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

Regency Newcastle, LLC
REGENCY NEWCASTLE
7454 NEWCASTLE GOLF CLUB ROAD
NEWCASTLE, WA 98059

RE: REGENCY NEWCASTLE License # 2018

Dear Administrator:

This letter addresses Compliance Determination(s) 70701 (Completion Date 12/30/2025) and 66694 (Completion Date 10/28/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/30/2025 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-2350-1, WAC 388-78A-2350-7-a, WAC 388-78A-2480-1, WAC 388-78A-24642-1, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-1, WAC 388-78A-2170-1, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2300-2-a-i, WAC 388-78A-2300-2-b, WAC 388-78A-2300-3-a, WAC 388-78A-2305-1, WAC 246-215-02310-5, WAC 388-78A-2474-1, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-112A-0400-3-a, WAC 388-112A-0400-4-a, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-1-a-ii, WAC 388-112A-0611-1-a-i, WAC 388-112A-0720-2-a, WAC 388-112A-0105-2-c, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-3090-2-c-iv, WAC 388-78A-3100-2

The Department staff who did the on-site verification:
Jane Hermano, NCI
Steven Garrett, LTC Licensor

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

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 the unannounced on-site full inspection on 10/06/2025 and 10/13/2025 of:
REGENCY NEWCASTLE
7454 NEWCASTLE GOLF CLUB ROAD
NEWCASTLE, WA 98059

The following sample was selected for review during the unannounced on-site visit: 11 of 68 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Young, Licensor
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

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.

Scotti Bower
Residential Care Services

12/08/2025
Date

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

Administrator (or Representative)

12/11/2025
Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to integrate into the service plan when to notify the doctor about high blood sugar readings as instructed for 1 of 2 residents (Resident 2) diagnosed with [redacted]. The facility failed to implement or obtain clarification for 2 of 6 sample residents (Resident 8 and Resident 9) physician orders. These failures placed Resident 2, Resident 8, and Resident 9 at risk of harm, not having care needs met, complications and improper care and services for medical diagnoses related to changes in conditions, and a diminished quality of life.

Findings included...

Review of the facility's policy titled, "Coordination of Care with Outside Health Services", revised July 2018, showed that the facility licensed nurse assisted in arranging outside care if needed and coordinated the resident's care with physicians to maintain and or enhance the health status of residents.

RESIDENT 2

Observation on 10/13/2025 at 11:17 AM, showed Resident 2 in their apartment. Resident 2 was unable to answer basic interview questions such as what the staff helped them with and who helped them with medications, consistent with Resident 2's primary diagnosis of [redacted].

Review of Resident 2's "Current Assessment", dated 07/24/2025, completed by the Department of Social and Health Services (DSHS) showed Resident 2 had a diagnosis of [redacted]

Review of the Medication Administration Records (MARS) dated 07/01/2015 – 10/11/2025, showed starting on 04/12/2025, the MARS instructed staff to check Resident 2's blood sugar before every meal on Saturdays and fax results over 180 to the doctor. Review of the MARS and corresponding progress notes showed the facility attempted one blood sugar check each Saturday at 4:00 PM. Resident 2 typically allowed one check a month. Review of the blood sugar entry on 09/27/2025 showed Resident 2 had a blood sugar of 212. Review of faxes sent to the doctor showed no fax sent for the blood sugar reading of 212.

Review of Resident 2's "Service Plan", dated 09/24/2025, showed no instruction for care staff to fax the doctor when Resident 2's blood sugar went over 180.

During an interview on 10/16/2025 at 1:57 PM, Staff D, Wellness Director, stated that they were checking whether staff sent the fax to the doctor. Staff D stated that one meal on Saturday blood sugar check was the correct instruction but was listed on the MARS incorrectly due to a glitch in their system. As of 10/28/2025, the facility was unable to produce evidence it contacted Resident 2's doctor as instructed regarding Resident 2's high blood sugar.

RESIDENT 8
Review of Resident 8's records showed the facility admitted Resident 8 on [redacted]/2022 with multiple diagnoses which included [redacted] and [redacted].

Review of Resident 8's Service Plan (also called service agreement), dated 06/04/2025, showed that the facility ensure safe medication administration, as directed in the physician's order. The Service Plan showed guidance for the care staff to monitor Resident 8 for signs and symptoms of low blood sugar levels.

