STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Highgate Vancouver LP
Highgate Senior Living
9803 NE Hazel Dell Ave
Vancouver, WA 98665

RE: Highgate Senior Living License # 2233

Dear Administrator:

This letter addresses Compliance Determination(s) 75606 (Completion Date 04/09/2026) and 74479 (Completion Date 03/30/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/09/2026 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-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2600-2-i

The Department staff who did the on-site verification:
Richard Westom, NCI, ALF Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Highgate Senior Living
Provider Type: Assisted Living Facility

License/Cert.#: 2233
Intake ID: 213565
Compliance Determination #: 74479
Region/Unit #: RCS Region 3 / Unit E
Investigator: Richard Westom
Investigation Date(s): 03/17/2026 through 03/30/2026
Complainant Contact Date(s):

Allegation(s):
1. Quality of care/Treatment. Resident eloped from locked memory care unit.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:
1. Quality of care/Treatment. After interview and record review the facility failed to follow their policy and procedures for a resident that eloped. Failed practice identified.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 03/17/2026 of:

Highgate Senior Living
9803 NE Hazel Dell Ave
Vancouver, WA 98665

This document references the following complaint number(s): 213565

The following sample was selected for review during the unannounced on-site visit: 3 of 54 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Richard Westom, NCI, ALF Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2233	Compliance Determination # 74479
Plan of Correction	Highgate Senior Living	Completion Date
Page 2 of 3	Licensee: Highgate Vancouver LP	03/30/2026

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.

Clinton Fridley RN
Residential Care Services

04/01/2026
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.

Administrator (or Representative)

4/3/2026
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow its policy requiring staff to complete a head count when an alarm sounded for 1 of 3 residents (Resident1 (R1)) reviewed for elopements. This failure resulted in R1 leaving the facility without staff knowledge and placed all memory care residents at risk for elopement and injury.

Findings included...

Record review of facility policy titled "Monitoring Resident Location," dated 07/2022, documented that when an alarm goes off, a [facility] team member should immediately go to the door or exit that is alarming. If there is no evidence of how the alarm was activated, the team member should conduct a head count to ensure all residents are accounted for.

Review of R1's face sheet, undated, showed an admission date of [redacted]/2026. R1 was admitted to the memory care locked unit with diagnoses including [redacted] and history of psychotic behaviors (behaviors due to a person has difficulty determining what is real or not).

Record review of facility document titled "Incident Investigation Summary," dated 02/20/26, showed that R1 eloped from memory care and walked to the bus stop and attempted to board a bus. Staff did not complete a head count after turning off the alarm. Documented that R1 had been attempting to elope since arriving at the facility on [redacted]/2026, no one verified that R1 was accounted for. R1 was returned to the facility by the police.

In an interview on 3/17/2026 at 12:09 PM, Staff A, Administrator, stated staff should have done a head count of all residents after R1 eloped out of the facility [meaning after the alarm sounded].

In an interview on 3/17/2026 at 12:19 PM, Staff B, Activities Director, stated that they shut off the alarm the day of the incident and "showed other staff members how to reset the alarm." Staff B stated that the sheriff brought R1 back about an hour and a half later. Facility policy is if the alarm sounds, staff are to do a head count and check rooms, none of us followed policy.

In and interview on 3/17/2026 at 12:25 PM, Staff C, Resident Care Coordinator (RCC), stated, "if an alarm goes off, staff are to check rooms and do a head count." "If staff would have done a head count, they would have known we were missing a resident."

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) 4|3|2026 .

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

ABazzano — 4/3/2026

Administrator (or Representative) — Date

Plan of Correction

Highgate Senior Living License # 2233

Complaint reference # 213565

SOD report dated 3/30/2026

1) WAC 388-78A-2600 Policies and Procedures.

   Immediate Correction Measures taken:

   - Staff has been retrained on the facility's policy titled "Monitoring Resident Location" dated 7/2022, emphasizing the importance of conducting a head count and checking rooms immediately when an alarm sounds in the cottage.
   - A mandatory training session was scheduled and completed on 3/31/2026 for all Staff to ensure they understand and adhere to the policy.

   Implementation of Monitoring system:

   - A new system has been implemented to ensure compliance with the policy. This includes assigning specific staff members to monitor alarms and conduct head counts during each shift.
   - Supervisors will conduct random checks to ensure the policy is being followed consistently
   - All deficiencies have been corrected. Completion date 4/1/2026

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