STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Highgate Yakima LP
HIGHGATE SENIOR LIVING
5605 W CHESTNUT AVE
YAKIMA, WA 98908

RE: HIGHGATE SENIOR LIVING License # 2224

Dear Administrator:

This letter addresses Compliance Determination(s) 74130 (Completion Date 03/11/2026) and 71009 (Completion Date 01/14/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/11/2026 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-2140-1-a-ii, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2290-3, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-4-a, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d, WAC 388-78A-2320-2-c, WAC 388-78A-2320-1-b, WAC 388-78A-2320-2-d, WAC 388-78A-2320-1-a, WAC 388-78A-2320-2-b, WAC 388-78A-2483-2, WAC 388-78A-2500-2, WAC 388-78A-2500-2-a, WAC 388-112A-0400-5, WAC 388-78A-2510, WAC 388-112A-0400-5, WAC 388-78A-2690-1, WAC 388-78A-2690-5, WAC 388-78A-2690-6-c

The Department staff who did the on-site verification:
Jessica Clapp, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager

Region 1, Unit G
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2224	Compliance Determination # 71009
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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 01/05/2026, 01/06/2026, 01/07/2026 and 01/08/2026 of:
HIGHGATE SENIOR LIVING
5605 W CHESTNUT AVE
YAKIMA, WA 98908

The following sample was selected for review during the unannounced on-site visit: 7 of 53 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Robin Barnes, Assisted Living Facility Licensor
Jessica Clapp, Assisted Living Facility Licensor
Tracy Ramirez, Assisted Living Facility Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

Statement of Deficiencies	License #: 2224	Compliance Determination # 71009
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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.

Laura Williams-Davis
Residential Care Services

01/29/2026
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.

Carla J. Bianchi
Administrator (or Representative)

2-6-2026
Date

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

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

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

(ii) The resident's full assessments;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the negotiated service agreements contained the necessary content needed to meet the needs of 4 of 7 residents (Resident 1, 3, 4 and 7). This failure placed the residents at risk of unmet care needs.

Findings included...

<Resident 1>

Review of Resident 1's full facility assessment, dated 11/23/2025, showed that the resident had history of falls with injury, required medication assistance, took pain medication as needed for generalized pain and was able to express pain verbally. Resident 1's assessment showed that the facility was responsible for medication management.
Review of Resident 1's Negotiated Service Agreement (NSA), dated 11/23/2025, showed that the resident was a fall risk and staff were to monitor and implement resident specific interventions to help prevent falls. The NSA did not list any fall prevention interventions for staff to follow. The NSA showed that Resident 1 had generalized pain. Resident 1's NSA showed that the facility managed the resident's medication including pain management as needed. The NSA showed that Resident 1 was able to verbally express if they had pain. The NSA did not address Resident 1's chronic joint pain problems and treatments, nor did it show that the resident had migraines.

In an interview on 01/06/2026 at 1:40 PM, Resident 1 stated that they moved into the facility due to having a severe fall incident with injury that caused a hip fracture requiring surgery and rehabilitation. The resident further stated that they were afraid of falling again and now required a wheelchair for mobility. In addition, Resident 1 stated that they were receiving multiple routine injections for pain from their Orthopedic doctor (a bone and joint doctor) to both of their knees for severe arthritis and an injection to their right shoulder related to torn rotator cuff (muscles and tendons in the shoulder). Resident 1 stated that they had received the injections and could not recall the date. Finally, Resident 1 stated that they have been having severe headaches for weeks, had a history of migraines and reported the pain to staff.

Review of Resident 1's Primary Care Physician notes, dated 01/06/2026, showed, "[Resident 1] reports having a severe headache at the top of [their] head for many weeks now. Having approximately [five times per] week." The physician note showed that the resident and their family stated that Resident 1 had a history of migraines. Resident 1's physician note showed that the resident reported that they were having injections to their knees and right shoulder and that their pain continued. The physician note showed that they had ordered migraine medication for Resident 1.

In an interview on 01/08/2026 at 10:56 AM, Staff H, Registered Nurse/Healthcare Director, acknowledged that Resident 1's NSA did not contain direction for fall or pain interventions. Staff H stated that Resident 1's NSA also did not include the resident's history of migraines, chronic arthritis and their torn rotator cuff. Staff H stated that they were not aware Resident 1 received injections.