Review of Resident 8's August 2025, September 2025, and October 2025 medication administration records (MARs) showed the facility staff monitored Resident 8's morning blood sugar levels and blood pressure (BP). The MARs showed a physician's order to

hold the insulin medication if Resident 8's blood sugar was less than 100 milligrams per deciliter (mg/dL - a unit of measurement used to determine blood glucose levels). The August 2025, September 2025, and October 2025 MARS showed six incidences when blood sugar levels were less than 100 mg/dL.

Review of the MARs showed a physician's order to notify Resident 8's physician if the blood pressure reading was greater than 140/60 millimeters of mercury (mmHg). The July 2025, August 2025, and September 2025 MARs showed 10 incidences when the BP readings were greater than 140/60 mmHg.

Review of Resident 8's records showed no documentation the facility staff held the insulin medication when Resident 8's blood sugar was less than 100 mg/dL. Resident 8's records showed no documentation the facility staff notified the physician of Resident 8's BP readings over 140/60 mmHg.

During an interview on 10/13/2025 at 11:19 AM, Staff I, Regional Nurse, stated that the facility staff charted that the insulin medication was held on 08/23/2025. Staff I stated there was no additional information in the MAR documentation section or nursing progress notes that the facility staff held the insulin medication when Resident 8's blood sugar level was below 100 mg/dL.

RESIDENT 9
Review of Resident 9's records showed the facility admitted Resident on [redacted]/2025 with multiple diagnoses which included unspecified site of [redacted]. Review of Resident 9's records contained an outside physician summary visit note dated 08/19/2025. The summary note showed an order that requested the facility staff to monitor Resident 9's left wrist pain and notify the physician if pain persisted.

Review of Resident 9's records showed no documentation that Resident 9's pain on the left wrist was monitored. Review of the record showed Resident 9's pain assessment was not completed. The Service Plan dated 10/07/2025 did not include the instructions provided by the physician.

Observation on 10/08/2025 at 10:50 AM, showed Resident 9 repeatedly opened and closed their left hand. During an interview at this time, Resident 9 stated that they experienced pain on their left hand most of the days. Resident 9 stated that they were unaware there was an order to report to the physician about the pain to their left wrist. Resident 9 stated that they did not report the symptoms to the physician or staff.

During an interview on 10/09/2025 at 10:58 AM, Staff D, Wellness Director, stated that Resident 9 was alert and able to report to their physician if they experienced pain. Staff D stated that they did not clarify the order with Resident 9's physician.

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, REGENCY NEWCASTLE is or will be in compliance with this law and / or regulation on (Date) 12/12/25.

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

Administrator (or Representative) — Date: 12/11/25

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 observation, interviews and record reviews, the Assisted Living Facility failed to ensure 3 of 7 sampled staff (Staff A, Staff C, and Staff G) were screened for tuberculosis (TB) with an intradermal (Mantoux) test or a blood test (IGRA) within three days of hire. This failure placed all the residents at risk of potential exposure to TB, a serious and contagious respiratory disease.

Finding included...

Note. WAC 388-78A-2481 Tuberculosis—Testing method—Required. The assisted living facility must ensure that all tuberculosis testing is done through either: (1) Intradermal (Mantoux) administration with test results read: (a) Within forty-eight to seventy-two hours of the test; and (2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

Review of the facility's Employee Roster showed that the facility hired Staff A, Executive Director, on 03/19/2024. The facility hired Staff C, Resident Care Manager, on 06/13/2024. The facility hired Staff G, Aide, on 08/06/2024.

STAFF A
Review of Staff A's records showed that Staff A completed a two-step TB skin test on 06/10/2025 and 06/25/2025 that showed negative results for TB, 461 days after date of hire.

During an interview on 10/08/2025 at 11:15 AM, Staff A stated that they worked from

Monday through Friday. Staff A stated that they managed staff who provided care and services for residents. Staff A stated that they had repeated the two-step skin test. Staff A stated that their previous two-skin test results were missing.

STAFF C
Observation on 10/07/2025 through 10/10/2025, at variable times, showed Staff C assisted residents with their care.

During an interview on 10/10/2025 at 10:17 AM, Staff C stated they work from Tuesday through Saturday. Staff C stated that they provided care to the residents and supervised the care staff.

Review of Staff C's records showed that Staff C completed a two-step TB skin test on 08/21/2024 and 09/09/2024 that showed negative results for TB, 18 days after date of hire.

