



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

10/08/2025

FEDERAL WAY MEDICAL INVESTORS LLC
Garden Terrace Healthcare Center of Federal Way
491 S 338TH STREET
FEDERAL WAY, WA 98003

RE: Garden Terrace Healthcare Center of Federal Way # 1631

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 66918 (Completion Date 10/08/2025) and 63431 (Completion Date 08/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/08/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2070 Timing of preadmission assessment.

- (1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.
- (2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions.

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

- (1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:
 - (a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;
 - (b) Identifies the resident's immediate needs; and
 - (c) Provides direction to staff and caregivers relating to the resident's immediate needs,

capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(c) Other individuals the resident wants included;

(e) Staff designated by the assisted living facility.

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers 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:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background

check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

The Department staff who did the On Site verification:

Claudia Allis, ALF Licenser
Steven Garrett, LTC Licenser

If you have any questions, please contact me at (206)305-3489.

Sincerely,

A handwritten signature in cursive script that reads "Jim Sherman".

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

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



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

Statement of Deficiencies	License # 1631	Compliance Determination #63431
Plan of Correction	Garden Terrace Healthcare Center of Federal Way	Completion Date
Page 1 of 10	Licensee: FEDERAL WAY MEDICAL INVESTORS LLC	08/08/2025

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 07/30/2025 of:

Garden Terrace Healthcare Center of Federal Way
491 S 338TH STREET
FEDERAL WAY, WA 98003

This document references the following SOD dated: 08/08/2025

The following sample was selected for review during the unannounced on-site visit: 7 of 12 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licenser
Jane Hermano, NCI

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

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

08/21/2025

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)

8/25/25

Date

WAC 388-78A-2070 Timing of preadmission assessment.

- (1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.
- (2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete 2 of 2 residents (Resident 6 and Resident 7) pre-admission assessments. This failure placed Resident 6 and Resident 7 at risk for admission to a facility that was unable to meet resident needs and a decreased quality of life.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/02/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 07/18/2025.

RESIDENT 6

Review of Resident 6's information document showed the facility admitted Resident 6 on [REDACTED] 2025.

Review of Resident 6's records showed the facility admitted Resident 6 from a skilled

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nursing facility. The records showed the facility completed Resident 6's pre-admission assessment on [REDACTED]/2025, five days after Resident 6 moved into the facility.

During an interview on 07/30/2025 at 2:24 PM, Staff B, Director of Nursing, stated that Resident 6 was not an emergency placement and did not move-in under emergency circumstances. Staff B stated that the facility did not have an assessment for Resident 6 prior to them moving in on [REDACTED]/2025.

RESIDENT 7

Review of Resident 7's information document showed the facility admitted Resident 7 on [REDACTED]/2025.

Review of Resident 7's records showed the facility admitted Resident 7 from a skilled nursing facility. The records showed the facility completed Resident 7's pre-admission assessment on [REDACTED]/2025, the same day Resident 7 admitted to the facility.

During an interview on 07/30/2025 at 2:28 PM, Staff B, Director of Nursing, stated that Resident 7 was not an immediate placement and did not move in under emergency circumstances. Staff B stated that the facility did not have an assessment for Resident 7 prior to them moving in on [REDACTED]/2025.

During an interview on 07/30/2025 at 2:25 PM, Staff A, Executive Director, and Staff B, Director of Nursing, stated that resident assessments were conducted on the day of admission. Staff A and Staff B stated that they were not aware of the requirements for pre-admission assessments.

This is an uncorrected deficiency previously cited on 06/02/2025 for subsections (1) and (2).

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 4/17/25 9/17/25 Dr

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

[Signature]
Administrator (or Representative)

8/25/25
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(c) Other individuals the resident wants included;

(e) Staff designated by the assisted living facility.

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the

resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 2 of 6 residents (Resident 6 and Resident 7) service agreements a plan to monitor and address interventions required to meet the care and current clinical needs of the residents. This failure placed Resident 6 and Resident 7 at risk for unmet care needs and potential harm.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/02/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 07/18/2025.

RESIDENT 6

Review of Resident 6's information document showed the facility admitted Resident 6 on [REDACTED] /2025. The records showed Resident 6's diagnoses included: [REDACTED]

and [REDACTED]

Review of Resident 6's Service Plan Report (also known as the service agreement), dated 07/29/2025, showed no documentation that provided guidance for the care staff to monitor Resident 6 for signs and symptoms related to hypertension. The plan showed no instructions for behaviorally based supportive actions for staff to take when Resident 6 exhibited signs and symptoms of anxiety and depression. There was no documentation that provided staff with guidance about possible side effects from medications. The plan showed no guidance or instructions for staff who they needed to report needed to report signs and symptoms of anxiety, depression, and hypo/hyper glycemia (low blood sugar/high blood sugar) too.

RESIDENT 7

Review of Resident 7's information document showed the facility admitted Resident 7 on [REDACTED] /2025. The records showed Resident 7's diagnoses included [REDACTED]

and [REDACTED]

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

Review of Resident 7's Service Plan Report, dated [REDACTED] 2025, showed no documentation that provided guidance for the staff to monitor Resident 7 for signs and symptoms related to hypertension. There was no documentation that provided the staff with guidance about possible side effects related to anemia and congestive heart failure. The plan showed no guidance or instructions for staff who they needed to report the observed signs and symptoms of anemia, congestive heart disease, and hypo/hyper glycemia (low blood sugar/high blood sugar) too.

During an interview on 07/30/2025 at 2:23 PM, Staff A, Executive Director, and Staff B, Director of Nursing, stated that they were unaware of the need to provide care staff with guidance and directions for resident care in the negotiated service agreement. Staff A and Staff B stated that they were unaware of the comprehensive components required for a negotiated service agreement for assisted living residents.

This is an uncorrected deficiency previously cited on 06/02/2025 for subsection (1)(a)(b)(c).

