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

CRH PETERS CREEK LLC
PETERS CREEK RETIREMENT COMMUNITY
14431 REDMOND WAY
REDMOND, WA 98052

RE: PETERS CREEK RETIREMENT COMMUNITY License # 2245

Dear Administrator:

This letter addresses Compliance Determination(s) 66233 (Completion Date 09/26/2025) and 64161 (Completion Date 08/15/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/26/2025 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-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-2, WAC 388-112A-0720-2-a

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

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

Sincerely,

James Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

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

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

The department completed data collection for an unannounced on-site follow-up on 08/14/2025 of:
PETERS CREEK RETIREMENT COMMUNITY
14431 REDMOND WAY
REDMOND, WA 98052

This document references the following SOD dated: 08/15/2025

The following sample was selected for review during the unannounced on-site visit: 9 of 46 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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.

Laurie Anderson
Residential Care Services

08/27/2025
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)

9/23/25
Date

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

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

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

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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

(2) Assisted living facilities.

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

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

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

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

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

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

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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

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(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 sampled staff (Staff F, Staff X, and Staff Y) completed the continuing education (CE), as required. This failure placed all 46 residents at risk of receiving inadequate care from untrained staff.

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 07/09/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 08/12/2025.

Review of the facility's Resident Caregiver and Medication Caregiver job descriptions dated 02/01/2018, and the facility's undated Resident Services Director job description showed that care staff provided direct personal care and supervision to the residents consistent with Washington State regulations.

STAFF F
Review of the facility's undated employee list showed the facility hired Staff F, Medication Technician, on 03/14/2023. Review of the facility's employee schedule showed Staff F worked at the facility to provide personal care to the residents between June 2025 and August 2025.

Review of Staff F's employee records showed Staff F held an active Nursing Assistant Certification (NAC). The records showed Staff F's NAC was first issued on 09/01/2022. The records showed documentation that Staff F completed eleven hours of the required 12 hours of CE training, approved by the Department of Social and Health Services (DSHS), from their June 2024 birthday to their June 2025 birthday.

STAFF X
Review of the facility's undated employee list showed that the facility hired Staff X, Assisted Living Director, on 03/27/2018. Review of the facility's employee schedule showed Staff X worked at the facility to provide personal care to the residents between June 2025 and August 2025.

Review of Staff X's employee records showed Staff X held an active Home Care Aide (HCA) certification. The records showed Staff X's HCA certification was first issued on 07/05/2016. The records showed that as of 08/14/2025, Staff X completed six hours of the required 12 hours of CE training, approved by the DSHS, from their September 2023 birthday to their September 2024 birthday.

STAFF Y
Review of the facility's undated employee list showed that the facility hired Staff Y, Caregiver, on 10/30/2017. Review of the facility's employee schedule showed Staff Y worked at the facility to provide personal care to the residents between June 2025 and

August 2025.

Review of Staff Y's employee records showed Staff Y held an active NAC. The records showed Staff Y's NAC was first issued on 01/17/2008. The records showed that as of 08/14/2025, Staff Y completed zero hours of the required 12 hours of CE training, approved by the DSHS, from their April 2024 birthday to their April 2025 birthday.

During an interview on 08/14/2025 at 12:35 PM, Staff U, Executive Director, stated that they were unaware Staff F, Staff X, and Staff Y did not complete their 12 hours of continuing education training, as required.

During an interview on 08/15/2025 at 10:30 AM, Staff U stated that they were unable to locate any additional training documentation of CE trainings for Staff F, Staff X, and Staff Y.

This is an uncorrected deficiency previously cited on 07/09/2025, subsection (2)(e).

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 9/5/2025 .

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

Administrator (or Representative) — Date: 9/23/25

August 2025.

Review of Staff Y's employee records showed Staff Y held an active NAC. The records showed Staff Y's NAC was first issued on 01/17/2008. The records showed that as of 08/14/2025, Staff Y completed zero hours of the required 12 hours of CE training, approved by the DSHS, from their April 2024 birthday to their April 2025 birthday.

