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

ALJOYA HOUSE AT MERCER ISLAND LLC
ALJOYA MERCER ISLAND
2430 76TH AVENUE SE
MERCER ISLAND, WA 98040

RE: ALJOYA MERCER ISLAND License # 2019

Dear Administrator:

This letter addresses Compliance Determination(s) 68523 (Completion Date 11/10/2025) and 66379 (Completion Date 10/02/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/10/2025 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-2240

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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

Sincerely,

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 an unannounced on-site follow-up on 09/30/2025 of:
ALJOYA MERCER ISLAND
2430 76TH AVENUE SE
MERCER ISLAND, WA 98040

This document references the following SOD dated: 10/02/2025

The following sample was selected for review during the unannounced on-site visit: 5 of 30 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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.

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-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 1 of 1 sampled resident (Resident 7) received medications as prescribed. This failure resulted in Resident 7 not getting medications as ordered and placed the resident at risk for potential medical complications.

Findings included…

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 08/04/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 09/18/2025.

Review of the facility's document titled, "If Medications Are Not Available", dated 04/02/2013, showed the facility was responsible to eliminate situations in which resident did not have prescribed medications available.

Review of Resident 7's records showed the facility admitted Resident 7 in [redacted] 2025. The records showed that on 09/01/2025, the facility completed Resident 7's assessment. The assessment showed Resident 7 required assistance with medication management. The assessment showed the facility was responsible for ordering medications and communication with pharmacy. The records showed Resident 7's

medication orders included Acetaminophen (a pain-relieving medication) oral tablet, 325 milligram (mg), take two tablets by mouth, three times daily, for pain and discomfort and Carvedilol (a medication that high blood pressure) oral tablet, 3.125 mg, take one tablet by mouth, twice daily (Additional directions: Hold for Systolic Blood Pressure (SBP, the top number in a blood pressure reading, indicating the pressure in the arteries when the heart contracts and pumps blood) less than 110, for hypertension (high blood pressure).

Review of Resident 7's September 2025 electronic Medication Administration Record (eMAR) showed that between 09/18/2025 and 09/30/2025, Carvedilol was not available and was not administered for two doses on 09/22/2025 and two doses on 09/23/2025. The eMAR showed no documentation of Resident 7's blood pressure measurement on 09/22/2025 and 09/23/2025 when Carvedilol was not administered. The MARs showed between 09/18/2025 and 09/30/2025, Resident 7's SBP was above 130 for 11 of the 13 days. The eMAR showed that Acetaminophen was not available and was not administered for one dose on 09/28/2025 and three doses on 09/29/2025. There was no document that showed the two medications were discontinued by physicians.

Review of the facility's email titled "PM Shift Report 09/16/2025", dated 09/16/2025, showed the care staff notified the nurse that Resident 7's Carvedilol was down to five-days of doses. There was no documentation that showed the facility notified the pharmacy to obtain a refill of medication.

Review of Resident 7's progress notes showed that on 09/23/2025, the facility notified the hospice care team the Carvedilol ran out for "four days [sic]". The progress notes showed Resident 7's physician ordered to continue the Carvedilol while Resident 7 was under hospice care. The progress notes showed that on 09/23/2025, the facility sent the Carvedilol prescription to the preferred pharmacy.

Review of the facility's email titled "PM Shift Report 09/22/2025", dated 09/22/2025, showed the care staff notified the nurse that Resident 7's Acetaminophen was down to five-days of doses. Review of the facility document titled "Refill Order Form", dated 09/29/2025, showed that the facility submitted the refill of Acetaminophen for Resident 7 on 09/29/2025, one day after the Acetaminophen ran out and became unavailable.

During an interview on 09/30/2025 at 2:35 PM, Staff E, Lead Resident Assistant, stated that they were responsible to dispense medication for Resident 7 on 09/29/2025. Staff E stated that they found no Acetaminophen in the medication cart and that the medication ran out. Staff E stated that they notified the nurse in the morning on 09/29/2025. Staff E stated that no Acetaminophen medication was available to administer the scheduled PM dose, and they did not administer the medication to Resident 7. Staff E stated that the nurse placed the order on 09/29/2025; and the Acetaminophen was delivered on 09/30/2025. Resident 7 did not have Acetaminophen for one day.