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>9/17/25</u> <u>9/18/25</u> <u>Da</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>[Signature]</u> Administrator (or Representative)	<u>8/25/25</u> Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers 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:

- (a) Orientation and safety;
- (c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;
- (d) Cardiopulmonary resuscitation and first aid; and
- (e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 6 staff (Staff A, Staff D, Staff E, and Staff F) completed all required training to perform their job duties and responsibilities. This failure placed 9 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/02/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 07/18/2025.

Review of facility's undated personnel records showed the facility hired Staff A, Executive Director, 02/10/2025; Staff D, Care Staff/CAN (certified nursing assistant); Staff E, Care Staff/CAN (certified nursing assistant) on 04/29/2019, and Staff F, Care Staff/CAN (certified nursing assistant), on 10/11/2018.

SPECIALTY TRAINING

Review of Staff A's undated personnel records showed Staff A provided direct supervision of staff who worked with residents from 02/10/2025 through 07/30/2025, a total of 170 days. There was no documentation in Staff A's records that showed Staff A completed the specialty training for mental health.

Review of Staff D's undated personnel records showed Staff D provided direct care to residents from 04/03/2024 through 07/30/2025, a total of 483 days. There was no documentation in Staff D's records that showed Staff D completed the specialty training for mental health.

During an interview on 07/30/2025 at 2:15 PM, Staff A, Executive Director, stated that they were aware of the incomplete training records. Staff A stated that the facility's Disclosure of Services document showed the facility accepted residents with [REDACTED] and [REDACTED] diagnoses. Staff A stated that they were aware that staff were required to complete specialty training for mental health.

CPR AND FIRST AID

Review of Staff A's undated personnel records showed no documentation in Staff A's records that showed Staff A completed the required first aid training, as required.

Review of Staff F's undated personnel records showed Staff F provided direct care to residents from 10/11/2018 through 07/30/2025. There was no documentation in Staff F's records that showed Staff F completed the required first aid training.

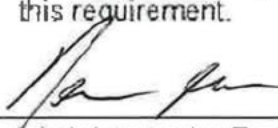
CONTINUING EDUCATION

Review of Staff E's undated personnel records showed Staff E provided direct care to residents from 04/29/2019 through 07/30/2025. There was no documentation in Staff E's records that showed Staff E completed the required 12 hours of continuing education between their 04/19/2024 birthday and their 04/19/2025 birthday.

Review of Staff F's undated personnel records showed no documentation that Staff F completed the required 12 hours of continuing education between their 01/25/2024 birthday and their 01/25/2025 birthday.

During an interview on 05/15/2025 at 2:25 PM, Staff A, Executive Director, stated that they were aware Staff A and Staff D had not completed first aid training. Staff A stated that they were unaware Staff E and Staff F had not completed the required 12 hours of continuing education requirements.

This is an uncorrected deficiency previously cited on 06/02/2025 for subsection (2)(c)(d)(e).

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>9/17/25</u> <u>9/15/25</u> <u>1/25</u> In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>8/25/25</u> Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The

assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a national fingerprint background check for 3 of 5 staff (Staff C, Staff D, and Staff F). This failure placed all 9 residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 06/02/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 07/18/2025.

STAFF C

Review of the facility employee records showed the facility hired Staff C, Care Staff/CNA (certified nursing assistant), on 10/17/2024. The records showed documentation that Staff C completed a DSHS name and date of birth background check on 10/14/2024. There was no documentation that showed Staff C completed a national fingerprint background check.

Review of the facility's employee roster showed Staff C provided direct care to facility residents for 256 days, without a national fingerprint background check.

STAFF D

Review of the facility employee records showed the facility hired Staff D, Care Staff/CNA (certified nursing assistant), on 04/03/2024. The records showed documentation that Staff D completed a DSHS name and date of birth background check on 04/17/2024. There was no documentation that showed Staff D completed a national fingerprint background check.

Review of the facility's employee roster showed Staff D provided direct care to facility residents for 484 days, without a national fingerprint background check.

STAFF F

Review of the facility employee records showed the facility hired Staff F, Care Staff/CNA (certified nursing assistant), on 10/11/2018. The records showed documentation that Staff F completed a DSHS name and date of birth background check on 04/15/2025.

There was no documentation that showed Staff F completed a national fingerprint background check.

Review of the facility's employee roster showed Staff F provided direct care to facility residents 2485 days, without a national fingerprint background check.

During an interview on 07/30/2025 at 2:15 PM, Staff A stated that when the facility hired Staff C, Staff D, and Staff F, the facility failed to submit a request for fingerprints. Staff A stated that they were aware that a national fingerprint background check was required for Staff C, Staff D, and Staff F.

This is an uncorrected deficiency previously cited on 06/02/2025 for subsection (1)(a)(b) (2).

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 9/17/25 9/15/25 AK

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



Administrator (or Representative)

8/25/25

Date



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

Statement of Deficiencies	License #: 1631	Compliance Determination #59437
Plan of Correction	Garden Terrace Healthcare Center of Federal Way	Completion Date
Page 1 of 29	Licensee: FEDERAL WAY MEDICAL INVESTORS LLC	06/02/2025

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 05/13/2025 and 05/15/2025 of:

Garden Terrace Healthcare Center of Federal Way
491 S 338TH STREET
FEDERAL WAY, WA 98003

The following sample was selected for review during the unannounced on-site visit: 5 of 9 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licenser
Jane Hermano, NCI

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

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

06/05/2025

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.

[Signature]
Administrator (or Representative)

6/13/25
Date

WAC 388-78A-2070 Timing of preadmission assessment.

- (1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.
- (2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete a pre-admission assessment for 3 of 5 (Resident 3, Resident 4, and Resident 5) assisted living residents. This failure placed Resident 3, Resident 4, and Resident 5 at risk for admission to a facility that was unable to meet resident needs and to have a decreased quality of life.

