STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Evergreen Fountains LLC
Evergreen Fountains Senior Living Community
1201 North Evergreen Road
Spokane Valley, WA 99216

RE: Evergreen Fountains Senior Living Community License # 1992

Dear Administrator:

This letter addresses Compliance Determination(s) 66795 (Completion Date 10/07/2025) and 65111 (Completion Date 09/03/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/07/2025 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-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2208

The Department staff who did the on-site verification:
Carla Rose, NCI Community Licensor

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 09/03/2025 of:

Evergreen Fountains Senior Living Community
1201 North Evergreen Road
Spokane Valley, WA 99216

This document references the following SOD dated: 09/03/2025

The following sample was selected for review during the unannounced on-site visit: 6 of 49 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Brian Zbylski, ALF Licensor
Patricia Eddy, Community Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

Statement of Deficiencies	License # 1992	Compliance Determination # 85111
Plan of Correction	Evergreen Fountains Senior Living Community	Completion Date
Page 2 of 4	Licensee: Evergreen Fountains LLC	09/03/2025

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.

Residential Care Services — 09/16/2025 (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) — 9.19.2025 (Date)

WAC 388-78A-2208 Respite Negotiated service agreement. With the participation of the individual, and where appropriate their representative, the assisted living facility must develop a negotiated service agreement, to maintain or improve the individual's health and functional status during their stay in the assisted living facility.

WAC 388-78A-2210 Medication services.

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

(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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to administer medications as prescribed for 2 of 3 residents (Resident 8 and 9). This failed practice resulted in Resident 8 and Resident 9 not receiving medications as prescribed and placed the residents at risk of health complications.

Findings included:

<Resident 8>

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 _____

WAC 388-78A-2208 Respite Negotiated service agreement. With the participation of the individual, and where appropriate their representative, the assisted living facility must develop a negotiated service agreement, to maintain or improve the individual's health and functional status during their stay in the assisted living facility.

WAC 388-78A-2210 Medication services.

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

(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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to administer medications as prescribed for 2 of 3 residents (Resident 8 and 9). This failed practice resulted in Resident 8 and Resident 9 not receiving medications as prescribed and placed the residents at risk of health complications.

Findings included…

<Resident 8>

Review of Resident 8's assessment, dated 04/30/2025, showed they were diagnosed with [redacted] and [redacted]. Further review showed the resident received medication assistance.

Review of Resident 8's Medication Administration Records (MARs) for August 2025 and September 2025, showed they were prescribed Kapspargo Sprinkle (medication to treat hypertension) to be administered twice daily. The order showed the medication should be held when the resident's pulse was below 60. Further review showed the resident's pulse was 54 on 08/01/2025 and the medication was administered when it should have been held.

<Resident 9>

Review of Resident 9's assessment, dated 05/09/2025, showed they were diagnosed with [redacted] and [redacted]. Further review showed the resident received medication assistance.

Review of Resident 9's MARs for August 2025 and September 2025, showed they were prescribed metoprolol (medication to treat hypertension) to be administered twice daily. The order showed the medication should be held when the resident's pulse was below 60. Further review showed the resident's pulse was 53 on 07/31/2025 and the medication was administered when it should have been held.

In an interview on 09/03/2025 at 2:05 PM, Staff R, Assisted Living Manager, stated that the facility did not complete periodic MAR audits to ensure prescriber set order parameters were being followed.

In an interview on 09/03/2025 at 2:30 PM, Staff R stated that they were not aware of the medication not being held for both residents.

This is an uncorrected deficiency previously cited on 07/11/2025 for subsections (1)(b).

Statement of Deficiencies	License #: 1982	Compliance Determination #55111
Plan of Correction	Evergreen Fountains Senior Living Community	Completion Date
Page 4 of 4	Licensee: Evergreen Fountains LLC	09/03/2025

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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date) 9.25.2025

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

Brokery Argo — 9.19.2025

Administrator (or Representative) — Date

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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1992	Compliance Determination # 62411
Plan of Correction	Evergreen Fountains Senior Living Community	Completion Date
Page 1 of 14	Licensee: Evergreen Fountains LLC	07/11/2025

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 07/07/2025, 07/08/2025, 07/09/2025, 07/10/2025 and 07/11/2025 of:
Evergreen Fountains Senior Living Community
1201 North Evergreen Road
Spokane Valley, WA 99216

The following sample was selected for review during the unannounced on-site visit: 7 of 49 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Joy Pipgras, LTC Surveyor
Jennifer Lee, Assisted Living Facility Licensor
Patricia Eddy, Community Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1992	Compliance Determination # 62411
Plan of Correction	Evergreen Fountains Senior Living Community	Completion Date
Page 2 of 14	Licensee: Evergreen Fountains LLC	07/11/2025

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.