During an interview on 09/30/2025 at 2:30 PM, Staff O, Registered Nurse, Area

Community Health Director, stated they did not locate any documentation that showed the facility placed the refill order of Carvedilol. Staff O stated that they did not locate any documentation of Resident 7's blood pressure measurement on 09/22/2025 and 09/23/2025. Staff O stated that they located a refill order of Acetaminophen that was sent to the pharmacy on 09/29/2025, when the Acetaminophen had already run out.

During an interview on 10/01/2025 at 4:02 PM, Staff I, Registered Nurse, Community Health Director, stated that Resident 7 used the prescribed Carvedilol for high blood pressure and the prescribed Acetaminophen for pain relief. Staff I stated they were aware Carvedilol oral tablet was not available and was not administered for 2 doses on 09/22/2025 and 2 doses on 09/23/2025. Staff I stated that when the Carvedilol ran out and was not administered for two days, they notified the hospice nurse to obtain a refill of the medication. Staff I stated they were told by hospice nurse that Carvedilol was not covered under hospice. Staff I stated that they reached out to their preferred pharmacy on 09/23/2025. Staff I stated they were told that there was no prescription of Carvedilol in the system. Staff I stated that on the same day 09/23/2025, they obtained the doctor's order of Carvedilol, sent the order to the preferred pharmacy, and the family pick up the medication from the pharmacy. Staff I stated that they did not locate any blood pressure readings for 09/22/2025 and 09/23/2025 in the resident records. Staff I stated that they were unsure whether their staff measured the blood pressure for Resident 7 when the Carvedilol was unavailable on 09/22/2025 an 09/23/2025. During the same interview, Staff I stated that they were aware Acetaminophen was not available and was not administered for one dose on 09/28/2025 and three doses on 09/29/2025. Staff I stated that their staff documented Acetaminophen was unavailable for the afternoon dose on 09/28/2025 because the staff did not find the medication in the medication cart. Staff I stated that the staff later found the Acetaminophen in the medication cart and administered the following evening dose. Staff I stated that Acetaminophen was unavailable and was not administered to Resident 7 on 09/29/2025. Staff I stated their staff found the Acetaminophen was unavailable and they did not administer the medication on 09/29/2025. Staff I stated that she was aware Staff E notified the nurse and submitted a refill order of Acetaminophen on 09/29/2025 after the medication ran out.

This is an uncorrected deficiency previously cited on 08/04/2025.

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, ALJOYA MERCER ISLAND 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

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 07/28/2025 and 07/30/2025 of:

ALJOYA MERCER ISLAND
2430 76TH AVENUE SE
MERCER ISLAND, WA 98040

The following sample was selected for review during the unannounced on-site visit: 7 of 32 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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.

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-2462 Background checks Who is required to have.

(3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:

(d) Contractors other than the administrator and caregivers who may have unsupervised access to residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a Washington state name and date of birth background check for 1 of 1 contracted housekeeping staff (Staff N). This failure placed all 32 residents at risk of harm from staff with an unknown background record.

Findings included…

During an interview at the entrance conference on 07/28/2025 at 10:00 AM, Staff H, Executive Director, stated that the facility employed contracted agency staff for resident care and housekeeping services. Staff H stated that there was one agency housekeeper, Staff N, that worked in the facility that morning.

Review of the facility's housekeeping schedule, dated July 2025, showed the shifts worked and the shifts scheduled to be worked by contracted agency housekeeping staff and by those employed directly by the facility.

During an interview on 07/29/2025 at 10:17 AM, Staff H stated that there was no Washington state name and date of birth background check (BGI) done through the Department of Social and Health Services (DSHS) for Staff N. Staff H stated that they

were aware Staff N was required to have a BGI done through the DSHS. Staff H stated that the facility had not completed BGIs through DSHS for facility contracted agency staff.

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, ALJOYA MERCER ISLAND 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

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

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

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 2 of 7 sample residents' (Resident 5 and Resident 7) assessment, as required. This failure placed Resident 5 and Resident 7 at risk for unmet care needs.