<Resident 3>

Review of Resident 3's full facility assessment, dated 11/01/2025, showed Resident 3 had diagnosies that included [redacted]. The assessment showed that Resident 3 smoked cigarettes and used supplemental oxygen independently.

Review of Resident 3's NSA, dated 11/01/2025, showed that Resident 3 used supplemental oxygen. The NSA did not show how Resident 3 used oxygen or who was responsible to manage it. The NSA did not show what staff were to monitor for regarding Resident 3's diagnosis and use of oxygen, or who to contact if problems occurred. Additionally, the NSA did not show the plan to monitor Resident 3 and address interventions for their safety regarding their smoking and use of oxygen.

Observation on 01/06/2026 at 12:41 PM, showed that Resident 3 had an oxygen concentrator (medical device that provides oxygen to people with respiratory problems) and a portable oxygen tank in their room.

In an interview on 01/06/2026 at 12:50 PM, Resident 3 stated that they used their oxygen concentrator at night and stated they would call facility staff if they had any problems with their oxygen concentrator.

<Resident 4>

Review of Resident 4's facility demographic sheet, undated, showed that the resident moved into the facility on [redacted]/2024.

Review of Resident 4's full facility assessment, dated 11/28/2025, showed that the resident had a diagnosis which included [redacted]. The assessment showed that Resident 4 had generalized pain and was able to request pain medication. The assessment also showed that Resident 4 required medication assistance from the staff.

Review of Resident 4's November 2025, December 2025 and January 2026 Medication Administration Records (MARs) showed that the resident's was prescribed two routine narcotic pain medications and one routine medication for muscle spasms.

Review of Resident 4's NSA, dated 11/28/2025, showed that the resident took pain medications as needed. The NSA did not show where Resident 4's pain was or what the staff should monitor for regarding their pain and use of pain medication.

In an interview on 01/07/2026 at 01:06 PM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 4 required more assistance from facility staff than in the past. CC1 stated that they delivered Resident 4's medications to the facility and

that facility staff assisted with administering the medications to the resident.

This is a recurring deficiency previously cited on the statement of deficiencies dated 01/29/2024, for Washington Administrative Code 388-78a-2140 for subsections (1)(a)(ii)(b)(c).

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 2/28/2026.

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

Carla J. Bianchi
Administrator (or Representative)

2/6/2026
Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to request a written plan for family medication assistance for 6 of 7 residents (Resident 1, 3, 4, 5, 6 and 7). This failure placed the residents at risk of not receiving their prescribed medications if the resident representative was not available.

Findings included...

Review of the facility's disclosure statement, undated, showed that a resident's representative could provide a resident with medication assistance. It showed that the representative would work with the facility to develop a written plan that included the process, contact information and a backup plan should the representative not be available.

Review of the facility's policy titled, "Family/Responsible Party Medication Management Primary Plan", undated, showed that a resident's representative was able to assist with their medications. The policy showed that a written plan was to be provided to the facility that included medications the resident was taking, who was responsible for the ordering of medications and an alternate plan if the primary individual could not fulfill their responsibility.

<Resident 1>

Review of Resident 1's full facility assessment, dated 11/23/2025, showed that the resident required medication assistance and the facility was responsible for medication management. A box on the assessment that indicated if family provided medication assistance was not checked.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 11/23/2025, showed that the facility managed all of the resident's medication. Review of Resident 1's NSA did not show that the resident had medications brought in by the resident's family. The NSA did not accurately show who was responsible for providing Resident 1's medications. In addition, the NSA did not show an alternative plan if the family was not able to fulfill their responsibility.

Review of Resident 1's Medication Administration Record (MAR), for November 2025, December 2025 and January 2026, showed that 11 of the 17 medications prescribed for the resident were provided by the family.

In an interview on 01/06/2026 at 1:40 PM, Resident 1 stated that their family brought in several of their prescribed medications to the facility.

As of 01/08/2026, Review of Resident 1's record did not include a family assistance plan for the resident's medications.

<Resident 3>

Review of Resident 3's full facility assessment, dated 11/01/2025, showed that the resident was independent with their medications. A box on the assessment that indicated if family provided medication assistance was not checked.