Residential Care Services — 07/21/2025 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) — 7.31.25 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions when bruises of unknown origin were discovered for 1 of 7 sampled residents (Resident 1). This failure placed the resident at risk of further harm due to not determining the cause of their injuries.

Findings included...

Review of Resident 1's Nursing Notes, dated 06/17/2025, showed a note written by Staff M, Clinical Registered Nurse Manager, that included the documentation, "newer bruising to forehead and hip of unknown origin." Further review showed the notes did not contain any additional information of an investigation to determine the origin of the bruises.

In an interview on 07/09/2025 at 4:30 PM, Staff L, Executive Director, stated that when an incident occurs, Staff M was to assess the resident and investigate.

In an interview on 07/11/2025 at 12:09 PM, Staff K, Resident Care Coordinator, stated that Staff M conducted the investigations after resident incidents and injuries. Staff K further stated they were unable to confirm the details of how the bruises occurred on

Resident 1 and stated it may have been from an unwitnessed fall. Staff K was unable to provide any documentation of an investigation by the conclusion of the inspection.

This is a recurring citation previously cited on 09/16/2022.

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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date) 8.25.25

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

Administrator (or Representative) 7.31.25 Date

WAC 388-78A-2208 Respite **Negotiated service agreement. With the participation of the individual, and where appropriate their representative, the assisted living facility must develop a negotiated service agreement, to maintain or improve the individual's health and functional status during their stay in the assisted living facility.**

WAC 388-78A-2210 Medication services.

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

(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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received their medication as prescribed for 1 of 7 sampled residents (Resident 1). This failure contributed to the resident developing symptoms and requiring treatment.

Findings included...

Review of Resident 1's Service Plan (the facilities titled negotiated service agreement), revised on 01/21/2025, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed the facility provided medication assistance to Resident 1.

Review of Resident 1's aftercare instructions from an on-call urgent care provider, dated 06/27/2025, showed an order to increase furosemide (medication to reduce excess fluid in the body) from once a day to two times per day for five days, then return to once daily dosing. Further review showed an order for potassium (medication given to replace potassium that was depleted by furosemide) to be administered on days three and five of the additional doses of furosemide. The document showed that day three would be 06/30/2025 and day five would be 07/02/2025.

Review of Resident 1's Medication Administration Record (MAR) for June 2025 showed two orders for furosemide 40 milligrams (mg) to be given daily. The first order originated on 12/20/2024 and was administered each day. The second order for 40 mg daily, was ordered for five days and showed the medication was not administered. Further review showed an order for potassium to be administered on 06/30/2025 and 07/02/2025, with no administrations documented in June 2025.

Review of Resident 1's MAR for July 2025, showed the additional order of furosemide, which should have started on 06/28/2025 for five days, and did not start until 07/01/2025. The furosemide was documented as "withheld per [doctor/registered nurse] orders" on 07/01/2025 and 07/02/2025 and administered on 07/03/2025 and 07/04/2025, for a total of two out of five doses administered. Further review showed the potassium was given on 07/02/2025 and 07/04/2025, which were not the third or fifth day of the additional doses of furosemide as ordered.

Review of a progress note, dated 07/02/2025, showed that Resident 1 had weight gain due to edema and required the on-call urgent care provider to assess the resident at the facility and that the provider administered furosemide and potassium.

In an interview on 07/11/2025 at 11:20 AM, Staff K, Resident Care Coordinator, stated the additional doses of furosemide were discontinued in error. Staff K stated they did not realize this until later and requested that the pharmacy reinstate the order on 06/30/2025. Staff K stated they were unsure why the medication was not reinstated until 07/01/2025 and they did not know why the medication was withheld on 07/01/2025 and 07/02/2025.