Findings included…

RESIDENT 5
Review of the facility's undated Resident Characteristic Roster showed that the facility admitted Resident 5 in [redacted] 2022.

Review of Resident 5's records showed that on 02/05/2024, the facility completed Resident 5's previous annual assessment. The records showed that on 02/11/2025, the facility completed Resident 5's current annual assessment. The current assessment showed no documentation that the facility assessed Resident 5 for diet preferences,

ability to chew and swallow, use of durable medical equipment (reusable medical equipment), any behaviors with symptoms, or any other conditions that required behavioral intervention strategies.

During an interview on 07/29/2025 at 1:15 PM, Collateral Contact 1 (CC 1, Resident 5's family) stated that Resident 5 previously had some behavioral concerns that required interventions. CC 1 stated that Resident 5 had improved and they were stable now.

During an interview on 07/30/2025 at 11:58 AM, Staff I, Registered Nurse, Community Health Director, stated that the Community Health Nurse completed Resident 5's current annual assessment. Staff I stated that they were unaware the nurse did not assess several areas for Resident 5 in the current annual assessment, as required.

RESIDENT 7
Review of the facility's undated Resident Characteristic Roster showed that the facility admitted Resident 7 in [redacted] 2025.

Observation in Resident 7's apartment on 07/30/2025 at 9:25 AM showed Resident 7 used a Roho cushion (a pressure relief cushion that is made of soft, flexible air cells to decrease the amount of pressure on a person's sitting area) on the wheelchair. Observation showed the center part of the Roho cushion collapsed. During an interview at this time, Staff E, Lead Resident Assistant, stated that Resident 7 used the Roho cushion and the wheelchair every day. Staff E stated that they were unsure of who provided Resident 7 the Roho cushion. Staff E stated they were unaware of when Resident 7 started using the Roho cushion. Staff E stated that they were unaware the Roho cushion was deflated.

Review of Resident 7's records showed that the facility completed a pre-admission assessment on 03/05/2025 and an initial assessment on 03/23/2025. The records showed Resident 7's hospice care started on 04/09/2025. There was no documentation that showed the facility assessed Resident 7 when the resident's conditions changed and the resident was admitted to hospice care. There was no documentation that showed the facility assessed Resident 7's ability to coordinate with hospice care. There was no documentation that showed the facility assessed Resident 7's ability to use the Roho cushion. There was no documentation that provided instructions about the maintenance of the Roho cushion for proper inflation.

During an interview on 07/30/2025 at 11:58 AM, Staff I stated that they did not assess Resident 7 when the resident's conditions changed and admitted to the hospice care in April 2025. Staff I stated that they did not assess and document Resident 7's use of a Roho cushion. Staff I stated that they did not assess Resident 7's ability to coordinate with hospice care and their ability to use the Roho cushion.

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, ALJOYA MERCER ISLAND 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

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 observation, interview, and record review, the facility failed to ensure 4 of 8 sampled residents (Resident 1, Resident 6, Resident 7, and Resident 8) received their medications as prescribed. This failure placed Resident 1, Resident 6, Resident 7, and Resident 8 at risk of medication errors and potential adverse medical outcomes.

Findings included…

Review of the facility's document titled "Assisting the Resident with Self Administration of Medication", dated 04/02/2013, showed that the facility provided residents assistance with self-administration of medication in accordance with all applicable state laws and licensing regulations.

RESIDENT 1
Review of Resident 1's move-in record showed the facility admitted Resident 1 in [redacted] 2016.
Review of Resident 1's records showed a diagnosis of [redacted], and [redacted].

Review of Resident 1's May 2025 electronic Medication Administration Record (eMAR) showed that Resident 1 received five milligrams (mg) of Amlodipine (medication to lower blood pressure), 25 mg of Metoprolol (medication to lower blood pressure and relieve chest pain or discomfort), and five mg Lisinopril (medication to lower blood pressure and treat heart conditions), each given by mouth daily, with parameters to hold the medications if the systolic blood pressure (SBP, the top number in a blood pressure reading, that represents the pressure in the arteries when the heart beats) was below 110. The eMAR showed that on 05/21/2025 at 9:00 AM the recorded blood pressure (BP) was 110/56. The eMAR showed that Staff J, Resident Assistant/Medication Technician (Med Tech-unlicensed staff who dispense and administer medications) held the Amlodipine, Metoprolol, and Lisinopril, and did not give them as ordered.