Staff G
Review of the Care Staffing schedule showed that from 07/21/2025 through 10/08/2025, Staff G worked at the facility. Review of Staff G's employee records showed that on 08/14/2024, Staff G completed a TB risk assessment with negative TB symptoms. Review of the records showed that Staff G had a chest Xray completed on 06/28/2024 prior to the date of hire. There was no documentation that showed Staff G was screened and tested for TB, within three days of hire, as required.

During an interview on 10/10/2025 at 12:46 PM, Staff A stated that they were aware that all facility staff required screening for TB within three days of hire. Staff A stated that Staff G provided care and services for residents. Staff A stated Staff G's records showed no documented positive result from a previous skin test or blood test.

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) — 12/11/25 Date

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 1 of 6 sampled staff (Staff C) completed a national fingerprint background check in a timely manner. This failure placed residents at risk for potential abuse, neglect, or exploitation from a staff with an unknown background.

Findings included...

Note: WAC 388-78A-24681 Background checks-Employment-Provisional Hire-Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty days and allow the caregiver or administrator to have unsupervised access to residents when: (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
WAC 388-78A-2467 Background check—Sharing by health care facilities. In accordance with RCW 43.43.832 a health care facility may share Washington state background check results with other health care facilities under certain circumstances. Results of the national fingerprint checks may not be shared. For the purposes of this section health care facility means a nursing home licensed under chapter 18.51 RCW, an assisted living facility licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

Observation on 10/07/2025 through 10/10/2025, at variable times, showed Staff C assisted residents with their care. During an interview at this time, Staff C stated that they updated the residents service plan and had direct access to residents.

Review of Staff C's facility personnel records showed the facility hired Staff C, Certified Nursing Assistant and Resident Care Manager on 06/13/2025. Staff C's completed initial Washington State name and date of birth background inquiry (BGI) on 06/13/2024 showed no disqualifying results. Review of the records showed that Staff C completed a national background fingerprint on 08/26/2025, 500 days from the date of hire.

Review of Collateral Contact (CC1, Background Check Central Unit) email, dated 10/16/2025, showed that Staff C failed to show up for the fingerprint background check on 06/13/2024, and 08/15/2024. CC1's email showed that Staff C's fingerprint was completed for another facility on 08/26/2025.

During an interview on 10/10/2025 at 1:00 PM, Staff A, Executive Director, stated that they were aware all staff with direct unsupervised contact to residents needed a valid national fingerprint background check. Staff A stated that they were unaware that submission of a fingerprint background check for any newly hired staff required a timeline.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 12.11.25

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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to integrate the initial Department of Health and Social and Health Services Assessment for 1 of 1 resident (Resident 2) into the resident's service plan. This failure placed Resident 2 at risk of harm, not having care needs met, and a diminished quality of life.

Findings included...

Observation on 10/13/2025 at 11:17 AM showed Resident 2 in bed in their apartment. Resident 2 was unable to answer basic interview questions such as what the staff helps them with and who helps them with medications.

Review of the facility's records for Resident 2 showed a primary diagnosis of [redacted].

Review of Resident 2's Current Assessment, dated 07/24/2025, completed by the Department of Social and Health Services (DSHS) showed, "Diabetic Foot Care Instructions. Daily foot care can help keep a client with diabetes feet safe. Keep the client's feet clean and dry, and look at the feet every day for skin and nail changes. Look for blisters, sores, swelling, dry or cracked skin, redness, or sore toenails. If you notice any of these changes tell the appropriate health care professional right away. Use warm water to wash your client's feet every day. Check the temperature to be sure it is not too hot. Dry your client's feet well, especially between all of the toes. It is okay to apply lotion to the feet, but not between the toes. Always encourage your client wear well-fitting shoes or slippers to protect the feet from injury."

Review of Resident 2's "Service Plan Report", dated 09/24/2025, showed the services provided by the facility to Resident 2. The Service Plan showed no services provided by the facility for daily foot care. Review of the progress notes dated 07/23/2025 – 10/16/2025, showed no notation the facility provided daily foot care to Resident 2.

During an interview on 10/16/2025 at 1:57 PM, Staff D, Wellness Director, stated that they read the DSHS Home and Community Services case manager's assessment of each resident to ensure nothing was missed related to the resident's care and services. Staff D stated that although the facility failed to integrate the DSHS diabetic foot care instructions into Resident 2's Service Plan, the staff dressed Resident 2 daily and would have noticed an issue.