RESIDENT 3

Review of Resident 3's Admission Record document showed the facility admitted Resident 3 on [REDACTED] 2025 directly from a hospital. The records showed Resident 3's diagnoses included: [REDACTED]

and [REDACTED]

Review of Resident 3's admission and assessment documentation showed no documentation that Resident 3 had a pre-admission assessment completed prior to

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admission to the assisted living facility.

During an interview on 05/15/2025 at 2:27 PM, Staff B, Director of Nursing, stated that Resident 3 was not an immediate placement and did not move-in under emergency circumstances. Staff B stated that Resident 3 did not have an assessment prior to moving in on [REDACTED] 2025.

RESIDENT 4

Review of Resident 4's Admission Record document showed the facility admitted Resident 4 on [REDACTED] /2025. The records showed Resident 4's diagnoses included [REDACTED] and [REDACTED].

Review of Resident 4's admission and assessment documentation showed no documentation that Resident 4 had a pre-admission assessment completed prior to admission to the assisted living facility.

During an interview on 05/15/2025 at 2:27 PM, Staff B, Director of Nursing, stated that Resident 4 was not an immediate placement and did not move-in under emergency circumstances. Staff B stated that Resident 4 did not have an assessment prior to moving in on [REDACTED] /2025.

RESIDENT 5

Review of Resident 5's information document showed the facility admitted Resident 5 on [REDACTED] /2025. The records showed Resident 5's diagnoses included [REDACTED] and [REDACTED].

Review of the facility's Pre-Admission Assessment showed that Resident 5's assessment was dated [REDACTED] /2025, the day Resident 5 move-in to the facility. Review of the record showed Resident 5 was admitted from another assisted living facility.

During an interview on 05/15/2025 at 2:27 PM, Staff B, Director of Nursing, stated that Resident 5 was not an immediate placement and did not move-in under emergency circumstances. Staff B stated that Resident 5 did not have an assessment prior to moving in on [REDACTED] 2025.

During an interview on 05/15/2025 at 2:25 PM, Staff A, Executive Director, and Staff B, stated that residents had assessments conducted on the day of admission. Staff A and

Staff B stated that they were not aware of the requirements for pre-admission assessments for Assisted Living residents.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 7/9/25.

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



Administrator (or Representative)

6/17/25

Date

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:

- (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;
- (b) Chronic, current, and potential skin conditions; or
- (c) Known allergies to foods or medications, or other considerations for providing care or services.

(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;
- (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.

(4) Individual's sensory abilities, including:

- (a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(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.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(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

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment of the care and service needs, capabilities, and preferences for 3 of 4 sampled residents (Resident 1, Resident 2, and Resident 3) within 14 days of admission. This failure placed Resident 1, Resident 2, Resident 3, and Resident 4 at risk for unmet care needs.

Findings included...

RESIDENT 1

Review of Resident 1's records showed the facility admitted Resident 1 on [REDACTED]/2025. The records showed no assessment was completed for Resident 1 within 14 days of admission.

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 on [REDACTED]/2025. The records showed no assessment was completed for Resident 2 within 14 days of admission.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. The records showed the facility completed Resident 3's assessment that lacked the full assessment components, as required. The assessment was undated. The assessment failed to document Resident 3's current medications with potential side effects and the level of medication management assistance required. The assessment failed to document Resident 3's need for any nursing related services. The assessment failed to document any evaluation for Resident 3's special needs related to any diagnosis of [REDACTED] or [REDACTED]. The assessment failed to document Resident 3's personal preferences for foods, activities, spirituality, community contacts, and personal care services. The assessment failed to document Resident 3's legal decision maker and advance directive choices.

During an interview on 05/13/2025 at 10:30 AM with Staff A, Executive Director, and Staff B, Director of Nursing, stated that the facility utilized an electronic documentation system for assessments and negotiated service agreements. During an interview on 05/15/2025 at 2:21 PM, Staff B stated that they were still untrained to use the facility's electronic documentation system. Staff A and Staff B stated that they were unaware of the required components needed for full assessments of assisted living residents. Staff A stated that they were unaware the electronic documentation system did not include all required components when an assessment was completed.

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

- (1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:
 - (a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;
 - (b) Identifies the resident's immediate needs; and
 - (c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.
- (2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;
- (5) Involve the following persons in the process of developing and updating a negotiated service agreement:
 - (a) The resident;
 - (b) The resident's representative to the extent he or she is willing and capable, if the resident has one;
 - (c) Other individuals the resident wants included;
 - (e) Staff designated by the assisted living facility.
- (6) Ensure:
 - (a) Individuals participating in developing the resident's negotiated service agreement:
 - (i) Discuss the resident's assessed needs, capabilities, and preferences; and
 - (ii) Negotiate and agree upon the care and services to be provided to support the resident; and
 - (b) Staff persons document in the resident's record the agreed upon plan for services.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 3 of 5 residents (Resident 2, Resident 3, and Resident 4) service agreements a plan to monitor and address interventions required to meet the care and current clinical needs of the residents. This failure placed Resident 2, Resident 3, and Resident 4 at risk for unmet care needs and potential harm.

Findings included...

RESIDENT 2

Review of Resident 2's Admission Record document showed that the facility admitted Resident 2 on [REDACTED]/2025.

Observation of Resident 2's apartment on 05/14/2025 at 1:20 PM, showed a sealed plastic canister on the floor with amber-colored urine. Observation showed that the canister was approximately three-quarters full of collected urine.

During an interview on 05/14/2025 at 1:24 PM, Collateral Contact 1 (CC1, Resident 2's Representative), stated that Resident 2 used an external catheter with a flexible fabric wick and a suction pump that draw urine into the collection canister at night. CC1 stated that they were unsure if Resident 2's service plan showed how to provide proper care before, during, and after use of the external catheter device. CC1 stated they were unaware what interventions were implemented. CC1 stated that they visited regularly around noon and during those visits, the urine canister was not emptied promptly.