Statement of Deficiencies	License #: 1992	Compliance Determination # 62411
Plan of Correction	Evergreen Fountains Senior Living Community	Completion Date
Page 5 of 14	Licensee: Evergreen Fountains LLC	07/11/2025

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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date) 8.25.25.

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

Administrator (or Representative) [signature] Date 7.31.25

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

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

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

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to develop a plan to include interventions and observations in the resident's negotiated service agreement for 2 of 7 residents (Resident 3 and 4). This failure placed the residents at risk of further health complications.

Findings included...

In an interview on 07/10/2025 at 12:45 PM, Staff L, Executive Director, stated that when residents had a change in condition, Staff M, Clinical Registered Nurse Manger, would assess the resident and write a "health alert" for a temporary change in condition or change the service plan if the resident had permanent changes.

<Resident 3>

Review of Resident 3's Nursing Notes showed that the resident had non-injury falls on 05/22/2025, 05/28/2025, and 06/02/2025.

In an interview on 07/11/2025 at 10:30 AM, Staff K, Resident Care Coordinator, stated that Resident 3 was diagnosed with [redacted]. Staff K then stated that Resident 3 was taken off their Parkinson's medication due to severe side effects, (involuntary movements, confusion, dizziness, low appetite) and then began having falls, so was placed back on the medication. Staff K further confirmed that there were no health alerts that directed staff on what to observe and there were no interventions listed on the resident's Service Plan.

Review of Resident 3's Service Plan, updated 05/29/2025, showed that the resident had a diagnosis of [redacted]. Further review showed that Resident 3 had decreased functional mobility and had restarted Parkinson's medication. No side effects of the medication were listed, no directions to staff on what to be aware of, and no interventions for Resident 3.

<Resident 4>

Review of Resident 4's assessment, dated 05/01/2025, showed the resident had a diagnosis of [redacted] and that they required continuous oxygen.

Observation on 07/09/2025 at 11:15 AM, showed Resident 4 wearing a nasal cannula (tube placed under the nose used to deliver oxygen) with oxygen being administered.

Review of Resident 4's medication administration records (MARs) for May, June, and July 2025, showed that the resident had an order for albuterol (fast acting inhaled medication to open airways and decrease shortness of breath) to be administered every six hours as needed.

Review of a staff communication log, dated 06/23/2025, showed a note that Resident 4 "had non-breathing episode, panic attack?", further review showed the note was written by Staff B, Medication Technician.

In an interview on 07/09/2025 at 10:30 AM, Staff B stated that Resident 4 wore oxygen continuously. Staff B stated that Resident 4 often became anxious which caused them to become short of breath, and they would request their inhaler multiple times per day. Staff B further stated that when Resident 4 requested the inhaler, they were educated on breathing through their nose which helped to calm the resident. Staff B stated that decreasing Resident 4's anxiety often improved their shortness of breath and reduced their need for the albuterol inhaler. When asked if care staff were given instructions on what interventions to implement for Resident 4 when they became short of breath, Staff B stated they were not.

Review of Resident 4's Service Plan dated 05/01/2025, showed there were no

instructions or interventions listed on what staff were to do if the resident became anxious or short of breath.

This is a recurring deficiency previously cited on 08/22/2024.

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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date) 8.25.25.

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

Administrator (or Representative) 7.31.25 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were available for 1 of 7 residents (Resident 3). This failure resulted in missed medications for the resident and placed the resident at risk of falls and health complications.

Findings included...

Review of Resident 3's Service Plan (the facility's titled negotiated service agreement), dated 05/29/2025, showed that the resident had a diagnosis of [redacted] and had started carbidopa-levadopa (medication for Parkinson's) on 05/29/2025.

Review of Resident 3's Nursing Notes showed that the resident had recently stopped taking their Parkinson's medication which resulted in non-injury falls due to decreased ambulation ability on 05/22/2025, 05/28/2025, and 06/2/2025.

Review of Resident 3's June 2025 and July 2025 medical administration records (MARs)

showed that Resident 3 took Centrum gummies vitamins once daily, and carbidopa-levodopa three times daily. Further review showed that Resident 3 missed 14 doses of the Centrum, and nine doses of the carbidopa-levodopa in June, and missed three doses of the Centrum and two doses of the carbidopa-levodopa in July. Both medications were documented as "waiting on medication."

