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

09/24/2025

SEA MAR COMMUNITY HEALTH CENTERS
THE CANNON HOUSE
113 23rd AVENUE SOUTH
SEATTLE, WA 98144

RE: THE CANNON HOUSE # 2056

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 65837 (Completion Date 09/24/2025) and 62302 (Completion Date 07/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/24/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

The Department staff who did the On Site verification:
Lisa Hauk, Complaint Investigator

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

Sincerely,

Jamie Singer

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

## Residential Care Services
### Investigation Summary Report

**Provider/Facility:** THE CANNON HOUSE
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2056
**Compliance Determination #:** 62302
**Intake ID:** 183188
**Investigator:** Lisa Hauk
**Region/Unit #:** RCS Region 2 / Unit J
**Investigation Date(s):** 07/09/2025 through 07/23/2025
**Complainant Contact Date(s):**

**Allegation(s):**
The Assisted Living Facility (ALF) did not allow the Named Resident (NR) to eat meals in the community dining room.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 67<br>Resident sample size: 4<br>Closed records sample size: 0 |
| **Observations:** | Identified resident<br>Residents<br>Activities<br>Dining<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Administration<br>Identified resident<br>Identified staff<br>Nursing staff<br>Residents<br>Family members |
| **Record Reviews:** | Medical records<br>Incident investigation<br>Facility policies |

**Investigation Summary:**
Interview and record review showed the NR showed disrespectful and offensive behaviors in the dining room. Other residents at the ALF complained to the ALF about the NR's behaviors. The ALF investigated and restricted the NR from eating in the DR. The NR was allowed to go to the kitchen half way through mealtimes to pick up meals to consume in his apartment and was allowed to continue to attend group activities. The ALF informed the NR of the dining room restrictions in writing and invited the NR to discuss steps to reinstate dining room privileges, but the NR had

not attempted to meet with the ALF to discuss privileges being reinstated. Interview showed sampled residents voiced no concerns of care or safety issues at the ALF. No violations of regulations identified.

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**Conclusion / Action:**

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

## Residential Care Services
### Investigation Summary Report

**Provider/Facility:** THE CANNON HOUSE
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2056
**Compliance Determination #:** 62302
**Intake ID:** 185354
**Investigator:** Lisa Hauk
**Region/Unit #:** RCS Region 2 / Unit J
**Investigation Date(s):** 07/09/2025 through 07/23/2025
**Complainant Contact Date(s):** 07/16/2025

**Allegation(s):**

1. A caregiver at the Assisted Living Facility (ALF) was rough with the Named Resident (NR) during a transfer which caused pain to the NR's hip.
2. Staff at the ALF checked on the NR at 0400 am and did not check on the NR again until 12:00 pm.
3. The ALF did not notify the resident's representative when the NR had a change of condition requiring hospitalization.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 67<br>Resident sample size: 4<br>Closed records sample size: 0 |
| **Observations:** | Residents<br>Activities<br>Dining<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Administration<br>Nursing staff<br>Residents<br>Family members |
| **Record Reviews:** | Medical records<br>Incident investigation<br>Facility policies |

**Investigation Summary:**

1. Interview and record review showed the ALF followed their policy, responded promptly and investigated the allegations per regulations. The NR's abilities had deteriorated during illness and she required a three-person transfer to the bed the day of her hospitalization. Interview showed the NR did not sleep on her back, but was placed on her back during care. Record review of the ALF's investigation showed no abuse or neglect was suspected. The ALF put interventions in place for

the NR upon return to the ALF. No violation of regulations identified.
2. Interview and record review showed that on the stated date (06/25/2025), a key log showed all entries into the NR's apartment. No staff entered the NR's apartment at 04:00 am. Staff entered the NR's apartment at 06:08 am and 06:22 am. Interview showed the NR was out of the apartment for breakfast and lunch. The next entry on the key log was the NR entering the apartment at 12:48 pm after lunch. No violation of regulations identified.
3. Interview and record review showed the NR had a health decline and the ALF assisted to call for transport to the hospital. Interview showed the NR called her representative from the hospital. Interview and record review showed the ALF did not notify the resident's representative or the physician that the NR was at the hospital. Violation of regulations identified. See citation WAC 388-78A-2640(1)(a)(b)(3)(a)(b)

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**Conclusion / Action:**

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

STATE OF WASHINGTON

# DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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



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

The department completed data collection for an unannounced on-site complaint investigation on 07/09/2025 of:

THE CANNON HOUSE
113 23rd AVENUE SOUTH
SEATTLE, WA 98144

This document references the following complaint number(s): 183188, 184574, 185354

The following sample was selected for review during the unannounced on-site visit: 4 of 67 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Lisa Hauk, Complaint Investigator

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

| Statement of Deficiencies | License #: 2056 | Compliance Determination # 62302 |
|---|---|---|
| Plan of Correction | THE CANNON HOUSE | Completion Date |
| Page 2 of 3 | Licensee: SEA MAR COMMUNITY HEALTH CENTERS | 07/23/2025 |

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.