Review of Resident 2's Boarding Home Negotiated Service Agreement (NSA), dated [REDACTED] 2025, showed that Resident 2's medical diagnosis included [REDACTED]. Review of the NSA and the facility's document titled, "Care Delivery Guide", dated [REDACTED]/2025, showed that Resident 2 required assistance from staff to use the toilet during the day. The NSA and care guide showed Resident 2 used an external catheter urine collection system at night. There were no instructions for staff about potential complications to Resident 2's catheter use. There were no instructions for staff about what actions were needed if Resident 2 experienced any complications.

During an interview on 05/15/2025 at 11:15 AM, Staff B, Director of Nursing, stated that the staff used the NSA and care guide as standard guidelines to ensure consistent and efficient care to the residents. Staff B stated that the NSA and care guide lacked documented instructions and guidance for staff about Resident 2's catheter care needs.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. The records showed Resident 3 admitted with diagnoses of [REDACTED] and [REDACTED].

Review of Resident 3's March 2025, April 2025, and May 2025 Medication Administration Records showed that Resident 3 received 50 milligrams (mg) of Lorazepam Intensol Oral Concentrate (medication used to treat anxiety- intense, excessive, and persistent worry and fear to everyday situations) every 4 hours as needed for anxiety or agitation daily, by mouth.

Review of Resident 3's Service Plan Report (also called service agreement), dated 03/09/2025, showed no documentation that provided guidance for the care staff to monitor Resident 3 for signs and symptoms related to hypertension. The plan showed no staff instructions or interventions used when Resident 3 exhibited signs and symptoms of anxiety and agitation. There was no documentation that provided the staff with guidance about possible side effects from Lorazepam.

RESIDENT 4

Review of Resident 4's Admission Record document showed the facility admitted Resident 4 on [REDACTED]/2025. The records showed Resident 4's diagnoses included [REDACTED] and [REDACTED].

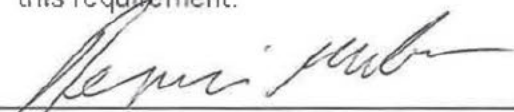
Review of Resident 4's Service Plan Report, dated [REDACTED]/2025, showed no documentation that provided guidance for the staff to monitor Resident 4 for signs and symptoms related to hypertension, diabetes, and diminished cognitive functioning. The plan showed no staff instructions or interventions used when Resident 4 exhibited signs and symptoms of delirium.

During an interview on 05/15/2025 at 2:23 PM, Staff A, Executive Director, and Staff B stated that they were unaware of the negotiated service agreement required components for assisted living residents.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 7/19/25.

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



Administrator (or Representative)

8/18/25

Date

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

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 out of 5 residents (Resident 2, Resident 3, and Resident 4) or their representative signed an annual Negotiated Service Agreement (NSA). This failure placed Resident 2, Resident 3, and Resident 4 at risk of being uninformed about the care and services to be provided by the facility and the potential for unmet care needs.

Findings included...

Review of the Department's "Secure Tracking and Reporting System" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 12/29/2023. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 01/28/2024.

Review of the facility's resident files showed the facility admitted Resident 2 on [REDACTED]/2025. The files showed the facility admitted Resident 3 on [REDACTED]/2025. The files showed the facility admitted Resident 4 on [REDACTED]/2025.

RESIDENT 2

Review of Resident 2's NSA, dated [REDACTED]/2025, showed only a facility staff's signature. There was no documentation that showed Resident 2, or their representative, reviewed and signed the NSA.

During an interview on 05/14/2025 at 12:58 PM, Collateral Contact 1 (CC1, Resident 2's Representative), that they did not review or sign the initial NSA when the facility admitted Resident 2 in [REDACTED] 2025.

RESIDENT 3

Review of Resident 3's NSA, dated [REDACTED]/2025, showed only a facility staff's signature. There was no documentation that showed Resident 3, or their representative, reviewed and signed the NSA.

RESIDENT 4

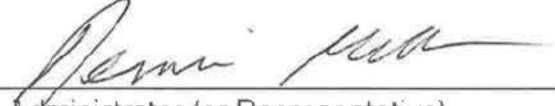
Review of Resident 4's undated NSA showed only a facility staff's signature. There was

no documentation that showed Resident 4, or their representative, reviewed and signed the NSA.

During an interview on 05/14/2025 at 1:58 PM, Collateral Contact 2 (CC2, Resident 4's Representative), stated that they were not notified of any negotiated service agreement. CC2 stated that they did not review or sign any NSA when the facility admitted Resident 4 in [REDACTED] 2025.

During an interview on 05/14/2025 at 11:10 AM, Staff B, Director of Nursing, stated that the facility used both an electronic health system and written documentation. Staff B stated that they maintain a written service plan for all the residents. Staff B stated that when the nursing staff completed the service plan, the staff discussed the plan with the resident or family representative and obtained their signature. Staff B stated that they were unaware the Resident 2, Resident 3, and Resident 4's service plans were not signed and dated by the resident or their representative, as required.

This deficiency was previously cited on 12/14/2023 for subsection (1).

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>7/9/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>6/18/25</u> _____ Date

WAC 388-78A-2300 Food and nutrition services.

- (1) The assisted living facility must:
 - (c) Ensure all menus:
 - (iii) Include all food and snacks served that contribute to nutritional requirements;
 - (vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

This requirement was not met as evidenced by:

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

Based on interview and record review, the facility failed to ensure the menus in 1 of 1 dining room (main dining room) included all food items offered for meals and snacks, and that food items were not repeated within a three-week timeframe. These failures placed all residents at risk of a decreased quality of life from lack of meal choices and variety and at risk of receiving food that did not meet their dietary needs.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 12/14/2023. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 02/05/2024.