Review of Resident 3's "Medication Self – Administrative Assessment," dated 10/01/2025, showed that the facility assessed Resident 3 to self-administer their oral medications and did not include an assessment for the resident's inhalers. The assessment did not show that Resident 3 received family assistance with their medication.

Review of Resident 3's NSA, dated 11/01/2025, showed that the resident managed their medication independently. The NSA did not show that Resident 3 had family assistance for their medications. The NSA did not accurately show who was responsible for providing Resident 3's medications. In addition, the NSA did not show an alternative plan if the family was not able to fulfill their responsibility.
Review of Resident 3's MAR for November 2025, December 2025 and January 2026, showed that the resident took medication for high blood pressure, cholesterol and pain. In addition, the MAR showed that Resident 3 used two inhalers for Chronic Obstructive Pulmonary Disease (COPD) (condition that causes shortness of breath, wheezing). The MAR showed that Resident 3 administered their medications and inhalers independently.

In an interview on 01/06/2026 at 12:50 PM, Resident 3 stated that their representative assisted with their medications. Resident 3 stated that their representative ordered refills, brought medications to the facility and pre-filled their medication organizer every two weeks. Resident 3 stated that if their representative could not set up their medications that the facility staff would do it. Observation at the same time showed that Resident 3 had a medication organizer that was placed next to their recliner.

As of 01/08/2026, Review of Resident 3's record did not include a family assistance plan for the resident's medications.

<Resident 4>

Review of Resident 4's full facility assessment, dated 11/28/2025, showed that the

resident had diagnoses which included [redacted] and [redacted].

Review of Resident 4's, NSA, dated 11/28/2025, showed that the resident family assisted with their medications and did not show who was responsible for ordering and delivering the medications. In addition, the NSA did not show an alternative plan if the family was not able to fulfill their responsibility.

Review of Resident 4's MAR for November 2025, December 2025 and January 2026, showed that all of the medications prescribed for the resident were provided by the family.

In an interview on 01/07/2026 at 1:06 PM, Collateral Contact 1 (CC1), Resident Representative, stated that they ordered and delivered Resident 4's medication to the facility and that the facility administered the medications to the resident. CC1 stated that the alternate plan was for another family member to order and deliver the medications when CC1 was not able.

As of 01/08/2026, Review of Resident 4's record did not include a family assistance plan for the resident's medications.

<Resident 6>

Review of Resident 6's full facility assessment, dated 08/11/2025, showed that the resident had diagnoses which included [redacted] and a history of having a kidney transplant. The assessment also showed that Resident 6 required the facility to provide medication assistance. A box on the assessment that indicated if family provided medication assistance was not checked.

Review of Resident 6's NSA, dated 02/11/2025, showed that the facility was responsible for providing the resident's medication assistance. Resident 6's NSA did not show that the resident had medications brought in by the resident's family. The NSA did not show who was responsible for providing Resident 6's supplements and organ transplant medications. In addition, the NSA did not show an alternative plan if the family was not able to fulfill their responsibility.

Review of Resident 6's November 2025, December 2025 and January 2026 MARs showed that the resident required three over-the-counter supplements which the family provided. The MARs also showed that the resident required two medications to prevent organ transplant rejection, which the family provided.

In an interview on 01/06/2026 at 1:20 PM, CC2, Resident Representative, stated that they were bringing Resident 6's medication prior to 01/06/2026. CC2 stated that

Resident 6 had a change of condition and no longer required those medications.

As of 01/08/2026, Review of Resident 6's record did not include a family assistance plan for the resident's medications.

<Resident 7>

Review of Resident 7's full facility assessment, dated 06/26/2025, showed that the resident had diagnoses of [redacted] and [redacted]. The assessment showed that Resident 7 needed medication assistance provided by the facility. A box on the assessment that indicated if family provided medication assistance was not checked.

Review of Resident 7's NSA, dated 06/26/2025, showed that the facility was responsible for providing the resident's medication assistance. Resident 7's NSA did not show that the resident had medications brought in by the resident's family. The NSA did not show who was responsible for providing Resident 7's supplement. In addition, the NSA did not show an alternative plan if the family was not able to fulfill their responsibility.