Review of Resident 1's June 2025 eMAR showed that on 06/06/2025, the 9:00 AM recorded blood pressure was 110/64. The eMAR showed that on 06/06/2025 the 9:00 AM dose of Amlodipine, Lisinopril and Metoprolol were held and not given by Staff K, Lead Resident Assistant/Med Tech, as ordered.

During an interview on 07/30/2025 at 1:15 PM, Staff I, Registered Nurse, Community Health Director, stated that when the Amlodipine, Lisinopril, and Metoprolol were held for Resident 1, it was an isolated occurrence. Staff I stated that they were unaware the Resident Assistants/Med Techs were inconsistent as to when to give or hold the Amlodipine, Lisinopril and Metoprolol when Resident 1's SBP was 110. Staff I stated that they did not realize some of the Medication Technicians gave Resident 1 their blood pressure medications when the SBP was 110 while others held the blood pressure medications.

RESIDENT 8
Review of a facility incident report, dated 06/04/2025, showed that Resident 8 complained to the Resident Assistant and Staff N, Licensed Nurse, that they felt tired and weak. The report showed Resident 8's blood pressure was 68/42 at the time of the incident. The report showed that Staff N reviewed Resident 8's eMAR and discovered that Resident 8 received their morning dose of Carvedilol (medication used to treat high blood pressure) when their blood pressure was 114/78. The report showed that the prescriber's order gave parameters to hold the Carvedilol when Resident 8's SBP was less than 120.

RESIDENT 6
Review of the facility's undated Resident Characteristic Roster showed that the facility admitted Resident 6 in [redacted] 2024 with a medical diagnosis of [redacted].

Observation on 07/30/2025 at 9:10 AM showed Staff E, Lead Resident Assistant, dispensed Resident 6's oral medications.

Review of Resident 6's records showed Resident 6 received assistance for medication

management. Review of Resident 6's July 2025 eMARs showed that Resident 6's medication orders included Metoprolol Succinate (a medication lowers blood pressure), 25 mg, one tablet by mouth nightly at bedtime. The medication order instructed to hold the medication if SBP was below 110.

Review of Resident 6's July 2025 eMAR showed that on 07/24/2025 at 8:00 PM, the recorded SBP was 106. The eMAR showed that on 07/24/2025 at 8:00 PM, staff signed the eMAR that showed the scheduled dose of Carvedilol was administered.

RESIDENT 7
Review of the facility's undated Resident Characteristic Roster showed that the facility admitted Resident 7 in [redacted] 2025 with a medical diagnosis of [redacted].

Observation on 07/30/2025 at 8:11 AM showed Staff E measured Resident 7's blood pressure (BP). Observation showed that after Staff E obtained Resident 7's BP reading, Staff E gave Resident 7 their oral medications.

Review of Resident 7's records showed Resident 7 received assistance for medication management. Review of Resident 7's May 2025, June 2025, and July 2025 eMARs showed that Resident 7's medication orders included Carvedilol oral tablet, 3.125 mg, one tablet by mouth, two times a day. The medication order instructed to hold the medication if the SBP was below 110.

Review of Resident 7's May 2025 eMAR showed that on 05/23/2025 at 5:00 PM, the recorded SBP was 140. The eMAR showed that on 05/23/2025, the scheduled dose of Carvedilol was not given.

Review of Resident 7's June 2025 eMAR showed that on 06/15/2025 at 8:00 AM the recorded SBP was 151. The eMAR showed on 06/15/2025 at 8:00 AM, the scheduled dose of Carvedilol was not given. The eMAR showed that on 06/17/2025 at 7:00 PM, the recorded SBP was 133. The eMAR showed on 06/17/2025 at 7:00 PM, the scheduled dose of Carvedilol was not given.

Review of Resident 7's July 2025 eMAR showed that on 07/03/2025 at 7:00 PM, Resident 7's SBP was 106. The eMAR showed that on 07/03/2025 at 7:00 PM, staff signed the eMAR that showed the scheduled dose of Carvedilol was administered.

