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

THE LODGE AT EAGLE RIDGE LLC
THE LODGE AT EAGLE RIDGE
1600 S EAGLE RIDGE Dr S
Renton, WA 98055

RE: THE LODGE AT EAGLE RIDGE License # 1798

Dear Administrator:

This letter addresses Compliance Determination(s) 67137 (Completion Date 10/13/2025) and 63634 (Completion Date 08/26/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/13/2025 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-2210, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2430, WAC 388-78A-2430-1, WAC 388-78A-2430-2, WAC 388-78A-2430-2-a, WAC 388-78A-2430-2-b

The Department staff who did the on-site verification:
Karri Hernandez, Community Complaint Investigator

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

Sincerely,

Jim Sherman

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE LODGE AT EAGLE RIDGE
License/Cert.#: 1798
Compliance Determination #: 63634
Investigator: Karri Hernandez
Investigation Date(s): 08/05/2025 through 08/26/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 190786
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):
Facility did not provide medical records to interested parties on request

Investigation Methods:

Sample:	Total residents: 64 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Family members
Record Reviews:	State reporting log Facility policies Medical records

Investigation Summary:
Reviewed intake, facility documents. Interviewed relevant parties. Observed facility, residents and staff. Named Resident Durable Medical Power of Attorney requested medical records and did not receive with in two business days. Facility citation issued 08/25/2025.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE LODGE AT EAGLE RIDGE
License/Cert.#: 1798
Compliance Determination #: 63634
Investigator: Karri Hernandez
Investigation Date(s): 08/05/2025 through 08/26/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 191560
Region/Unit #: RCS Region 2 / Unit D

Allegation(s):

1. Resident received another residents medication
2. Medication not administered to resident as ordered.

Investigation Methods:

Sample:	Total residents: 64 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:

Reviewed intake, facility documents. Interviewed relevant parties. Observed facility, residents and staff.

1. Named Resident 1 received a pain patch that was prescribed for another resident. When discovered, the improper pain patch was removed from Named Resident 1 and Named Resident 1 was placed on alert charting to monitor for any adverse effects.
2. Injectable medication ordered for Named Resident 2 every 21 days. Injectable

medication was not given to Named Resident 2 for three doses. Named Resident 2 was sent to hospital for medical complications related to the primary diagnosis for which injectable medication prescribed.
Facility citation issued 08/25/2025.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE LODGE AT EAGLE RIDGE
License/Cert.#: 1798
Compliance Determination #: 63634
Investigator: Karri Hernandez
Provider Type: Assisted Living Facility
Intake ID: 187877
Region/Unit #: RCS Region 2 / Unit D
Investigation Date(s): 08/05/2025 through 08/26/2025
Complainant Contact Date(s): 08/05/2025

Allegation(s):
Medications not provided to resident as ordered

Investigation Methods:

Sample:	Total residents: 64 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Staff to resident interactions Resident rooms Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Family members
Record Reviews:	Medical records Hospital records State reporting log Facility policies

Investigation Summary:
Reviewed intake, facility documents. Interviewed relevant parties. Observed facility, residents and staff. Named Resident had a pain patch ordered to be placed once per week. Facility staff changed the day of the week the pain patch was to be changed. Facility staff unavailable to place pain patch on day scheduled. Pain patch was placed on Named Resident seven days later. Named Resident had an order for antibiotics every other day (or every 48 hours). Medication was given on two consecutive days, not every other day as ordered. Facility citation issued on 08/25/2025.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE LODGE AT EAGLE RIDGE
License/Cert.#: 1798
Compliance Determination #: 63634
Investigator: Karri Hernandez
Provider Type: Assisted Living Facility
Intake ID: 187957
Region/Unit #: RCS Region 2 / Unit D
Investigation Date(s): 08/05/2025 through 08/26/2025
Complainant Contact Date(s): 08/05/2025

Allegation(s):

1. Medications not available or improperly dispensed to resident by facility staff
2. Facility staff administering medications outside scope of practice

Investigation Methods:

Sample:	Total residents: 64 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

Reviewed intake, facility documents. Interviewed relevant parties. Observed facility, residents and staff.

1.Named Resident had a pain patch ordered to be placed once per week. Facility staff changed the day of the week the pain patch was to be changed. Facility staff unavailable to place pain patch on day scheduled. Pain patch was placed on Named Resident seven days later. Named Resident had an order for antibiotics every other day (or every 48 hours). Medication was given on two consecutive days, not every other day as ordered. Facility citation issued on 08/25/2025.