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) — 12.11.25 Date

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

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with

the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 4 residents (Resident 1) consistent with their assessed needs, used a bed rail resistant to entrapment. This failure placed Resident 1 at risk of injury or death.

Findings included...

Review of the facility's policy, "Devices with Restraining Qualities Assessment", dated 08/2018, set guidelines for devices with restraining qualities. The guidelines showed a registered nurse (RN) and/or a therapist should complete the assessment; the correct use and precautions should be documented in the resident's service plan; the use of other less restrictive alternatives should be documented; and the assessor should review the risks and benefits of the device with the resident and family.

Review of facility's document titled, "ALF Device with Restraining Qualities Assessment", dated 04/20/2025, showed Staff J, Assistant Wellness Director, completed the assessment. Review showed Resident 1 was informed of the risks of using a bed cane including bruising cuts, scrapes, bodily injury, entrapment, strangulation, suffocation, or death. Review showed the facility assessed that Resident 1 understood the risks. There was no documentation that the facility assessed the device for safety.

Review of Staff J's professional credentials showed Staff J was a Licensed Practical Nurse (LPN) not a Registered Nurse per the facility's policy.

Observation on 10/13/2025 at 10:55 AM of Resident 1's bed showed a medical device attached to the right side of the mattress. It had a padded curved handle on top and three horizontal metal poles attached between two vertical metal poles. The distance from the largest gap from the curved poles to the first horizontal pole was 4.5 inches. The distance between each additional horizontal pole was 5 inches.

During an interview on 10/13/2025 at 10:55 AM, Resident 1 stated that an outside agency physical and occupational therapists told them the bed rail should be covered to prevent entrapment.

During an interview on 10/20/2025 at 12:17 PM, Staff J stated that they determined bed rails/canes were safe "if the resident's cognition was not confused", the bed rail was covered and "fit right". Staff J stated that they thought the safe distance between the rails may be six inches. Staff J stated that they could not recall if they saw Resident 1's bed rail. Staff J stated that they could not recall if the gaps below the poles were safe.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 12.11.25

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess 1 of 5 sampled resident (Resident 4) for safe and proper use of an assistive device. This failure placed Resident 4 at risk of potential entrapment and harm or injury.

Findings included...

Note: 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: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

Review of the facility's policy titled "Devices with Restraining Qualities Assessment", revised August 2018 showed that the facility allowed the use of assistive devices with restraining qualities. The policy stated that the facility's registered nurse and or therapist assessed the residents in need of an assistive device. The policy stated a restraint review were completed quarterly or upon a significant change in resident's

status. The policy stated that the device's assessment was documented in the resident's service plan which included device type and purpose, correct use and precautions.

RESIDENT 4
Review of Resident 4's records showed that the facility admitted Resident 4 on [redacted]/2025.

Observation of Resident 4's apartment on 10/07/2025 at 10:08 AM showed a U-shaped assistive device was attached near the head of the bed, along the right side. The assistive device had a seven-inch gap between the bars. The device shifted when moved with minimal effort which created a gap wider than three inches between the mattress and the device. Observation showed the device's base was anchored beneath the mattress and sat on top of the bed platform. The device was not securely attached to the bed frame.

During an interview on 10/07/2025 at 10:35 AM, Resident 4 stated that they used the assistive device to sit up, and to get in and out of the bed. Resident 4 stated that their son brought in the device when they moved into the facility. Resident 4 stated that they were unaware of any safety concerns when they used the device.

Review of Resident 4's 30-day comprehensive assessment, dated 04/09/2025 showed Resident 4 was able to transfer independently. There was no documentation Resident 4 was assessed to safely use an assistive device.

Review of Resident 4's service plan (also called service agreement), dated 06/02/2025 showed Resident 4 was independent with transfer and bed mobility. The service plan showed no documentation that Resident 4 used any assistive device.

During an interview on 10/08/2025 at 11:06 AM, Staff I, Regional Nurse stated that the facility required an assessment of residents for devices with restraining qualities. Staff I stated they were unaware there was no documentation that Resident 4 was assessed to safely use the assistive device.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 12.11.25

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

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(b) Prescribed nutrient concentrates and supplements when prescribed in writing by a health care practitioner.

(3) The assisted living facility may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

(a) Modified or therapeutic diets;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain 1 of 1 dietary manual (dietary manual 1) and make available to food preparation staff. This failure placed all 68 residents at risk of not having their nutritional needs adequately met.

Findings included...

