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

11/14/2025

Providence Health & Services - Washington
Providence Mount St. Vincent
4831 35th Ave SW
Seattle, WA 98126

RE: Providence Mount St. Vincent # 198

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 68732 (Completion Date 11/14/2025) and 65314 (Completion Date 09/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/14/2025 and found no deficiencies.

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

The Department staff who did the On Site verification:

Lisa Hauk, Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 09/08/2025 of:

Providence Mount St. Vincent
4831 35th Ave SW
Seattle, WA 98126

This document references the following SOD dated: 09/23/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 71 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Lisa Hauk, Complaint Investigator

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

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.

Jamie Singer
Residential Care Services

09/30/2025
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)

10/6/2025
Date

WAC 388-78A-2210 Medication services.

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

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(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, the Assisted Living Facility (ALF) failed to ensure 1 of 4 sampled residents (Resident 1) received a medication as prescribed. This failure resulted in Resident 1 not receiving medications as ordered and placed them at risk for worsening post-traumatic stress disorder (PTSD – a condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress) and nightmares.

Findings included...

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

Residential Care Services

Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

Date

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Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 4 sampled residents (Resident 1) received a medication as prescribed. This failure resulted in Resident 1 not receiving medications as ordered and placed them at risk for worsening post-traumatic stress disorder (PTSD – a condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress) and nightmares.

Findings included…

Record review of a Full Assessment – Negotiated Service Agreement (NSA), dated 05/30/2025, showed the ALF admitted Resident 1 on [redacted]/2024 with [redacted] and other medically disabling diagnoses. The NSA showed Resident 1 required assistance with medication management.

Record review of a Physician's Order (PO), dated 05/14/2025, showed Resident 1 was prescribed Prazosin (a medication used to treat nightmares related to PTSD) 1 milligram (mg), take three capsules (a total of 3 mg) at bedtime for 14 days, then on 05/28/2025, start Prazosin 2mg capsule, take two capsules (a total of 4 mg) at bedtime.

Record review of Resident 1's May, June, July and August 2025 electronic Medication Administration Record (eMAR) showed that on 05/28/2025, the Prazosin order on the eMAR changed to Prazosin 1mg capsule, give 2 capsules (a total of 2 mg) at bedtime.

In interview, on 09/08/2025, Staff A (Assisted Living Director) acknowledged Resident 1 was getting half of the prescribed dose of Prazosin since 05/28/2025.

This is an uncorrected deficiency previously cited on 07/23/2025.

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, Providence Mount St. Vincent is or will be in compliance with this law and / or regulation on (Date) 10/31/2025.

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

Administrator (or Representative) — Date: 10/6/2025

Record review of a Full Assessment – Negotiated Service Agreement (NSA), dated 05/30/2025, showed the ALF admitted Resident 1 on [redacted]/2024 with [redacted], [redacted] and other medically disabling diagnoses. The NSA showed Resident 1 required assistance with medication management.

Record review of a Physician's Order (PO), dated 05/14/2025, showed Resident 1 was prescribed Prazosin (a medication used to treat nightmares related to PTSD) 1 milligram (mg), take three capsules (a total of 3 mg) at bedtime for 14 days, then on 05/28/2025, start Prazosin 2mg capsule, take two capsules (a total of 4 mg) at bedtime.

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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) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Providence Mount St. Vincent
Provider Type: Assisted Living Facility
License/Cert.#: 198
Intake ID: 185475
Compliance Determination #: 62585
Region/Unit #: RCS Region 2 / Unit J
Investigator: Lisa Hauk
Investigation Date(s): 07/15/2025 through 07/23/2025
Complainant Contact Date(s): 07/23/2025

Allegation(s):

1. The Assisted Living Facility (ALF) attempted to kick the Named Resident (NR) out of her apartment and move her into an Adult Family Home (AFH).
2. ALF staff did not visit the NR at the hospital to complete an assessment.
3. The ALF did not administer the NR's medications ordered by a physician which may have contributed to the NR's pain and injury.