2. Review of facility documents showed facility staff completed the state required

training. Review of state licensing requirements showed facility staff had appropriate certifications to complete the basic duties of medication administration. Facility met regulatory requirements.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 08/05/2025 and 08/06/2025 of:

THE LODGE AT EAGLE RIDGE
1600 S EAGLE RIDGE Dr S
Renton, WA 98055

This document references the following complaint number(s): 187877, 187957, 190786, 191560

The following sample was selected for review during the unannounced on-site visit: 5 of 64 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Karri Hernandez, Community Complaint Investigator

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

Statement of Deficiencies	License #: 1788	Compliance Determination # 63634
Plan of Correction	THE LODGE AT EAGLE RIDGE	Completion Date
Page 2 of 6	Licensee: THE LODGE AT EAGLE RIDGE LLC	08/26/2025

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Laurie Anderson
Residential Care Services

08/27/2025
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)

8/28/25
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, facility failed to ensure 2 of 2 sampled residents (Resident 1 and Resident 2) received their medications as prescribed to meet their medical needs. This failure placed Resident 1 and Resident 2 at risk for potential decline in their medical conditions and a decreased quality of life.

Finding included...

Review of an undated facility document titled, "Medication Services", showed that when medications were given staff were expected to check for the "right medication", the "right dose" at the "right time", and "to the right resident" as part of the five rights of

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

08/27/2025 — 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)

Date

WAC 388-78A-2210 Medication services.

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(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, facility failed to ensure 2 of 2 sampled residents (Resident 1 and Resident 2) received their medications as prescribed to meet their medical needs. This failure placed Resident 1 and Resident 2 at risk for potential decline in their medical conditions and a decreased quality of life.

Finding included...

Review of an undated facility document titled, "Medication Services", showed that when medications were given staff were expected to check for the "right medication", the "right dose" at the "right time", and "to the right resident" as part of the five rights of

medication administration.

RESIDENT 1
Review of Resident 1's July 2025 and August 2025 Medication Administration Records (MAR) showed Resident 1 used a five micrograms (mcg) Buprenorphine medication patch (time release medication used to manage severe chronic pain). The MARs showed the patch was to be changed once a week. The MARs showed that on 07/04/2025, the medication patch was placed on Resident 1. On 07/18/2025, 14 days later, a new patch was administered.

Durning an interview on 08/06/2025 at 12:10 PM, Staff A, Executive Director, stated that administration of nurse administered medications and tasks changed from a seven-day week schedule to a five-day week schedule. Staff A stated that the medication patch for Resident 1 moved from the weekly application on Sundays to Fridays. Staff A stated that they were unsure if Resident 1's Primary Care Provider (PCP) was consulted on the date change for the administration of the medication.

During an interview on 08/06/2025 at 12:10 PM, Staff B, Acting Wellness Director (AWD), stated that from 07/11/2025 to 07/18/2025, staff completed a daily assessment of Resident 1. The daily assessments showed Resident 1 experienced no ill effects from the missed weeks' application of a new medication patch.

During an interview on 08/05/2025 at 2:37 PM, Collateral Contact 1 (CC1), family member, stated that Resident 1's medication patch was moved from application on Sunday to Friday. CC1 stated that Resident 1 suffered "classic signs and symptoms of withdrawal" when the medication patch was not administered on 07/11/2025. CC1 stated that these symptoms reportedly started on 07/11/2025 or 07/12/2025. CC1 stated that on 07/22/2025, they reported the changes of Resident 1 to Staff A in an email.

Review of an email from Staff A to CC1 dated 07/22/2025, showed that on 07/11/2025, the nurse was not present in facility to apply patch when it was due. The email showed this as the reason why the medication patch was not applied to Resident 1 on the correct scheduled day.

During an interview on 08/20/2025 at 11:20 AM, Staff A stated that on 08/15/2025, there was a second medication error with Resident 1's pain patch. Staff A stated that the med tech placed a medication patch on Resident 1 that belonged to another resident. The wrong medication patch was at a significantly higher dose (20 mcg instead of five mcg). The stronger patch caused Resident 1 to display signs and symptoms of increased agitation. Staff removed the wrong medication patch and Resident 1 was placed on increased monitoring. The correct prescribed medication patch was placed on Resident 1, as ordered, the following day.

Review of document Renewal Response, dated 07/14/2025, showed an order for Resident 1 to begin antibiotics on 07/14/2025, for three doses every other day (or every 48 hours).