In an interview on 07/11/2025 at 10:30 AM, Staff K, Resident Care Coordinator, stated that they were not aware that the medication had not been given. Staff K further stated that on 06/16/2025, 06/17/2025, and 06/20/2025, the carbidopa-levodopa was marked as given in error. This resulted in a total of 12 missed doses in June 2025.

In an interview on 07/11/2025 at 10:42 AM, Staff E, Medication Technician (Med Tech), stated that the Med Techs are to reorder the medications "one to two weeks" before the medication needed to be refilled, and if it had not arrived "a couple of days before running out," they were to call the pharmacy directly.

Review of the facility's policy titled, "Unavailable Medications," dated 11/2007, showed "the designated staff person will contact the licensed nurse, who will evaluate the significance of the medication not being delivered to the resident on time and take appropriate actions to ensure resident safety and welfare."

Review of Resident 3's undated medical chart showed no documentation regarding an evaluation of the resident as to medications not being administered.

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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date) 8.25.25.

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

Administrator (or Representative) — Date: 7.31.25

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;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that all dietary staff had current food handler cards for 4 of 24 staff (Staff G, H, I, and J) sampled for food handlers cards and failed to maintain on-site food service in compliance with the Washington State Retail Food Code Chapter 246-215 WAC related to cross contamination, food temperatures, cleanliness, dating opened foods and storing of opened food packages in 1 of 1 kitchens (Facility Kitchen). This failed practice placed residents at risk of food borne illness.

Findings included...

<Food handler cards>

Review of the dietary staff schedule for 07/07/2025 – 07/10/2025, showed there were 24 dietary staff scheduled to work. Further review showed that Staff G, H, I, and J (Dietary Staff), had worked in the kitchen during that time.

In an interview on 07/09/2025 at 11:15 AM, Staff N, Dietary Manager, stated they kept a folder with current food handler cards for all kitchen staff but that "some of the new staff might not be in there."

Review of the food handler card folder showed no food handler cards for Staff G, H, I and J.

In an interview on 07/09/2025 at 3:35 PM, Staff F, Business/Human Resources Assistant, confirmed that Staff G, H, I, and J all worked in the kitchen, and they did not have current food handler cards.

<Cleanliness>

Per the Washington State Retail Food Code 04615, Non-food Contact Surfaces, must be cleaned at a frequency necessary to preclude accumulation of soil residues.

Observation of the kitchen on 07/09/2025 at 10:00 AM, showed the following:

-The floor had a sticky residue.

-Cluttered hallway with a duct tapped office chair, walker, jumble of extension cords, floor polisher, grease filter covered with debris, and fry oil.

-Four of the six bulbs above the grill were broken.

-One grill had a buildup of food and debris over the cooking surface.

-The deep fryer had food debris and grease buildup on the top and sides.

-The floor under and behind the grill and fryer had food debris and grease buildup.

-The freezer had areas with ice patches and chunks of ice on the floor.

In an interview on 07/09/2025 at 10:00 AM, Staff N stated the items in the hallway had been there for about six months. Staff N further stated the floor polisher was broken and the walker was theirs but they had not used it in several months.

<Preparing fresh fruits and vegetables>

Per the Washington State Retail Food Code 03300 (2) – Preventing contamination from hands, food employees may not contact exposed READY-TO-EAT food with their bare hands.

An observation on 07/08/2025 at 11:40 AM showed Staff Q, Prep Cook, cutting cantaloupe, and Staff P, Dietary Assistant Manager, cutting peppers with ungloved hands.

<Checking temperatures of foods>

Per the Washington State Retail Food Code 03525 (1)(a)(b), Time/temperature control for safety food, hot and cold holding, hot foods must be held at 135 degrees or above and cold foods must be held at 41 degrees or less.

In an interview on 07/09/2025 at 11:15 AM, the department requested Staff O, Bistro Staff, to take the temperature of the salads placed in the bistro salad bar. Staff O stated the macaroni salad was 42 degrees, and the potato salad was 44 degrees.