Review of Resident 7's November 2025, December 2025, and January 2026 MARs showed that the resident was prescribed an over-the-counter supplement that supported eye health. The MAR showed that Resident 7's family provided the supplement.

As of 01/08/2026, Review of Resident 7's record did not include a family assistance plan for the resident's medications.

In an interview on 01/07/2026 at 2:23 PM, Staff H, Registered Nurse/Healthcare Director, stated that they were unaware of the requirements for family assistance with medication plans. Staff H stated that the facility did not have a family assistance with medication agreement in place for Resident 1, Resident 3, Resident 4, Resident 6 and Resident 7.

This is a recurring deficiency previously cited on the statement of deficiencies dated 01/29/2024, for Washington Administrative Code 388-78a-2290 for subsections (3)(a)(b)(c)(d)(4)(a)(b)(c)(d).

Statement of Deficiencies	License #: 2224	Compliance Determination # 71009
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
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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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 2/28/2026.

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

Administrator (or Representative) Carla J. Bianchi Date 2/6/2026

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that requirements for intermittent nursing services were met for nurse delegation which included reassessing and evaluating residents every 90 days, for 1 of 1 resident (Resident 6) who received delegated task assistance from staff. This failure placed the resident at risk of medical complications.

Findings included...

Review of WAC 246-840-930, Criteria for delegation, showed that the Registered Nurse Delegator (RND) was required to assess the resident for the need and appropriateness of nurse delegation, and reassess and reevaluate the resident at least every 90 days for all delegated tasks. The RND must assess and document that the resident's condition was stable and predictable.

Review of a facility policy titled, "Medications Policy," dated 08/2025, showed that the Healthcare Director (HD) was responsible to delegate resident medications when needed. The policy showed that the HD was to ensure delegation was done properly and be reevaluated as required.

Review of Resident 6's undated facility demographics sheet showed that the resident admitted to the facility on [redacted]/2025.

Review of Resident 6's full facility assessment, dated 08/11/2025, showed that the resident had diagnoses which included [redacted] and [redacted]. The assessment also showed that Resident 6 required medication assistance which included oral medications, Insulin (injected medication which regulates blood sugar levels, and blood sugar testing (to monitor levels of sugar in the blood stream). The assessment did not show that Resident 6 required nurse delegation of their medications, nor did it show if the resident was stable and predictable.

Review of Resident 6's updated full facility assessment, dated 01/06/2026, showed that the resident required medication assistance four or more times per day and might include insulin and blood sugar testing. The assessment did not show that Resident 6 required nurse delegation of medications, nor did it show if the resident was stable and predictable.

Review of Resident 6's Negotiated Service Agreement (NSA), dated 02/11/2025, showed that the resident had cognitive limitations, needed redirection throughout the day, and required medication assistance. The NSA did not include information regarding nurse delegation.

Review of Resident 6's December 2025 and January 2026 Medication Administration Records (MARs) showed that the resident required blood sugar checks to be done four times per day. The MARs showed that Resident 6 was prescribed Insulin Lispro four times per day and Lantus Twice per day. The MARs also showed that Resident 6 was prescribed 14 oral medications, all which were to be crushed and given in applesauce or pudding. (These were all tasks that required nurse delegation for Resident 6.)

Review of Resident 6's nurse delegation records showed a "Nurse Delegation: Nursing Visit" form, dated 12/02/2025, signed by Staff H. The form showed that Resident 6's oral medications, blood sugar testing and administration of insulin were delegated tasks. The form included a "Notes" section which read, "See assessment in chart."

Review of Resident 6's nurse delegation records showed an updated "Nurse Delegation: Nursing Visit" form, dated 01/06/2025, signed by Staff H. The form showed that Resident 6's delegation tasks changed to include only their oral medications. The form

included the same "Notes" section which read, "See assessment in chart."

Review of Resident 6's progress notes from 09/16/2025 through 01/05/2026 showed the following changes in the resident's condition:

- 12/15/2025-Resident 6 was having poor intake of food and having low blood sugars. Resident 6 would see their doctor the following day.
- 12/16/2025 Resident 6's doctor had changed their insulin doses. Resident 6 ate 35% of their dinner.
- 12/23/2025 Resident 6 had a follow up visit with their doctor regarding the low blood sugars and poor appetite. Resident 6's doctor decreased their insulin and added an oral medication to stimulate appetite.
- 01/02/2026 Resident 6 was sent to the hospital for not feeling well.
- 01/05/2026 Resident 6 would be returning to the facility with hospice (end of life care) services.