During an interview on 08/06/2025 at 11:20 AM Staff B stated that Resident 1's physician ordered an antibiotic to be given every other, for three doses. Staff B stated that the order was not followed correctly, and the antibiotic was given improperly. Staff

B stated that on 07/17/2025 when they went to dispense the second dose of the antibiotic, they noticed that one dose was missing from the medications. Staff B stated that there was no documentation that showed when the first dose was given. Staff B stated that they called the med tech that gave the antibiotic, and the med tech stated that they gave Resident 1 the antibiotic. Staff B stated that they did not clarify what day the med tech administered the antibiotic. It was later discovered the first dose of the antibiotic was given on 07/16/2025, not 07/15/2025. The second dose was given on 07/17/2025, a consecutive day, and not every other day as ordered.

During an interview on 08/05/2025 at 2:37 PM with CC1 stated that Resident 1 was ordered an antibiotic to be given every other day, for three doses, to begin on 07/14/2025. CC1 stated that the antibiotic was not given by facility staff on 07/14/2025, as ordered. CC1 stated that staff administered the antibiotic on 07/16/2025, 07/17/2025 and 07/19/2025.

RESIDENT 2
Review of facility document, Face Sheet dated 04/15/2025, showed that when the facility admitted Resident 2 to facility, Resident 2 had a diagnosis of [redacted].

Review of the facility Charting Notes for Resident 2, dated 08/04/2025, showed the hospital admitted Resident 2 "over the weekend" for respiratory issues.

Review of facility Charting Notes, dated 08/05/2025, showed Dupixent (an injectable medication used to treat asthma) prescribed beginning 04/08/2024 not administered for three injections, on 06/15/2025, 07/06/2025, 07/27/2025 or over a time period of 63 days. Injectable medication Dupixent for Resident 2 ordered to be administered every 21 days. Last documented administration of injectable medication shown to be 05/25/2025.

Review of an email from Staff 1 to department investigator and facility Licensed Nurse, dated 08/19/2025, showed Resident 2 was scheduled to be given the injectable medication every 21 days, on Sundays. The email showed that due to a change of the nursing schedule from seven days week to five-day a week, Resident 2's injection was missed on multiple occasions.

Review of Valley Medical Center's After Visit Summary (AVS) for Resident 2, dated 08/05/2025, showed the hospital admitted Resident 2 on 08/04/2025 for "asthma in adult, severe persistent, with acute exacerbation (an increase in the severity of the problem)". The AVS showed Resident 2 discharged with two new medications, prednisone (medication prescribed to decrease inflammation in treatment of asthma) and DuoNeb (medication prescribed to relax muscles in airways for patients with asthma).

During an interview on 08/06/2025 at 1:30 PM. Resident 2 stated that they still had a hard time breathing properly. Resident 2 stated that they could not recall the last time they received their injectable medication. Resident 2 stated that they were in the hospital on a breathing machine that blew air in their nose to help them get better. Resident 2 stated that they were tired from being sick and unable to breathe.

Statement of Deficiencies	License #: 1798	Compliance Determination # 63634
Plan of Correction	THE LODGE AT EAGLE RIDGE	Completion Date
Page 5 of 6	Licensee: THE LODGE AT EAGLE RIDGE LLC	08/26/2025

During an interview on 08/13/2025 at 4:07 PM, Collateral Contact 2 (CC2) family member, stated that on 08/04/2025, the hospital admitted Resident 2 for asthma exacerbation. CC2 stated that this hospital admission was related to Resident 2 not getting the injectable medication prescribed to manage their asthma. CC2 stated that they spoke with the Licensed Nurse at the facility and they were told that the last time Resident 2 received the injectable medication was in late May of 2025.

During an interview on 08/14/2025 at 12:20 PM, Staff B stated that a review of Resident 2's medical record showed the last administration of the injectable medication was 05/25/2025. Staff B stated that the injectable medication was a Treatment Administration Record (TAR) assigned task. Staff B stated that the task of a Licensed Nurse administering medications was assigned in the TAR. Staff B stated that the TAR items did not populate into the MAR and were only seen by nursing staff. Staff B stated that the TAR reflected a Sunday rotation for Resident 2's injectable medication. Staff B stated that that when the facility was on five-day week for nurse tasks, the injectable medication did not get re-scheduled to be administered sometime between Monday and Friday when nursing staff were present in facility. Staff B stated that this failure to re-schedule resulted in three missed doses of Resident 2's injectable medication.