Review of the facility's Disclosure of Services showed the facility provided prescribed general low sodium diets, general diabetic diets, and mechanical soft diets.

Review of the facility's undated Resident Characteristic Roster showed the facility provided care and services to 15 residents diagnosed with [redacted].

[redacted]. The Resident Characteristic Roster showed the facility noted three residents had special dietary needs.

Observation of the commercial kitchen and residents' dining room on 10/08/2025 between 8:50 AM and 9:32 AM and between 12:30 PM and 1:55 PM, showed there was no current dietary manual available to the food preparation staff.

During an interview on 10/08/2025 at 9:32 AM, Staff L, Cook, stated that they were unaware of and never used a dietary manual to prepare food for residents.

During an interview on 10/08/2025 at 1:55 PM, Staff K, Dietary Manager, stated that they knew of the practice of using a dietary manual from another facility where they worked. Staff K stated that they were unaware of the use of a dietary manual in this facility.

During a group interview on 10/08/2025 at 10:30 AM, five anonymous residents stated that they had concerns about food services not meeting their nutritional needs with meals that were not balanced. The residents stated that the menu was low on sources of protein and iron.

During an interview on 10/13/2025 at 11:27 AM, Resident 3 stated that they were dissatisfied with the menus because the facility did not meet their basic nutritional needs. Resident 3 stated that during outside medical care they were told they were malnourished.

During an interview on 10/09/2025 at 10:49 AM, Staff A, Executive Director, stated that the facility uses a dietary manual. Staff A stated that the facility did not make special diets available to residents because that would not permit choice.

During an interview on 10/13/2025 at 11:47 PM, Staff D, Wellness Director, stated that the facility would not provide residents with a special diet such as a general diabetic diet even if prescribed by a medical provider and agreed to by the resident.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 12.11.25

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(5) After handling soiled equipment or utensils;

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, interview, and record review, the facility failed to ensure that 1 of 1 dishwasher staff (Staff H) in the main commercial kitchen washed their hands after handling soiled utensils and dishes used during meal service and handling clean utensils and dishes. This failure placed all 68 residents at risk of food contamination, foodborne illness, and a diminished quality of life.

Findings included...

Review of the facility's policy titled, "Hand Hygiene", dated 08/2018, showed the facility instructed staff to wash their hands after handling soiled equipment or utensils.

Review of the facility's document titled, "In-Service Training Record" showed Hand Washing/Infection Control was presented to staff on 07/29/2025. Review showed Staff H, Dishwasher, attended the training.

Review of the facility's undated Resident Characteristic Roster showed the facility provided care and services to 68 residents.

Observation on 10/08/2025 at 8:51 AM, showed Staff H, Dishwasher, prepared soiled utensils and dishes to load into the commercial dishwasher. Observation showed Staff H spread the soiled utensils in the basket using their bare hands before placing them into the dishwasher. Staff H wiped their hands on a soiled dish cloth hanging from their waistband. Staff H then moved to putting away clean utensils and dishes without washing their hands. Staff H repeated the same process.

During an interview on 10/09/2025 at 1:21 PM, Staff K, Dietary Manager, stated that they were unaware Staff H did not wash their hands when moving from handling dirty dishes to clean dishes.

Plan/Attestation Statement

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Administrator (or Representative) — 12.11.25 — Date

WAC 388-112A-0105 Who is required to obtain home care aide certification and by when?

(2) The following individuals must obtain home care aide certification as follows:

(c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire;

WAC 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(a) Developmental disabilities specialty training as described in WAC 388-112A-0420 ;

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(a) Developmental disabilities specialty training as described in WAC 388-112A-0420 .

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:

(i) A certified home care aide;

(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);

(iii) A certified nursing assistant;

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

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

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(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:

(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 observation, 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) met all their professional certification and training requirements required to provide resident care. These failures placed all 68 residents at risk of harm, not having care needs met, and a diminished quality of life from untrained staff.

Findings included...

Review of the facility's undated Resident Characteristic Roster showed the facility provided care and services to 68 residents.

Review of the undated Staff Roster showed the facility hired Staff A, Executive Director, in March 2024. Review showed the facility hired Staff B, Certified Nursing Assistant, in August 2024. Review showed the facility hired Staff C, Resident Care Manager, in June 2024. Review showed the facility hired Staff D, Wellness Director, in August 2024. Review showed the facility hired Staff E, Aide, in December 2022. Review showed the facility hired Staff F, Aide, in July 2023.