Jamie Singer
Residential Care Services

7/23/2025
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.

Jeri Smith
Administrator (or Representative)

7/24/2025
Date

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify a resident's representative and physician when 1 of 4 residents (Resident 2) had a change of condition and was transported to the hospital. This failure resulted in Resident 2's representative and physician being unaware of the health status or location of Resident 2.

Findings included...

Review of an undated Admission Record (AR) showed the ALF admitted Resident 2 on [redacted]/2025 with multiple medically disabling diagnoses. A Pre-Admission Assessment, dated 06/04/2025, showed Resident 2 was independent with bed mobility, transfers and toileting.

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

Jamie Singer
Residential Care Services

7/23/2025
Date

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

Administrator (or Representative)

Date

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

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Based on interview and record review, the Assisted Living Facility (ALF) failed to notify a resident's representative and physician when 1 of 4 residents (Resident 2) had a change of condition and was transported to the hospital. This failure resulted in Resident 2's representative and physician being unaware of the health status or location of Resident 2.

Findings included...

Review of an undated Admission Record (AR) showed the ALF admitted Resident 2 on [redacted]/2025 with multiple medically disabling diagnoses. A Pre-Admission Assessment, dated 06/04/2025, showed Resident 2 was independent with bed mobility, transfers and toileting.

| Statement of Deficiencies | License #: 2056 | Compliance Determination # 62302 |
|---|---|---|
| Plan of Correction | THE CANNON HOUSE | Completion Date |
| Page 3 of 3 | Licensee: SEA MAR COMMUNITY HEALTH CENTERS | 07/23/2025 |

In interview, on 07/09/2025 at 2:54 PM, Staff A (Administrator) stated that Resident 2 was transported to the hospital on [redacted]/2025 because she had deteriorated and was not able to stand independently. Staff A stated Resident 2 had become incontinent the week prior to the hospitalization.

In interview, on 07/11/2025 at 3:12 PM, Collateral Contact 1 (CC1 – Resident 2's Representative) stated the ALF did not notify her that Resident 2 had declined and was sent to the hospital. CC1 stated, "My mom called me from the emergency room a day later and that's how I found out she was there."

Record review of Progress Notes, from 06/13/2025 through 07/09/2025, showed no documentation that Resident 2's representative or physician was notified of Resident 2's hospitalization on [redacted]/2025. Review of records showed no documentation of the ALF contacting Resident 2's representative or physician.

In interview, on 07/15/2025 at 3:36 PM, Staff A confirmed that the ALF did not notify CC1 that Resident 2 had been transported to the hospital.

Record review of an email from Staff A, dated 07/15/2025 at 3:11 PM, confirmed the ALF did not notify the physician that Resident 2 had been transported to the hospital.

**Plan/Attestation Statement**

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE CANNON HOUSE is or will be in compliance with this law and / or regulation on (Date) 9/16/2025.

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

Yeni Smith
Administrator (or Representative)

7/24/2025
Date

In interview, on 07/09/2025 at 2:54 PM, Staff A (Administrator) stated that Resident 2 was transported to the hospital on [redacted]/2025 because she had deteriorated and was not able to stand independently. Staff A stated Resident 2 had become incontinent the week prior to the hospitalization.

In interview, on 07/11/2025 at 3:12 PM, Collateral Contact 1 (CC1 – Resident 2's Representative) stated the ALF did not notify her that Resident 2 had declined and was sent to the hospital. CC1 stated, "My mom called me from the emergency room a day later and that's how I found out she was there."

Record review of Progress Notes, from 06/13/2025 through 07/09/2025, showed no documentation that Resident 2's representative or physician was notified of Resident 2's hospitalization on [redacted]/2025. Review of records showed no documentation of the ALF contacting Resident 2's representative or physician.

In interview, on 07/15/2025 at 3:36 PM, Staff A confirmed that the ALF did not notify CC1 that Resident 2 had been transported to the hospital.

Record review of an email from Staff A, dated 07/15/2025 at 3:11 PM, confirmed the ALF did not notify the physician that Resident 2 had been transported to the hospital.

**Plan/Attestation Statement**

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE CANNON HOUSE 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