As of 01/08/2026, review of the progress notes in Resident 6's record showed no nurse assessments for nurse delegation.

As of 01/08/2026, review of Resident 6's record (chart) showed no nurse delegation assessments done every 90 days.

In an interview on 01/05/2026 at 10:15 AM, Staff G, Administrator, stated that the facility provided intermittent nursing services to residents, which included delegation of medications and treatments. Staff stated that Staff H, Registered Nurse (RN)/HD, was the RND for the facility.

In an interview on 01/05/2026 at 2:50 PM, Staff H stated that Resident 6 was in the hospital due to a significant decline in their condition. Staff H stated that Resident 6 would be returning to the facility on 01/06/2026 with hospice services.

Observation on 01/06/2026 at 1:20 PM, showed Resident 6 lying in bed, eyes closed. Resident 6 did not respond when spoken to. Resident 6's skin was pale.

In an interview on 01/06/2026 at 1:28 PM, Collateral Contact 2 (CC2), Resident 6's family member, stated that the resident was no longer eating and all medications had been discontinued due to a decline in their condition. CC2 stated that Resident 6 was no longer able to get out of bed.

In an interview on 01/07/2026 at 1:30 PM, Staff H stated that they did not document and retain nurse delegation assessments.

In an interview on 01/08/2025 at 11:18 AM, Staff H stated that there were not any nurse assessments done for Resident 6's delegation visits dated 12/02/2025 and 01/06/2026.

This is a recurring deficiency previously cited on the statement of deficiencies dated 01/29/2024, for Washington Administrative Code 388-78a-2320 for subsections (1)(a)(b)(2)(b).

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 2/28/2026 .

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

Carla J. Bianchi — Administrator (or Representative)

2/6/2026 — Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interviews and record review, the facility failed to ensure a one-step test for tuberculosis was completed within three days of hire for 1 of 4 Staff (Staff A). This failed practice placed residents at risk of potential exposure to a communicable disease.

Findings included...

Review of personnel file for Staff A, Caregiver, showed that they started working at the facility on 03/04/2025. Staff A's file did not show that a one step Tuberculosis (TB) test was completed when they started working.

On 01/07/2026 at 2:55 PM, Staff H, Registered Nurse, stated that they did not do a one step TB test when Staff A was hired. Staff H stated that Staff A had a TB test completed within twelve months of their hire date and did not know that a one step TB test was required.

This is a recurring deficiency previously cited on 01/29/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 2/28/2026.

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

Carla J. Bianchi — Administrator (or Representative)

2/6/2026 — Date

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

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure that specialty training for mental health was completed for staff who provided care to 3 of 3 residents (Resident 3, 4 and 7) diagnosed with mental health for 2 of 4 staff (Staff C and D). This failure placed residents at risk of care from untrained staff.

Findings included...

Review of Resident 3's undated demographic sheet showed that the resident had a diagnosis that included [redacted].

Review of Resident 4's undated demographic sheet showed that the resident had a diagnosis that included [redacted] and [redacted].

Review of Resident 7's undated demographic sheet showed that the resident had a diagnosis that included [redacted].

Review of the personnel file for Staff C, Caregiver, showed that they started working at the facility on 04/24/2024. Staff C's file showed they obtained the specialty training for mental health on 01/30/2025 (281 days after they started working).

Review of the personnel file for Staff D, Caregiver, showed that they started working at the facility on 07/18/2024. Staff C's file showed they obtained the specialty training for mental health on 07/03/2025 (350 days after they started working).

In an interview on 01/07/2026 at 11:00 AM, Staff I, Community Resource Manager, stated that they did not know why the specialty training for mental health was late for Staff C and Staff D and that the facility nurse is responsible for the training.

In an interview on 01/07/2026 at 2:50 PM, Staff H, Registered Nurse, stated that they were the facility's instructor to teach the specialty training for mental health and did not know when staff were to complete the training.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 2/28/2026.