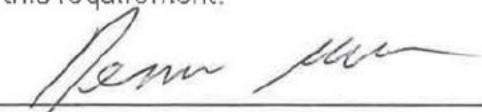
Review of the April 2025 and May 2025 facility food menus showed the facility served roasted chicken as the lunch entrée on 04/20/2025 and 05/04/2025. Review of the April 2025 and May 2025 facility food menus showed the facility served roasted chicken as the dinner entrée on 04/28/2025 and 05/01/2025. The menus showed that a hamburger/cheeseburger sandwich was served as the dinner entrée on 04/22/2025, as the lunch entrée on 05/02/2025 and as the dinner entrée on 05/09/2025. Review of the alternative meal menus showed that a burger, with or without cheese, and fries was listed as an optional choice in place of the main meal offered.

During an interview on 05/14/2025 at 1:45 PM Staff H, Dietary Director, stated that the facility offered menu items and alternatives based on available options from the corporate dietary manual. Staff H stated that they were only aware of the corporate requirements for skilled nursing facilities. Staff H stated that they were unaware of the Washington Administrative Code for Assisted Living Facilities. Staff H stated that they were aware the current menus did not include all mealtime and snack food options available. Staff H stated that they were unaware of the requirement for the menus to include all food items available to residents. Staff H was unaware that the items were not to be repeated within a three-week period.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 7/9/25.

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


 Administrator (or Representative)

6/15/25
 Date

WAC 246-215-03360 Preventing contamination from the premises Food preparation (FDA Food Code 3-305.14). During preparation, unpackaged food must be protected from environmental sources of contamination.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to implement systems to ensure the dietary staff performed the required sanitation procedures in the kitchen food preparation areas. This failure placed 9 of 9 residents at risk for foodborne illness and cross-contamination from food stored and prepared in an unsanitary area.

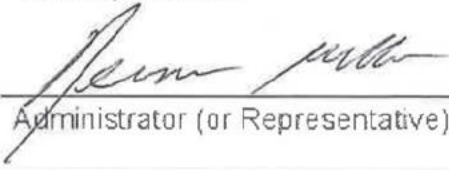
Findings included...

Observation in the kitchen food prep area on 05/14/2025 at 11:45 AM, showed the ceiling vent fans were visibly coated with dust and a brown residue. The ceiling tiles were discolored and splattered with a brown residue. Observation showed the light fixture mounted on the ceiling above the steam table and the food preparation surface was covered with a brown residue and dust. The metal shelves attached to the wall located next to the food service area were visibly covered with gray dust on the edges and the surfaces. Observation showed the fan grate coverings of the walk-in refrigerator, and the walk-in freezer were covered with black, sticky residue and visible strands of dust. Observation showed uncovered, undated, and uncooked meat in a clear plastic bag placed in a metal pan sitting on the bottom shelf of a holding rack. Observation showed an uncovered metal pan with multiple pieces of cooked chicken on the third level of the holding rack. Observation showed an uncovered metal pan with multiple pieces of cooked sausages on the third level of the holding rack. There were several pieces of food debris observed on the floor mat in the walk-in refrigerator.

Observation in the kitchen food prep area on 05/15/2025 at 11:20 AM, showed the ceiling vent fans were visibly coated with dust and brown residue. The ceiling tiles were discolored and splattered with a brown residue. Observation showed the light fixture mounted on the ceiling above the steam table and the food preparation surface was covered with a brown residue and dust. The metal shelves attached to the wall located next to the food service area were visibly covered with gray dust on the edges and the surfaces. Observation showed the fan grate coverings in the walk-in refrigerator, and the walk-in freezer were covered with black, sticky residue and visible strands of dust. There were pieces of food debris observed on the floor mat in the walk-in refrigerator.

During an interview on 05/15/2025 at 1:15 PM, Staff H, Dietary Director, stated that the current kitchen cleaning schedule included daily, weekly, and monthly tasks. Staff H stated that the cleaning schedule included tasks for both the kitchen staff and maintenance staff. Staff H stated that they were unsure if the facility maintenance staff were aware of the kitchen cleaning schedule. Staff H stated that they were unaware the

cleaning tasks were not followed.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>7/9/25</u>. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>8/15/25</u> Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 4 staff (Staff A and Staff C) were screened for tuberculosis (TB) within three days of employment. This failure placed all the residents at risk of contracting TB, a serious and contagious respiratory disease.

Findings included...

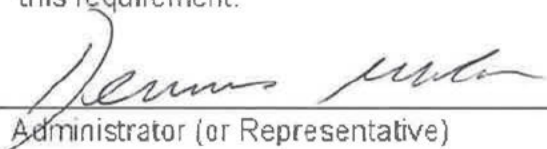
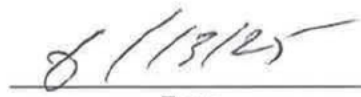
Review of the facility's personnel records showed the facility hired Staff A, Executive Director, on 02/10/2025. The facility hired Staff C, Care Staff/CNA (certified nursing assistant), on 10/17/2024.

Review of the Staff A's records showed that from 02/10/2025 through 05/15/2025, Staff A worked at the facility. Staff A supervised staff who provided care and services for residents. The records showed no documentation that the facility screened Staff A for TB.

Review of Staff C's records showed that from 10/17/2024 through 05/15/2025, Staff C worked at the facility. Staff C provided care and services for residents. The records showed no documentation that the facility screened Staff C for TB.

During an interview on 05/15/2025 at 2:10 PM, Staff A stated that they were not aware

that all facility staff required screening for tuberculosis within three days of employment.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>7/9/25</u>. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	 Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the Department of a change in 1 of 1 assisted living facility administrator (Administrator A) within 10 days of hire, as required. This failure placed all nine residents at risk of receiving care from an unqualified staff member.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 12/14/2023. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 02/05/2024.

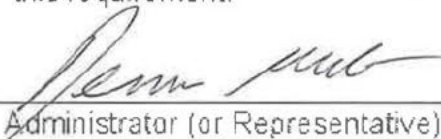
Review of STARS on 05/12/2025 showed that Staff I, Previous Executive Director, was identified as the Administrator.