During an interview on 08/14/2025 at 12:35 PM, Staff U, Executive Director, stated that they were unaware Staff F, Staff X, and Staff Y did not complete their 12 hours of continuing education training, as required.

During an interview on 08/15/2025 at 10:30 AM, Staff U stated that they were unable to locate any additional training documentation of CE trainings for Staff F, Staff X, and Staff Y.

This is an uncorrected deficiency previously cited on 07/09/2025, subsection (2)(e).

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

Community Name: Peters Creek Retirement

Survey Date: 8/14/2025

Plan of Correction

Regulation #	Deficient System or Standard	Action Plan	Team Member's Name	Estimated date of completion	Signature/Date
WAC 388-112A-0611 Continuing Education	***WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required and when must they be completed?*** *(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.* *(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:* *(iii,} A certified nursing assistant;* *(2) A long-term care worker ·who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.*	The community is reviewing continuing education credits daily based on staff birthdays. The community is working with our payroll program to message team members who are due to complete their CEU's Employees will be removed from the schedule prior to birthday if they have not completed their CEU's allowing them time to complete.	• Executive Director • Administrative Assistant • Resident Care Coordinator	9/5/2025 & Ongoing	9/23/25

Plan of Correction

Regulation #	Deficient System or Standard	Action Plan	Team Member's Name	Estimated date of completion	Signature/Date
WAC 388-112A-0720 ***What are the CPR and first-aid training requirements?***	*(2) Assisted living facilities.* *(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days or their date of hire.*	The community is reviewing CPR & First Aid expiration dates and scheduling team members to complete courses prior to expiration Employees will be removed from the schedule prior to expiration if they have not completed their certifications or recertifications allowing them time to complete.	• Executive Director • Administrative Assistant • Resident Care Coordinator	9/5/2025 & Ongoing	9/23/25
WAC 388-18A-2474 Training and home care aide certification requirements.	*(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:* *(d) Cardiopulmonary resuscitation and first aid; and* *(e) Continuing education.*	The community is reviewing hiring dates and training completions at hire and communicating with employees regarding test dates and completion. Community is also keeping track of extensions and ensuring that all staff continue to meet requirements.	• Executive Director • Administrative Assistant • Resident Care Coordinator	9/5/2025 & Ongoing	9/23/25

*****Community is tracking all birthdays, expirations of certificates etc. on a master excel spreadsheet that is kept updated by Administrative Assistant.**

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 06/30/2025 and 07/03/2025 of:
PETERS CREEK RETIREMENT COMMUNITY
14431 REDMOND WAY
REDMOND, WA 98052

The following sample was selected for review during the unannounced on-site visit: 8 of 46 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, 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

Statement of Deficiencies	License #: 2245	Compliance Determination #: 51546
Plan of Correction	PETERS CREEK RETIREMENT COMMUNITY	Completion Date
Page 2 of 15	Licensee: CRH PETERS CREEK LLC	07/09/2025

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.

Laurie Anderson
Residential Care Services

07/10/2025
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)

7-15-25
Date

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

(5) After handling soiled equipment or utensils;

WAC 246-215-03510 Temperature and time control Thawing (FDA Food Code 3-501.13). Except as specified in subsection of this section, time/temperature control for safety food must be thawed:

(5) reduced oxygen packaged fish that bears a label indicating that it is to be kept frozen until time of use must be removed from the reduced oxygen environment:

(a) Prior to thawing under refrigeration as specified in subsection (1) of this section; or

(b) Prior to, or immediately upon completion of, thawing using procedures specified in subsection (2) of this section.