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

Carla J. Bianchi — Administrator (or Representative)

2/6/2026 — Date

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

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility failed to ensure that specialty training for dementia was completed for staff who provided care for residents diagnosed with [redacted] for 2 of 4 staff (Staff C and D). This failure placed residents at risk of care from untrained staff.

Findings included...

Review of the facility's undated characteristic roster showed that the facility provided care and services for 25 residents that had a diagnosis of [redacted].

Review of the personnel file for Staff C, Caregiver, showed that they started working at the facility on 04/24/2024. Staff C's file showed they obtained the specialty training for dementia on 01/30/2025 (281 days after they started working).

Review of the personnel file for Staff D, Caregiver, showed that they started working at the facility on 07/18/2024. Staff C's file showed they obtained the specialty training for dementia on 07/03/2025 (350 days after they started working).

In an interview on 01/07/2026 at 11:00 AM, Staff I, Community Resource Manager, stated that they did not know why the specialty training for dementia was late for Staff C and Staff D and that the facility nurse is responsible for the training.

In an interview on 01/07/2026 at 11:00 PM, Staff H, Registered Nurse, stated that they were the facility's instructor to teach the specialty training for dementia and did not know when staff were to complete the training.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 2/28/2026.

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

Administrator (or Representative) Carla J. Bianchi Date 2/6/2026

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that access to electronic video monitoring in a resident's room was documented in the negotiated service agreements and the need for the monitoring was reevaluated quarterly, for 3 of 3 residents (Residents 5, 6 and 7). This failure placed the residents at risk of violation of their rights and privacy.

Findings included...

Review of a facility policy titled, "Safey You Policy," dated 01/2021, showed that use of the facility's video monitoring system called, "Safely You" was to be added to a resident's Negotiated Service Agreement (NSA) after the resident or their responsible party consented to the use of the system. The policy showed that use of the system was to be reevaluated every 90 days and a new consent was to be signed.

In an interview on 01/05/2026 at 10:53 AM during the environmental tour, Staff J, Maintenance Manager, stated that the facility used a video monitoring system called, "Safely You." Staff J stated that the system could detect when a resident fell in their room and would video record the resident only when a fall was detected.

<Resident 5>

Review of Resident 5's, "Resident Consent to Fall Detection Program," form showed that it was signed on 07/30/2025 by Resident 5's representative. The consent showed that Artificial Intelligence (AI) software was used to detect resident falls. The consent showed that Safely You personnel would conduct video monitoring safety checks to determine potential health and safety risks for the resident. Additionally, the consent showed that use of the system required that a sign be posted near the resident's door to inform visitors and staff of the video monitoring.

Review of Resident 5's assessment, dated 10/20/2025, showed that the resident's representative had consented to the use of Safely You fall monitoring. The assessment was not signed by Resident 5 or their representative.

Review of Resident 5's Negotiated Service Agreement (NSA), dated 10/20/2025, showed that the resident walked independently with no assistive devices and was not a fall risk. Resident 5's NSA did not show that the resident used the Safely You system. Resident 5's NSA did not identify who had access to the video monitoring.

Review of Resident 5's progress notes from 09/16/2025 through 01/07/2026 did not show any documentation of an evaluation regarding the resident's use of Safely You.

<Resident 6>

Review of Resident 6's assessment, dated 08/11/2025, showed that the resident's representative had consented to the use of Safely You fall monitoring. The assessment was not signed by Resident 6 or their representative.

Review of Resident 6's, "Resident Consent to Fall Detection Program," form showed that it was signed on 02/18/2025 by Resident 6's representative. The consent showed that AI software was used to detect resident falls. The consent showed that Safely You personnel would conduct video monitoring safety checks to determine potential health and safety risks for the resident. Additionally, the consent showed that use of the system required that a sign be posted near the resident's door to inform visitors and staff of the video monitoring.

Review of Resident 6's NSA, updated 12/29/2025, showed that the resident walked independently. The NSA did not show that the resident used the Safely You system. Resident 6's NSA did not identify who had access to the video monitoring.

Review of Resident 6's progress notes from 09/16/2025 through 01/05/2026 did not show any documentation of an evaluation regarding the resident's use of Safely You.