Review of the facility records showed the facility hired Staff A, current Executive Director, on 02/10/2025. There was no documentation that showed the facility reported the change of administrator to the Department, as required.

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

During an interview on 05/15/2025 at 1:15 PM, Staff A stated that they were the facility's current administrator for the assisted living unit and skilled nursing units. Staff A stated that the facility failed to submit a change of administrator form to the Department.

This deficiency was previously cited on 12/14/2023.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>7/9/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>6/15/25</u> _____ Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

- (1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;
- (2) Be provided both orally and in writing in a language that the resident understands;
- (3) Be provided to prospective residents, before they are admitted to the home;
- (4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;
- (5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and
- (6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to provide 5 of 9 residents (Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5) with a copy of the facility's policy for acceptance of Medicaid as a payment source. The facility failed to ensure the residents, or the residents representative acknowledged the facility policy on Medicaid as a payment source with a signature and date. These failures placed Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5 at risk of being discharged and

unable to reside in the facility on state Medicaid assistance as a payment source.

Findings included...

Review of the facility's undated Disclosure of Services document showed the facility did not accept Medicaid as a payment source.

During an interview on 05/14/2025 at 11:55 AM, Staff A, Executive Director, stated that the facility did not have a Medicaid contract. Staff A stated that the facility did not accept Medicaid as a payment source for residents who resided in their assisted living care unit.

Review of the facility's resident admission records showed the facility had no written Medicaid policy on a separate document, as required. The records showed no documentation of any acknowledgement by residents or representatives that showed the facility explained the options available if a resident needed to use Medicaid as a payment source.

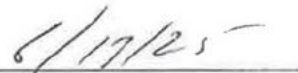
During an interview on 05/15/2025 at 12:30 PM, Staff A stated that there was no separate Medicaid policy document provided to residents, as required. Staff A stated that they were unaware of any current residents' records that contained this type of documentation.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 7/9/25.

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


Administrator (or Representative)


Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers 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:

(a) Orientation and safety;

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

- (c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;
- (d) Cardiopulmonary resuscitation and first aid; and
- (e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 6 staff (Staff A, Staff D, Staff E, and Staff F) completed all required training to perform their job duties and responsibilities. This failure placed 9 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff A, Executive Director, 02/10/2025; Staff D, Care Staff/CNA (certified nursing assistant); Staff E, Care Staff/CNA on 04/29/2019, and Staff F, Care Staff/CNA, on 10/11/2018.

Review of the facility's undated personnel records showed that from 02/10/2025 through 05/15/2025, Staff A provided direct supervision of staff who worked with residents. The records showed that from 04/03/2024 through 05/15/2025, Staff D provided direct care to residents. The records showed that from 04/29/2019 through 05/15/2025, Staff E provided direct care to residents. The records showed that from 10/11/2018 through 05/15/2025, Staff F provided direct care to residents.

During an interview on 05/15/2025 at 2:15 PM, Staff B, Director of Nursing, stated that the facility currently provided care and services to five residents with [REDACTED] and [REDACTED] diagnoses.

ORIENTATION

Review of Staff A's undated personnel records showed no documentation that Staff A completed the orientation and safety training.

SPECIALTY TRAINING

Review of Staff A's undated personnel records showed no documentation that Staff A completed the specialty trainings for dementia and mental health.

Review of Staff D's undated personnel records showed no documentation that Staff D completed the specialty trainings for dementia and mental health.

During an interview on 05/15/2025 at 2:15 PM, Staff A, Executive Director, stated that

they were unaware of the incomplete staff training records. Staff A stated that they were unaware of the requirement for staff to complete orientation and safety training. Staff A stated that the facility's undated Disclosure of Services document showed the facility accepted residents with [REDACTED] and [REDACTED] diagnoses. Staff A stated that they were unaware that staff were required to complete specialty training in dementia and mental health.

CARDIOPULMONARY RESUSCITATION (CPR) and FIRST AID

Review of Staff A's undated personnel records showed no documentation that Staff A completed the required CPR and first aid training, as required.

Review of Staff F's undated personnel records showed no documentation that Staff F completed the required CPR and first aid training, as required.

CONTINUING EDUCATION

Review of Staff E's undated personnel records showed no documentation that Staff E completed the required 12 hours of continuing education between their 04/19/2024 birthday and their 04/19/2025 birthday.

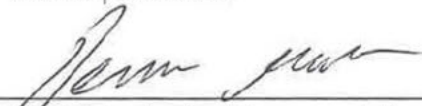
Review of Staff F's undated personnel records showed no documentation that Staff F completed the required 12 hours of continuing education between their 01/25/2024 birthday and their 01/25/2025 birthday.

During an interview on 05/15/2025 at 2:25 PM, Staff A, Executive Director, stated that they were unaware Staff A and Staff D did not complete CPR and first aid training. Staff A stated that they were unaware Staff E and Staff F did not complete the required 12 hours of continuing education requirements.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 7/9/25.

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



Administrator (or Representative)

6/13/25

Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

- (i) Bathrooms and toilet rooms;
- (ii) Resident living rooms and resident sleeping rooms; and
- (iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide 9 of 9 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9) with a system to call staff for assistance with care, services, and potential emergencies. This failure placed all nine residents at risk of unmet care needs and not receiving assistance in an emergency.

Findings included...

During the facility entrance interview on 05/13/2025 at 11:05 AM, Staff A, Executive Director, and Staff B, Director of Nursing, stated that residents were provided with bedside call bells. Staff A and Staff B stated facility residents were not provided with call pendants.

Observations of the common areas, hallways, bathrooms, and the enclosed outdoor common area on 06/13/2025 at 11:30 AM showed no communication system, such as call bells, for residents to summon staff for assistance.