DEVELOPMENTAL DISABILITY SPECIALTY TRAINING
NOTE: RCW 71A.10.020(6) showed, "Developmental disability" means a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition of an individual found by the secretary to be closely related to an intellectual disability or to require treatment similar to that required for individuals with intellectual disabilities, which disability originates before the individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to the individual. By June 30, 2025, the administration shall promulgate rules to further define developmental disability without the use of intelligence quotient scores.

Review of the facility's undated Disclosure of Services showed the facility provided care and services to residents with developmental disabilities.

Review of the facility's undated Resident Characteristic Roster showed the facility had identified no residents with a developmental disability.

Review of the employee records for Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F showed the facility failed to ensure the staff received the Developmental Disability Specialty Certification.

Review of Resident 10's records showed the facility admitted Resident 10 in [redacted]ll 2016. Review showed Resident 10 had a primary diagnosis of [redacted]. Review showed Resident 10 had a secondary diagnosis of [redacted]. Review showed that of the other secondary diagnoses listed, none related to mental health or dementia, the other criteria for triggering the care and administrative staff to complete specialty training.

Observation on 10/08/2025 at 1:00 PM showed Resident 10 had motor impairment characterized by a wide-based style of walking with legs spread apart from the knees. Resident 10 showed difficulty with balance and walking and difficulty with fine motor control of the hands, wrists, and fingers. Resident 10 had slurred speech with difficulty enunciating words.

During an interview on 10/16/2025 at 2:10 PM, Staff C, Wellness Director, stated that they were unaware that Resident 10 met the criteria for having a development disability because they were not intellectually disabled.

CONTINUING EDUCATION
Review of the facility's undated Certified Nursing Assistant Job Description showed Aides provided quality nursing care to residents while they provided individualized attention to ensure the highest level of mental, physical, and psychosocial well-being.

STAFF E
Review of Staff E's employee file showed Staff E maintained an active Nursing Assistant Registration. The records showed no documentation Staff E completed any of the required 12 hours of continuing education training from their July 2024 birthday to their July 2025 birthday.

Review of the care staff schedule from 09/22/2025 – 10/09/2025, showed the facility routinely scheduled Staff E for five shifts a week.

During an interview on 10/09/2025 at 11:07 AM, Staff M, Business Office Manager, stated that they were aware that Staff E had completed no hours of continuing education from birthday to birthday.

FIRST AID/CARDIOPULMONARY RESUSITATION (CPR)
STAFF F
Review of Staff F's employee file showed Staff F failed to complete First Aid/CPR training in January 2025 when their training expired.

During an interview on 10/09/2025 at 11:07 AM, Staff M, Business Office Manager, stated that they were aware that Staff F failed to renew their First Aid/CPR training certificate. Staff M stated that Staff F worked for several months without the certification until leaving the country this summer.

HOME CARE AIDE (HCA) CERTIFICATION
NOTE: Per the Dear Provider Letter, dated 10/13/2023, the Department initially extended the HCA certification requirements for staff hired between 10/01/2022 to 06/30/2023 for completion by 01/31/2025. The Home Care Aide Certification requirement was extended again to 365 days from the date of hire. This rule will expire on December 31, 2027.

Review of Staff E's employee file showed Staff E, hired on 12/08/2022, failed to obtain their professional HCA certification by the extended 01/31/2025 deadline.

During an interview on 10/09/2025 at 11:07 AM, Staff M stated that they were aware that Staff E had failed to complete their HCA certification while they remained on the care schedule providing resident care and services.

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, REGENCY NEWCASTLE is or will be in compliance with this law and / or regulation on (Date) 12-12-25 .

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

Administrator (or Representative) — 12.11.25 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the mechanical air exchange vents were functional for 13 of 15 air exchange vents for Janitor's Closets (JC) with a mop sink, residents' Laundry Rooms (LR), and commercial kitchen (CK) chemical closet with a mop sink (JC 4th Floor South, JC 4th Floor North, JC 3rd Floor North, JC 3rd Floor South, JC 2nd Floor South, JC 1st Floor North, JC 1st Floor South, RL 4th Floor South, RL 4th Floor North, RL 3rd Floor South, RL 1st Floor North, and CK chemical closet). The facility failed to ensure 1 of 1 double-slider window set of double-paned windows (Slider Left and Slider Right) in the Creekside Dining Room maintained their seals. The facility failed to ensure that 1 of 1 patio transition (Patio 1) from the Main Dining Room to the patio was free of an abrupt edge with a slant between the landing and patio. These failures placed all 68 residents at risk of poor air quality, respiratory distress, injury, and a diminished quality of life.