Investigation Methods:

Sample:	Total residents: 73 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Administration Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Interview and record review showed the NR became very fatigued and had increased pain. The ALF followed their policies, assessed the NR and had the NR transported to the hospital. The ALF did not issue a discharge letter. Interview showed the ALF did not attempt to kick the NR out of her apartment or move the NR to an AFH. The NR is enrolled with Providence ElderPlace (enrolled clients receive Medicare and [redacted] benefits through the program). Interview showed Providence ElderPlace made the decisions about the NR's placement. No violation of regulation

identified.
2. Interview and record review showed the ALF did not send staff to assess the NR at the hospital. The ALF utilized an Admissions department who communicated with the hospital. Employees of Providence ElderPlace were in charge of assessing the NR's needs and future placement. No violation of regulations identified.
3. Interview and record review showed the ALF did not administer medications to the NR that had been ordered by a physician. The ALF followed their policies, investigated and put measures in place to prevent the error from occurring again. Violation of regulations identified. See citation 388-78A-2210(1)(a)(b)(2).

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
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 198	Compliance Determination # 62585
Plan of Correction	Providence Mount St. Vincent	Completion Date
Page 1 of 5	Licensee: Providence Health & Services - Washington	07/23/2025

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 complaint investigation on 07/15/2025 of:

Providence Mount St. Vincent
4831 35th Ave SW
Seattle, WA 98126

This document references the following complaint number(s): 185475, 186125, 187135

The following sample was selected for review during the unannounced on-site visit: 2 of 73 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Lisa Hauk, Complaint Investigator

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

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

Jeanie Seigner
Residential Care Services

7/28/2025
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.

Debra J Walch
Administrator (or Representative)

8/5/2025
Date

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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, the Assisted Living Facility (ALF) failed to ensure 1 of 2 sampled residents (Resident 1) received newly prescribed medications. This failure put Resident 1 at risk for health complications by not receiving medications as prescribed.

Findings included...

Record review of an undated Record of Admission showed the ALF admitted Resident 1 on [redacted]/2024 with [redacted] and other medically disabling diagnoses. Review of a Full Assessment-Negotiated Service Plan, dated 01/17/2025, showed Resident 1 required medication assistance.

Record review of a physician's order, dated 04/30/2025, showed Resident 1 was prescribed Rivastigmine (used to improve or delay the progression of dementia symptoms. Patients should not discontinue Rivastigmine without consulting their health care provider. Sudden discontinuation may lead to mental or behavioral changes, convulsions (irregular brain activity that results in the stiffening and rhythmical jerking of muscles and loss of consciousness. Source: Epilepsy Foundation) and shock (a critical condition brought on by the sudden drop in blood flow through the body. Source: Mayoclinic.org) 1.5 milligram (mg) capsules to be titrated (increased gradually) every seven days for six weeks. The physician's order further instructed that after the titration of Rivastigmine 1.5mg capsules was completed, the ALF was to start Rivastigmine 9.5mg/24-hour patch on the skin daily.

Record review of two emails, dated 07/16/2025 at 12:46 PM and 1:26 PM, Staff A (Director of Assisted Living) explained that licensed nurses (LN) at the ALF administered narcotics, skin patches, eye drops, ear drops and diabetic medications. The ALF used an electronic Treatment Administration Record (eTAR) to document medications given by LNs. The ALF used Medication technicians to give residents' oral medications and documented on an electronic Medication Administration Record (eMAR).

Review of Resident 1's June 2025 eMAR showed the Rivastigmine 1.5 mg capsule titration order was completed on the evening of 06/12/2025. Record review of Resident 1's June 2025 eTAR showed the order for Rivastigmine 9.5

mg/24-hour
patch was not started until 06/26/2025.

Record review of a Medication Error Report (MER), dated 06/26/2025, showed that on 06/26/2025, a medication error was discovered. The MER stated Resident 1 did not receive her Rivastigmine 9.5mg /24-hour patch as prescribed.

Record review of a Progress Note, dated 07/03/2025, showed the ALF applied the first Rivastigmine 9.5mg/24-hour patch onto Resident 1's skin on 06/26/2025, fourteen days after the Rivastigmine 1.5mg capsule titration had ended.

In interview, on 07/10/2025 at 8:00 AM, Collateral Contact 1 (CC1 – Resident 1's Representative) stated, "The pills were titrated all the way up and they didn't put a patch on her. I asked staff about the Rivastigmine patch, and they [ALF staff] said, ""What patch?""

In interview, on 07/15/2025 at 11:35 PM, Staff A stated that the Rivastigmine patches were found on 06/26/2025 with Resident 1's other medications.

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, Providence Mount St. Vincent is or will be in compliance with this law and / or regulation on (Date) 8/26/2025.

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

Administrator (or Representative) [signature] Date 8/5/2025