration (FDA) website, on 10/06/2025, showed the FDA developed a document regarding SBR use in health care facilities titled, "A Guide to Bed Safety." The document outlined the importance of frequent assessments to monitor a resident's physical and mental status, monitoring high risk residents, and ensuring safe installation of SBRs. The document outlined risks of using side rails including strangulation, suffocation, bodily injury, or death when a person could get caught, an increased fall risk if not used properly, and feelings of isolation and unnecessary restriction and being prevented from completing activities of daily living.

Review of the FDA website, on 10/06/2025, showed specific measurements for SBR safety in a posting titled, "Overview of the U.S. food and drug administration's potential zones of bed entrapment." The overview specified the following information:

ZONE 1: Within the Rail - any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space: less than 4 34 inches (").

ZONE 3: Between the Rail and the Mattress - this area is the space between the inside surface of the bed rail and the mattress, and if too big it can cause a risk of head entrapment. FDA recommended space: less than 4 34".

ZONE 4: Under the Rail at the Ends of the Rail - a gap between the mattress and the lowermost portion of the rail poses a risk of neck entrapment. FDA recommended space is less than 2 38".

Record review showed that the ALF admitted Resident 8 on [redacted]/2022 with multiple diagnoses including [redacted]

[redacted] and [redacted] and [redacted].
Review of the undated Residents Characteristics Roster (RCR), showed that Resident 8 was identified as using a medical device.

Observation and interview, on 11/08/2025 at 10:30 AM, showed a ¼ size SBR attached to the right side of the bed in Resident 8's apartment. Observation showed Resident 8 was lying close to the SBR. There was a large open gap within the SBR measuring 25" in length and 15" high. Resident 8 stated that the SBR was installed by a family member, "I don't know when."

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, THE SUMMIT AT FIRST HILL is or will be in compliance with this law and / or regulation on (Date) 12.5.25 .
(corrected 11.6.25)

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

Administrator (or Representative) [signature] Date 12.5.25

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: [signature] 12.5.25

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Full Assessment contained updated medication management information from their pre-admission assessment for 3 of 3 sampled residents

(Residents 1, 2, and 10). This resulted in the Full Assessment containing incorrect medication management needs and placed Residents 1, 2, and 10 at risk for not receiving proper care and services, and at risk for deteriorating health conditions.

Findings included...

NOTE: Washington Administration Code (WAC) 388-78A-2020. Definitions. "Medication organizer" means a container with separate compartments for storing oral medications organized in daily doses.

RESIDENT 1
Review of the undated Resident Characteristics Roster (RCR) showed that Resident 1 required staff to administer medications. Records review showed that the ALF admitted Resident 1 on [redacted]/2025 with multiple diagnoses including [redacted].

Record review showed that the ALF conducted a "pre-move in" Resident Assessment (PMRA) for Resident 1 on 03/03/2025. The PMRA showed that Resident 1 was unable to obtain and take medication independently and effectively, and that Resident 1's family had helped. The PMRA did not stated the ALF would manage Resident 1's medications.

Observation and interview, on 11/06/2025 at 8:10 AM, showed that Resident 1's medications were stored in a medication cart in the Memory Care Unit (MCU) on the second floor. Staff J (Charge Licensed Practical Nurse) stated that the ALF's nurses had been managing Resident 1's medications.

Review of a Full Resident Assessment (FRA – equivalent to a Full Assessment), dated 04/09/2025 and reviewed 05/15/2025, showed family would manage Resident 1's medications, not the ALF.

In an interview, on 11/06/2025 at 2:40 PM, Staff G (Director of Assisted Living) stated that once Resident 1 had moved into the MCU, the ALF's nurses had been managing their medications. Staff G acknowledged that there was no assessment of Resident 1's need for medication management by the ALF's nurses after they moved into the ALF.

RESIDENT 2
Review of the undated RCR showed that Resident 2 required staff to administer medications.

Records review showed that the ALF admitted Resident 2 on [redacted]/2025 with multiple diagnoses including [redacted]

Review of a PMRA, dated 12/05/2024, showed that Resident 2 was unable to obtain and take medication independently and effectively. The PMRA showed that Resident 2's family member had managed their medications and used a pharmacy in the community. The PMRA did not stated the ALF would manage Resident 2's medications.

Observation and interview, on 11/06/2025 at 8:30 AM, showed that Resident 2's medications were stored in a medication cart in the MCU on the second floor. Staff J stated that nurses had been managing Resident 2's medications, and obtaining their medications from the ALF's contracted pharmacy.

Review of a FRA, dated 01/09/2025 and reviewed 06/03/2025, showed family would manage Resident 2's medications, not the ALF's nurses.

In an interview, on 11/06/2025 at 2:40 PM, Staff G stated that before moving in, Resident 2's family member was managing their medications. Staff G acknowledged that there was no other assessment showing Resident 2 's current need of medication management by the ALF's nurses after they moved into the ALF.

RESIDENT 10
Records review showed that the ALF admitted Resident 10 on [redacted]/2025 with multiple diagnoses. Review of an undated PARA showed that Resident 10 was unable to obtain and take medications independently and effectively. The PARA showed that Resident 10 had used a Medi-set (medication organizer) from a pharmacy in the community. The PMRA did not stated the ALF would manage Resident 10's medications.

Observation and interview, on 11/06/2025 at 10:20 AM, showed that Resident 10's medications were in a medication cart in the medication room on the third floor. Staff K (Registered Nurse) stated that the ALF's nurses had been managing Resident 10's medications and ordering them from the ALF contracted pharmacy. There was no Medi-set.

Review of a FRA, dated [redacted]2025 and reviewed 07/29/2025, showed Resident 10 would use a Med-set, not the ALF to manage their medications.

In an interview, on 11/06/2025 at 2:40 PM, Staff G confirmed that there was no other assessment showing Resident 10 's current need of medication management by the ALF's nurses after their moved into the ALF.

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(corrected 12.2.25)

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

Administrator (or Representative) [signature] Date 12.5.25