<Dating opened foods>

Per the Washington State Retail Food Code 03526 (2)(4)(c), refrigerated, ready-to-eat food must be clearly marked when the original container is opened and with a procedure to discard food on or before the last date by which the food must be consumed.

Observation on 07/09/2025 at 10:00 AM, showed the following:

-Taco meat and a corn/bean mix, in the walk-in refrigerator with no date.

-Tea in the walk-in refrigerator with no date.

-Ravioli in the freezer with no date.

-Four bags of chopped peanuts with a received date of 10/2024 and an expiration date of 04/25/2025.

-Bread in the food prep area with mold on it.

<Proper storage of foods>

Per the Washington State Retail Food Code 03200 (3), Compliance with food law, food must be labeled.

Per the Washington State Retail Food Code 03306 (1)(c), Preventing food and ingredient contamination, stored food in packages must have covered containers or wrappings.

Per the Washington State Retail Food Code 03309, Food storage containers, must be identified with common name of food, unless a food is unmistakenly recognized, foods removed from their original package must be identified with the common name of the food.

Observation on 07/09/2025 at 10:00 AM, showed the following:

-Cheese and flavored butter on the sandwich station uncovered.

-Taco meat and a bean/corn mix, in the walk-in refrigerator uncovered.

-The walk-in refrigerator had a container with raw pork and a second container of sauce placed in with the pork. The lid did not fully cover the contents of both containers.

-Two bins of basmati rice, one bin of white rice, and one bin of brown sugar in the prep area with unsecure lids.

-Dinner rolls in the freezer uncovered that appeared to be freezer burned.

-French fries in the freezer opened and falling out of the bag.

-An unlabeled and undated item in the freezer on the top shelf that appeared to be meat.

-Box of muffin mix, box of dried cranberries, and a bag of red velvet cake mix were opened and contents exposed to air in the pantry.

This is a recurring deficiency previously cited on 09/16/2022.

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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date) 8.25.25.

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

Administrator (or Representative) [signature] Date 7 31 25

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;

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff completed the required training for facility orientation for 3 of 5 staff (Staff A, B, and C) and continuing educational training for 3 of 5 staff (Staff C, D, and E). This failed practice placed residents at risk of care by untrained staff.

Findings included...

<Staff A>

Review of Staff A's, Medication Technician (Medtech), undated personnel file showed a hire date of 09/11/2024. Further review showed it did not contain documentation for facility orientation.

Review of the staff schedules from 06/01/2025 – 07/10/2025, showed that Staff A worked 13 shifts.

<Staff B>

Review of Staff B's, Medtech, undated personnel file showed a hire date of 12/31/2024. Further review showed it did not contain documentation for facility orientation.

Review of the staff schedules from 06/01/2025 – 07/10/2025, showed that Staff B worked 16 shifts.

<Staff C>

Review of Staff C's, Medtech, undated personnel file showed a hire date of 09/25/2023. Further review showed it did not contain documentation for facility orientation or continuing education.

Review of the staff schedules from 06/01/2025 – 07/10/2025, showed that Staff C worked 14 shifts.

Statement of Deficiencies	License #: 1992	Compliance Determination # 62411
Plan of Correction	Evergreen Fountains Senior Living Community	Completion Date
Page 14 of 14	Licensee: Evergreen Fountains LLC	07/11/2025

<Staff D>

Review of Staff D's, Medtech, undated personnel file showed a hire date of 02/04/2014. Further review showed it did not contain documentation for continuing education.

Review of the staff schedules from 06/01/2025 – 07/10/2025, showed that Staff D worked 12 shifts.

<Staff E>

Review of Staff E's, Medtech, undated personnel file showed a hire date of 03/27/2023. Further review showed it did not contain documentation for continuing education.

Review of the staff schedules from 06/01/2025 – 07/10/2025, showed that Staff E worked 16 shifts.

In an interview on 07/10/2025 at 10:56 AM, Staff F, Business/Human Resources Assistant, confirmed the facility did not have facility orientation for Staff A, B, and C, or continuing education for Staff C, D, and 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, Evergreen Fountains Senior Living Community is or will be in compliance with this law and / or regulation on (Date) 8.25.25

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

Administrator (or Representative) [signature] Date 7.31.25