<Resident 7>

Review of Resident 7's, "Resident Consent to Fall Detection Program," form showed that it was signed on 02/05/2025 by Resident 7's representative. The consent showed that AI software was used to detect resident falls. The consent showed that Safely You personnel would conduct video monitoring safety checks to determine potential health and safety risks for the resident. Additionally, the consent showed that use of the system required that a sign be posted near the resident's door to inform visitors and staff of the video monitoring.

Review of Resident 7's assessment, dated 06/26/2025, showed that the resident's representative had consented to the use of Safely You fall monitoring. The assessment was not signed by Resident 7 or their representative.

Review of Resident 7's NSA, dated 06/26/2025, showed that the resident walked independently with no devices and was not a fall risk. Resident 7's NSA did not show that the resident used the Safely You system. Resident 7's NSA did not identify who had access to the video monitoring.

Review of a facility incident report, dated 01/02/2026, showed that Resident 7 had fallen out of bed. The incident report showed that the fall had been captured on the Safely You video monitoring system.

Review of Resident 7's progress notes from 09/05/2025 through 01/04/2026 showed that there were no progress notes. The progress notes did not show any documentation of an evaluation regarding the resident's use of Safely You.

In an interview on 01/07/2025 at 10:37 AM, Staff H, Registered Nurse/Healthcare Director, stated that
Resident 7's record did not include any other progress notes for the three-month lookback period that was requested.

In an interview on 01/07/2026 at 3:15 PM, Staff H stated that it was the responsibility of Staff E, Resident Care Coordinator, to develop each resident's NSA.

In an interview on 01/07/2026 at 3:20 PM, Staff E stated that Resident 7 did have the Safely You video fall management recording in their room. Staff E stated that the facility's electronic system for developing residents' NSAs did not have a section where the use of electronic monitoring could be added to each resident's NSA.

Observation on 01/08/2026 at 10:02 AM, showed that there were small notices posted near the entry doors of Resident 5 and Resident 6's rooms. The notices indicated that there was, "Video recording for fall management" inside both resident's rooms. Observation showed that the same notice was not posted near Resident 7's room door.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 2/28/2026 .

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

Carla J. Bianchi — Administrator (or Representative)

2/6/2026 — Date

Plan of Correction

Department of Social and Health Services Administration
Home and Community Living Administration
1200 Alder Street, Union Gap, WA 98903

RE: ANNUAL SURVEY January 14, 2026

The department complete a full inspection of your Assisted Living Facility on 01/14/2026 and found that your facility does not meet the Assisted Living Facility licensing requirements for the WAC's listed below.

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

(1) The care and services necessary to meet the resident's needs, including:
(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
(ii) The resident's full assessments:
(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care of services to the resident in the assisted living facility, the assisted living facility must specify in the negotiate service agreement an alternate plan for providing care of service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan.
(a) Exclusively for the individual resident; or
(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This will be corrected by adding content regarding diagnosis, activities of daily living, behaviors, interventions, and any intermittent nursing services needed to the Negotiated Service Agreement.

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family

member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;
(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;
(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;
(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and
(4) The plan for family assistance with medications or treatments must be signed and dated by:
(a) The resident, if able;
(b) The resident's representative, if any;
(c) The resident's family member responsible for implement the plan; and
(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This will be corrected by any Resident requiring family assistance signing the family assistance plan which will be kept in a separate binder in the nursing office.

WAC 388-78A-2320 Intermittent nursing services systems

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:
(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and
(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.
(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:
(c) Nurse delegation, if provided;
(d) Initial and on-going assessments of the nursing needs of each resident;
(e) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident.

This will be corrected in our new system by reassessing and evaluating every 90 days those who receive delegated task assistance from staff.

WAC 388-78A-2483 Tuberculosis One Test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This will be corrected by conducting a TB test on every hire, even if they are a rehire within a year.

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

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician

This will be completed by conducting a class the first week of the third month of each quarter to ensure we stay in compliance.

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

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This will be completed by conducting a class the first week of the third month of each quarter to ensure we stay in compliance.

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

© The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is document in writing.

This will be corrected by adding consent for Safely You electronic monitoring to the negotiated service plan as well as updating the signed consent with the resident's family/representative every 90 days.