Findings included...

NOTE: The facility provided an environmental tour of the interior and exterior of the building on 10/08/2025 and 10/13/2025. Staff A, Executive Director, provided the first part of the tour on 10/08/2025. Staff N, Maintenance Director, provided the second part of the tour on 10/13/2025.

AIR EXCHANGE VENTS
Observation during the environmental on 10/08/2025 at 9:48 AM showed the air exchange vent in the fourth-floor Janitor's Closet air exchange vent between the inside and outside of the building was not functioning. Observation on 10/08/2025 at 9:52 AM of the fourth-floor residents' Laundry Room South showed the air exchange vent was not functioning. Observation on 10/08/2025 at 9:57 AM of the fourth-floor North Janitor's Closet showed the air exchange was not functioning. Observation on 10/08/2025 at 10:00 AM of the fourth-floor residents' North Laundry Room showed the air exchange vent was not functioning. Observation on 10/08/2025 at 10:07 AM of the third-floor North Janitor's Closet showed the air exchange vent was not functioning. Observation on 10/08/2025 at 10:20 AM of the third-floor South Janitor's Closet showed the air exchange vent was not functioning.

Observation on 10/13/2025 at 8:54 AM of the second-floor residents' Laundry Room showed the air exchange vent was not functioning. Observation on 10/13/2025 at 8:55 AM of the second-floor South Janitor's Closet showed the air exchange vent was not functioning. Observation on 10/13/2025 at 9:20 AM of the first-floor residents' North Laundry Room showed the air exchange vent was not functioning. Observation on 10/13/2025 at 9:24 AM of the first-floor Janitor's Closet showed the air exchange vent was not functioning. Observation on 10/13/2025 at 9:30 AM of the first-floor Ladies' Bathroom showed the air exchange vent was not functioning. Observation on 10/13/2025 at 9:32 AM of the Commercial Kitchen's chemical closet showed the air exchange vent was not functioning. Observation on 10/13/2025 at 9:52 AM of the first-floor South Janitor's closet showed the air exchange vent was not functioning.

During an interview on 10/08/2025 at the times of the observations of the nonfunctioning air exchange vents, Staff A confirmed that the vents were not functioning. During an interview on 10/13/2025 at the time of the observations of the nonfunctioning air exchange vents, Staff N confirmed that the vents were not functioning.

DOUBLE-PANED WINDOWS
Observation on 10/13/2025 at 9:25 AM of the Creekside Dining Room showed a set of double pane windows with a stationary center and two sliding windows on both sides. Observation showed fog between the double panes.

During an interview on 10/13/2025 at 9:25 AM, Staff N, stated that there was moisture leakage between the windowpanes.

During a group interview on 10/08/2025 at 10:30 AM, five anonymous residents stated that they had concerns about the facility's willingness to adequately maintain the building. The residents stated that they heard from management that certain repairs were too expensive to complete. The residents stated that one of their concerns was double-paned windows in some common areas and some residents' apartments had broken seals. The residents stated broken seals created fog between the windowpanes and drafts.

During an interview on 10/13/2025 at 1:51 PM, Staff A, Executive Director, stated that the cost of replacing double-paned windows was too much to fall within the budget.

PATIO TRANSITION
Observation on 10/13/2025 at 10:23 AM of the exterior patio accessible from the main residents' dining room, showed a flat concrete landing outside of the door. The landing was followed by a lip and a downward slant of the concrete patio leading to tables and chairs.

During an interview on 10/13/2025 at 10:23 AM, Staff N, stated that they were aware it was a "tripping hazard" for residents.

During a group interview on 10/08/2025 at 10:30 AM, five anonymous residents stated that the change sharp change in direction from a flat to a slanted surface of the concrete surface leading from the main dining room to the outside patio created a risk for residents to fall.

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, REGENCY NEWCASTLE is or will be in compliance with this law and / or regulation on (Date) 12.12.25.

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

Administrator (or Representative) — Date: 12.11.25

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 2 housekeeping carts (Cart 2), 1 of 1 Housekeeping Utility Room/Commercial Laundry Room (HUR/CL), and 1 of 1 Sprinkler Riser Room (Sprinkler Riser Room) that stored hazardous cleaning chemicals and equipment was locked when unattended by staff. This failure placed all 68 residents at risk of ingestion and hazardous chemicals and injury.