Observation through the dining room windows on 05/14/2025 at 11:06 AM, showed an unidentified Staff and two residents seated in the enclosed outdoor common area. At 11:20 AM, observation showed the unidentified staff knocked on the window. The unidentified staff opened the door and called out, "Hello, the resident needs a blanket, I am trying to get the aides attention". Observation showed there were no other staff located nearby to assist. Observation at 11:22 AM showed the unidentified staff moved the two residents from the outdoor area into the facility dining room. The unidentified staff stated "they (the residents) got too cold, so I brought them in". At 11:26 AM, observation showed a second staff entered the dining room. The second staff person stated that they did not hear the unidentified staff person call out for assistance. The second staff person stated residents "just have to wait... there's only two of us".

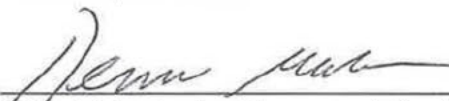
During an interview on 05/15/2025 at 1:40 PM, Staff A and Staff B, Director of Nursing, stated that the staff had no way to communicate with one another if they were not face to face. Staff A and Staff B stated that unit staff were in verbal communication with one another every 10 minutes. Staff A stated that the facility did not provide radios or phones for staff-to-staff communication. Staff A stated that staff to staff verbal communication was appropriate based on the units' physical size and the current resident census. Staff A stated that verbal communication between staff was adequate

to provide safe care and services for residents and in emergency situations.

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, Garden Terrace Healthcare Center of Federal Way is or will be in compliance with this law and / or regulation on (Date) 7/9/25.

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


Administrator (or Representative)

8/13/25
Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to submit a Department of Social and Health Services (DSHS) background authorization form to conduct a Washington state name and date of birth background check for 1 of 6 staff (Staff A). The facility failed to complete a national fingerprint background check for 5 of 6 staff (Staff A, Staff C, Staff D, Staff E, and Staff F). These failures placed all nine facility residents at risk of potential abuse or neglect by caregivers with unknown backgrounds.

Findings included...

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

STAFF A

Review of Staff A, Executive Director's, facility employee records showed the facility hired Staff A on 02/10/2025. The records showed no documentation that Staff A completed a DSHS name and date of birth background check. There was no documentation that showed Staff A completed a national fingerprint background check.

Review of the facility's employee roster showed Staff A provided supervision of direct care to facility residents for 95 days without a completed DSHS background authorization form and a national fingerprint background check.

During interview on 05/14/2025 at 12:50 PM, Staff A stated that they were a "corporate employee". Staff A stated that their employee records were maintained by the corporate office. Staff A stated that they were unaware they needed to maintain their background and fingerprint check results at the facility.

STAFF C

Review of Staff C, Care Staff/CNA (certified nursing assistant)'s, facility employee records showed the facility hired Staff C on 10/17/2024. The records showed documentation that Staff C completed a DSHS name and date of birth background check on 10/14/2024. There was no documentation that showed Staff C completed a national fingerprint background check.

Review of the facility's employee roster showed that as of 05/15/2025, Staff C provided direct care to facility residents for 210 days without a completed national fingerprint background check.

STAFF D

Review of Staff D, Care Staff/CNA's, facility employee records showed the facility hired Staff D on 04/03/2024. The records showed documentation that Staff D completed a DSHS name and date of birth background check on 04/17/2024. There was no documentation that showed Staff D completed a national fingerprint background check.

Review of the facility's employee roster showed that as of 05/15/2025, Staff D provided direct care to facility residents for 407 days without a completed DSHS background authorization form and a national fingerprint background check.

STAFF E

Review of Staff E, Care Staff/CAN's, facility employee records showed the facility hired Staff D on 04/29/2019. The records showed documentation that Staff E completed a recent DSHS name and date of birth background check on 03/24/2025. There was no documentation that showed Staff E completed a national fingerprint background check.

Review of the facility's employee roster showed that as of 05/15/2025, Staff E provided direct care to facility residents for 2206 days without a national fingerprint background

check.

During an interview on 05/14/2025 at 11:15 AM, Staff A stated that the facility had no record of any Washington State Name and Date of Birth background check from Staff E's date of hire. Staff A stated that the facility did not have a copy of Staff E's BGI for 2021 or 2023.

STAFF F

Review of Staff F, Care Staff/CAN's, facility employee records showed the facility hired Staff F on 10/11/2018. The records showed documentation that Staff F completed a DSHS name and date of birth background check on 04/15/2025. There was no documentation that showed Staff E completed a national fingerprint background check.

Review of the facility's employee roster showed that as of 05/15/2025, Staff F provided direct care to facility residents for 2406 days without a national fingerprint background check.

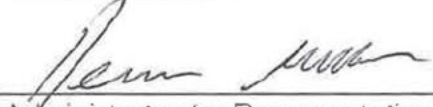
During an interview on 05/14/2025 at 11:15, Staff A stated that the facility did not have a record of any Washington State Name and Date of Birth background check from Staff F's date of hire. Staff A stated that the facility did not have a copy of Staff F's BGI for 2020, 2022 or 2024.

During an interview on 05/15/2025 at 2:45 PM, Staff A stated that when the facility hired Staff A, the facility failed to complete and submit a DSHS background authorization form. Staff A stated that when the facility hired Staff A, Staff C, Staff D, Staff E, and Staff F, the facility failed to submit a request for fingerprints. Staff A stated that they were unaware that a national fingerprint background check was required for Staff A, Staff C, Staff D, Staff E, and Staff F.

Plan/Attestation Statement

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


Administrator (or Representative)

8/13/25
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

- (a) Maintain or enhance the quality of life for residents including resident decision-making rights;
- (b) Provide the necessary care and services for residents, including those with special needs;
- (c) Safely operate the assisted living facility; and
- (d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 11.88, 11.92, 11.94, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

- (l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on observation and interview, and record review, the facility failed to write and implement policies and procedures for 9 of 9 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9) that explained the services provided. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9 at risk of unmet care needs and a decreased quality of life.

Findings included...