During an interview on 07/30/2025 at 2:10 PM, Staff I stated that they were unaware their Medication Technicians did not dispense the blood pressure medications according to the physician's medication orders. Staff I stated that one or two Medication Technicians had problems following the blood pressure parameters to dispense the blood pressure medications to the residents.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, ALJOYA MERCER ISLAND 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

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 observation, interview, and record review, the facility failed to ensure 1 of 7 sampled residents (Resident 7) received medications as prescribed. This failure placed Resident 7 at risk for compromised health and potential medical complications.

Findings included…

Review of the facility's document titled, "If Medications Are Not Available", dated 04/02/2013, showed the facility was responsible to eliminate situations in which resident did not have prescribed medications available.

Review of Resident 7's records showed the facility admitted Resident 7 in [redacted] 2025. The records showed that on 03/23/2025, the facility completed Resident 7's assessment. The assessment showed Resident 7 required assistance with medication management. The records showed Resident 7's medication orders included Acetaminophen (a pain-relieving medication), oral tablet, 325 milligram (mg), two tables by mouth, three times daily, for pain and discomfort.

Observation on 07/30/2025 at 8:11 AM showed Staff E, Lead Resident Assistant, dispensed Resident 7's oral medications. During an interview at this time, Staff E stated that they did not dispense Resident 7's Acetaminophen medication this morning because the medication ran out.

Review of Resident 7's July 2025 electronic Medication Administration Record (eMAR)

showed that between 07/23/2025 and 07/30/2025, the facility's staff failed to administer Resident 7's Acetaminophen 21 times. The eMAR documented that the reason for the missed doses of Acetaminophen was "Medication not available". There was no documentation that showed the staff notified the pharmacy and Resident 7's physician when the Acetaminophen medication ran out.

During an interview on 07/30/2025 at 11:50 AM, Staff I, Registered Nurse, Community Health Director, stated that Resident 7 used the prescribed Acetaminophen for pain relief. Staff I stated they were aware Resident 7's Acetaminophen ran out a week ago. Staff I stated that their nurse reordered the prescription. Staff I stated that they were unaware the medication refill was not delivered, and the resident did not receive the prescribed medication for a week.

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, ALJOYA MERCER ISLAND 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

WAC 388-78A-2480 Tuberculosis Testing Required.

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to screen 1 of 8 sampled staff (Staff A) for Tuberculosis (TB), within three days of hire, as required. This failure placed all 32 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

Review of the facility's undated employee roster showed the facility hired Staff A, Resident Assistant, on 12/26/2024. Review of Staff A's employee records showed that on 01/07/2025, 13 days after the date of hire, Staff A completed the Quantiferon-TB Gold Plus test (a blood test used to screen for TB) with a negative result.

During an interview on 07/29/2025 at 8:45 AM, Staff H, Executive Director, stated that they were familiar with the TB testing requirements. Staff H stated that they hired Staff A during the holidays, which delayed Staff A completing the TB test within three days of hire, as required.

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, ALJOYA MERCER ISLAND 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
20425 72nd Avenue S, Suite 400, Kent, WA 98032

ALJOYA HOUSE AT MERCER ISLAND LLC
ALJOYA MERCER ISLAND
2430 76TH AVENUE SE
MERCER ISLAND, WA 98040

RE: ALJOYA MERCER ISLAND # 2019

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 08/04/2025 and found that your facility does not meet the Assisted Living Facility requirements.

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:

Laurie Anderson, Community 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-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

The facility failed to update the service plan of one sampled resident to show contact information for Hospice services (end of life care), to provide information on the resident’s impaired communication, and how to effectively communicate with the resident. During the full inspection, the facility updated the service plan to reflect the resident’s current needs to meet the regulation.

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

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

The Assisted Living Facility failed to ensure that one culinary staff (Staff G) obtained a food worker card issued by the Washington State Department of Health within 14 days of hire. On 07/29/2025, during the Department’s full inspection, Staff G completed the food worker training through the Public Health Department for Seattle and King County to meet the requirement.

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.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

• Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson, Community Field Manager
Region 2, Unit D
Residential Care Services

Enclosure