Findings included...

Review of the facility's undated Resident Characteristic Roster showed the facility provided care and services to 68 residents . The roster showed the facility provided care to 26 residents diagnosed with [redacted] and/or [redacted]. The roster showed the facility provided care to 10 residents with behaviors and/or psychosocial issues - characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior.

HOUSEKEEPING CART
Observation on 10/08/2025 at 10:14 AM, showed Staff O, Housekeeper, took their duster and walked away from the housekeeping cart that was located about 2/3 of the way down the resident hallway. Staff O turned left entering the next hall. Observation showed Staff O left a bin of hazardous cleaning chemicals on the outside of the unlocked cart. Observation showed that Staff A, Executive Director, who was providing the environmental tour, walked past the cart to the end of the hall not noticing the licensor stopped behind then and was reading the warning labels until called back by the licensor. The chemicals included toilet cleaner, floor cleaner, and glass cleaner. The warning labels included that the chemicals were for industrial use only, hazardous to humans, and an eye irritant.

During an interview on 10/08/2025 at 10:21 PM, Staff P, Housekeeping Supervisor, stated that Staff O was new. Staff P stated that Staff O was trained to keep unattended chemicals locked. Staff P stated that they could provide the corresponding training record. Staff P stated that they were unable to provide a policy related to locking unattended hazardous chemicals.

During an interview on 10/09/2025 at 10:53 AM, Staff A stated that the cart was "never unattended" since they were in the hall. Staff A stated they would have noticed anyone approaching the cart.

Record review of Staff O's training documentation provided titled, "Assisted Living

Community General Orientation/Training Checklist", dated 09/25/2025, "Code of Business Conduct and Compliance Guide" dated 09/26/2025, "Our Culture, Our Values, Our Standard of Performance", dated 09/26/2025, showed no evidence the facility trained Staff O to lock unattended hazardous chemicals.

Record review of the undated the facility's Housekeeper Job Description showed no evidence the facility trained Housekeepers to lock unattended hazardous chemicals.

HOUSEKEEPING UTILITY ROOM/COMMERCIAL LAUNDRY
Observation on 10/13/2025 at 10:07 AM, showed the Housekeeping Utility Room that lead into the unlocked and unattended Commercial Laundry. Observation showed unlocked cabinets in the utility room containing hazardous chemicals. Observation showed a sign on the back of the door that instructed staff to lock the door. Observation of the unlocked commercial laundry room showed three five-gallon buckets of chlorine bleach with caution labels.

During an interview on 10/13/2025 at the time, Staff N, Maintenance Director, stated that they were unaware staff needed to keep chemicals locked when unattended.

SPRINKLER RISER ROOM
Observation on 10/13/2025 at 10:16 AM showed the Sprinkler Riser Room located in the parking garage just outside of a hallway exit. The room was gated. Observation showed the gate was ajar, which caused unlocked access. Observation of the room showed hazardous chemicals with warning labels and unlocked power and hand tools.

During an interview on 10/13/2025 at the time, Staff N confirmed that the gate was open. Staff N stated that residents parked in the garage.

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, REGENCY NEWCASTLE is or will be in compliance with this law and / or regulation on (Date) 12.12.25 .

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

Administrator (or Representative) — Date: 12.11.25

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

AMENDED
12/08/2025

Regency Newcastle, LLC
REGENCY NEWCASTLE
7454 NEWCASTLE GOLF CLUB ROAD
NEWCASTLE, WA 98059

RE: REGENCY NEWCASTLE # 2018

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/28/2025 and found that your facility does not meet the Assisted Living Facility requirements.

You requested an Informal Dispute Resolution (IDR) review. The IDR review resulted in the enclosed amended Statement of Deficiencies.

The Department:
- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

James Sherman, Field Manager

Residential Care Services
Region 2, Unit D
Preferred methods:
eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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;

The facility failed to obtain acknowledgment signatures for three sampled residents' current Service Plan Report (SPR), equivalent to the Negotiated Service Agreement. During the inspection, facility staff obtained signatures acknowledging the current SPR from residents, to meet regulatory requirements. This deficiency was corrected by the exit conference.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:
• Please contact me at (206)305-3489.

Sincerely,

IDR Program Manager signed for James Sherman

James Sherman, Field Manager
Region 2, Unit D

Residential Care Services

Enclosure