Observation on 05/13/2025 at 10:46 AM, showed that the facility was in a single building with one Assisted Living (AL) unit and four Skilled Nursing (SN) units.

Review of facility records showed that Staff A, Executive Director, and Staff B, Director of Nursing, were responsible for management of the one Assisted Living facility unit. The records showed that Staff A and Staff B were also responsible for the management of the three Skilled Nursing Facility units.

Review of the facility's records showed no documentation of any written policies or procedures that explained the care and services provided to the assisted living residents. There were no written policies about how the facility safely operated the assisted living facility. The records showed the policies and procedures in place were written and used for the skilled nursing facility residents .

During an interview on 05/15/2025 at 2:10 PM, Staff A, Staff B, and Staff G, Regional

Director of Clinical Services, stated that the facility did not develop and did not utilize any Assisted Living facility written policies and procedures.

During an interview on 05/14/2025 at 1:48 PM Staff A stated that the facility used a third-party pharmacy for all medication management services. Staff A stated that there were policies and procedures in place for the third-party pharmacy that were general and applied to both the assisted living facility and the skilled nursing facility. Staff A stated that there were no policies and procedures written for any care and services provided specific to the assisted living facility.

Plan/Attestation Statement

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

[Signature]
Administrator (or Representative)

6/13/25
Date

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

This requirement was not met as evidenced by:

Based on observation and record review, the facility failed to ensure 5 of 5 residents (Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5) over-the-counter medications prescribed by a primary care provider for were labeled for individual residents' use and stored separately from other assisted living resident medications. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5 at risk for medication errors and a potential for complications of their medical diagnoses.

Findings included...

Observations on 05/14/2025 at 9:15 AM, showed the medication storage areas and medication carts had large containers of multiple over-the-counter medications. The

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

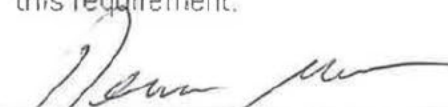
over-the-counter medications included the following: acetaminophen oral (by mouth) and acetaminophen suppository (rectal) (acetaminophen is a non-steroidal medication used for relief of pain and fever); docusate sodium liquid (a medication used to treat constipation); milk of magnesia hydroxide liquid (a medication used to treat constipation); and barrier cream (a cream placed on the skin to protect the skin from excess moisture and breakdown).

During an interview on 05/14/2025 at 2:15 PM, Staff B, Director of Nursing, stated that prescribed over-the-counter medications were ordered by the skilled nursing facility units as "stock medications". The medications used from the stock supply were given to residents in the amount, frequency (how often), and dosage as prescribed by each individual residents' primary care provider's instructions. Staff B stated that the residents were not charged for the use of "stock medications". Staff B stated that it was the responsibility of the nurse administering medications to ensure the accuracy of the prescriptive directions, frequency, dosage, and amount of a medication dispensed to a given resident. Staff B stated that they were unaware of the requirements within Washington Administrative Code Chapter 388-78A for medication services in assisted living facilities. Staff B stated that the facility did not have any policies and procedures for assisted living facility medication services.

Plan/Attestation Statement

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Administrator (or Representative)

6/15/25

Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

(B) Home care aide certification as required by this chapter and chapter 246-980 WAC;

(C) Cardiopulmonary resuscitation;

(D) First aid; and

(E) HIV/AIDS training.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 6 of 6 staff (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) completed and maintained documentation of all required qualifications to perform their job duties and responsibilities in the facility. This failure placed all nine residents at risk of unmet care needs from staff with unknown qualifications and incomplete trainings.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff A, Executive Director, on 02/10/2025; Staff B, Director of Nursing, on 04/21/2025; Staff C, Caregiver/CNA (certified nursing assistant) on 10/17/2024; Staff D, Caregiver/CNA on 04/03/2024; Staff E, Caregiver/CNA on 04/29/2019; and Staff F, Caregiver/CNA on 10/11/2018.

On 05/14/2025, review of the facility records showed that the facility did not develop any Assisted Living policies and procedures that instructed and guided Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F of the standards of care provided to residents.

STAFF A

Review of the facility's personnel records showed no documentation of Staff A's credentials, orientation, and training.

During interview on 05/14/2025 at 12:50 PM, Staff A stated that they were a "corporate employee". Staff A stated that their employee records were maintained by the corporate office. Staff A stated that they did not complete any facility orientation. Staff A stated that they did not complete any long-term care worker requirements. Staff A stated that they were unaware they needed to maintain all their credential and training records at the facility.

STAFF B

Review of the facility's personnel records showed no documentation Staff B received and completed orientation training. The records showed no documents that Staff B completed any long-term care worker training.

During an interview on 05/15/2025 at 11:25 AM, Staff B stated that they were not aware of any assisted living policies and procedures used to provide guidance for the Director of Nursing position. Staff B stated that the facility did not provide them with any orientation and training on the electronic documentation system utilized by the facility.

STAFF C

Review of the facility's personnel records showed no documentation Staff C received and completed orientation training. The records showed no documentation Staff C received training related to the care and service responsibilities for their position in an assisted living facility.

STAFF D

Review of the facility's personnel records showed no documentation Staff D received and completed orientation training. The records showed no documentation Staff D received training related to the care and service responsibilities for their position in an assisted living facility.

STAFF E

Review of the facility's personnel records showed no documentation Staff E received and completed orientation training. The records showed no documentation Staff E received training related to the care and service responsibilities for their position in an assisted living facility.

STAFF F

Review of the facility's personnel records showed no documentation Staff C received and completed orientation training. The records showed no documentation Staff F received training related to the care and service responsibilities for their position in an assisted living facility.

During an interview on 05/15/2025 at 11:20 AM, Staff G, Regional Director for Clinical Operations, stated that they were aware the facility did not develop and utilize Assisted Living Facility Washington Administrative Code requirements as documented in Chapter 388-78A.

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Administrator (or Representative)

6/18/25

Date