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 LODGE AT EAGLE RIDGE is or will be in compliance with this law and / or regulation on (Date) 10/9/25 .

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

Administrator (or Representative) 8/28/25 Date

WAC 388-78A-2430 Resident review of records.

(1) The assisted living facility must assemble all records pertaining to a resident and make them available to a resident within twenty-four hours of the resident's or the resident's representative's request to review the resident's records per RCW 70.129.030 .

(2) The assisted living facility must provide to the resident or the resident's representative, photocopies of the records or any portions of the records pertaining to the resident, within two working days of the resident's or resident's representative's request for the records.

(a) For the purposes of this section, "working days" means Monday through Friday, except for legal holidays.

During an interview on 08/13/2025 at 4:07 PM, Collateral Contact 2 (CC2) family member, stated that on 08/04/2025, the hospital admitted Resident 2 for asthma exacerbation. CC2 stated that this hospital admission was related to Resident 2 not getting the injectable medication prescribed to manage their asthma. CC2 stated that they spoke with the Licensed Nurse at the facility and they were told that the last time Resident 2 received the injectable medication was in late May of 2025.

During an interview on 08/14/2025 at 12:20 PM, Staff B stated that a review of Resident 2's medical record showed the last administration of the injectable medication was 05/25/2025. Staff B stated that the injectable medication was a Treatment Administration Record (TAR) assigned task. Staff B stated that the task of a Licensed Nurse administering medications was assigned in the TAR. Staff B stated that the TAR items did not populate into the MAR and were only seen by nursing staff. Staff B stated that the TAR reflected a Sunday rotation for Resident 2's injectable medication. Staff B stated that that when the facility was on five-day week for nurse tasks, the injectable medication did not get re-scheduled to be administered sometime between Monday and Friday when nursing staff were present in facility. Staff B stated that this failure to re-schedule resulted in three missed doses of Resident 2's injectable medication.

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Administrator (or Representative) Date

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Statement of Deficiencies	License #: 1798	Compliance Determination # 63634
Plan of Correction	THE LODGE AT EAGLE RIDGE	Completion Date
Page 6 of 6	Licensee: THE LODGE AT EAGLE RIDGE LLC	08/26/2025

(b) The assisted living facility may charge the resident or the resident's representative a fee not to exceed twenty-five cents per page for the cost of photocopying the resident's record.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide records requested for 1 of 1 resident (Resident 2) records. This failure violated Resident 2's rights to have access to and review all personal records at the facility.

Finding included...

During an interview on 08/13/2025 at 4:07 PM, Collateral Contact 2 (CC2), Resident Representative stated that on 08/06/2025, the Durable Power of Attorney (DPOA), another interested party named on Resident 2's records, submitted a written request for copies of Resident 2's medical records. CC2 stated that as of 08/13/2025, the facility had not provided the requested documents.

Review of a forwarded email from DPOA to CC2, dated 08/13/2025, showed DPOA sent an email on 08/06/2025 to the Licensed Nurse at the facility to request Resident 2's medical records. The email showed there was no reply from the facility staff.

During an interview on 08/20/2025 at 11:20 AM, Staff A, Executive Director, stated that they verified the email address used to request the records was the correct email address of the Licensed Nurse at the facility. Staff A stated that they were unaware that a records request was made and were unable to explain why the records were not provided.

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) 8/28/25 Date

(b) The assisted living facility may charge the resident or the resident's representative a fee not to exceed twenty-five cents per page for the cost of photocopying the resident's record.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide records requested for 1 of 1 resident (Resident 2) records. This failure violated Resident 2's rights to have access to and review all personal records at the facility.

Finding included...

During an interview on 08/13/2025 at 4:07 PM, Collateral Contact 2 (CC2), Resident Representative stated that on 08/06/2025, the Durable Power of Attorney (DPOA), another interested party named on Resident 2's records, submitted a written request for copies of Resident 2's medical records. CC2 stated that as of 08/13/2025, the facility had not provided the requested documents.

Review of a forwarded email from DPOA to CC2, dated 08/13/2025, showed DPOA sent an email on 08/06/2025 to the Licensed Nurse at the facility to request Resident 2's medical records. The email showed there was no reply from the facility staff.

During an interview on 08/20/2025 at 11:20 AM, Staff A, Executive Director, stated that they verified the email address used to request the records was the correct email address of the Licensed Nurse at the facility. Staff A stated that they were unaware that a records request was made and were unable to explain why the records were not provided.

Plan/Attestation Statement

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Administrator (or Representative) Date