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

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the faciltiy failed to ensure staff followed proper food safety guidelines in 1 of 1 commercial kitchens (main kitchen). The facility failed to ensure 1 of 1 dishwasher staff (Staff J) followed proper hand sanitation guidelines. The facility failed to ensure 1 of 1 counter height two-drawer refrigerators (two-drawer frig 1) maintained food at a temperature of 41 degree Fahrenheit (F) or less. These failures placed all 46 residents at risk of contracting foodborne illnesses.

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 _____

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(a) Prior to thawing under refrigeration as specified in subsection (1) of this section; or

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Based on observation, interview, and record review, the faciltiy failed to ensure staff followed proper food safety guidelines in 1 of 1 commercial kitchens (main kitchen). The facility failed to ensure 1 of 1 dishwasher staff (Staff J) followed proper hand sanitation guidelines. The facility failed to ensure 1 of 1 counter height two-drawer refrigerators (two-drawer frig 1) maintained food at a temperature of 41 degree Fahrenheit (F) or less. These failures placed all 46 residents at risk of contracting foodborne illnesses.

Findings included…

HANDWASHING
Review of the facility's policy titled, "Handwashing", dated 2022, showed food service workers adhered to strict handwashing procedures to prevent foodborne illnesses. The policy showed food service workers washed their hands after handling soiled items. The policy showed food service managers actively supervised staff for compliance. The policy owners were shown as the Culinary Services Director and the Executive Director.

Observation on 07/01/2025 at 1:02 PM, showed multiple times that Staff J, Dishwasher, handled dirty dishes and utensils with bare hands and moved to put away clean dishes without any handwashing between the tasks.

During an interview on 07/01/2025 at 1:12 PM, Staff I, Culinary Director, stated that dishwasher staff never washed their hands between handling dirty and clean dishes. Staff I stated that they would not ensure Staff J washed their hands between the handling of dirty and clean dishes.

COLD HOLDING
Review of the facility's policy titled, "Food Temperatures", dated 2022, showed the facility's primary goal was to prevent foodborne illness by controlling the growth of harmful bacteria by keeping food out of the "Temperature Danger Zone". The policy showed food was kept at or below 40 degrees Fahrenheit (F). The policy owners were shown as the Culinary Services Director and the Executive Director.

Observation on 07/01/2025 at 12:56 PM, showed a counter height two-drawer refrigerator in the main kitchen. The drawers held several perishable foods. When checked, the hardboiled eggs measured at a temperature of 46.8 degrees F; the cucumbers measured at 47.4 degrees F; and the tomatoes measured at 44.8 degrees F. Observation on 07/02/2025 at 11:14 AM, showed the hardboiled eggs measured at 47.5 degrees F.

During an interview on 07/01/2025 at 12:54 PM, Staff I stated that food in cold holding should be below 41 degrees F. Staff I stated that they were aware the refrigerator ran warm. Staff I stated that they did not tell management and did not plan to tell management. Staff I stated that management would not do anything about it.

During an interview on 07/02/2025 at 11:14 AM, Staff I confirmed the eggs had been in the refrigerator all morning. Staff I stated that the eggs were not maintained at a safe temperature.

Staff K, Vice President of Operations, stated that staff were expected to follow the facility's policies related to all kitchen services.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 8/12/25.

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

Administrator (or Representative) — Date: 7/15/25

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

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

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

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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

(2) Assisted living facilities.

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

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

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 7 sampled staff (Staff B, Staff D, and Staff F) completed Cardiopulmonary Resuscitation, first aid

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, PETERS CREEK RETIREMENT COMMUNITY 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

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(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 7 sampled staff (Staff B, Staff D, and Staff F) completed Cardiopulmonary Resuscitation, first aid

certification, and specialized training for mental health illness, as required. These failures placed all 46 residents at risk of receiving inadequate care from untrained staff.

Findings included…

Review of the facility's Resident Caregiver and Medication caregiver job descriptions, dated 02/01/2018, showed the positions required current cardiopulmonary resuscitation and first aid certification or achieved within 30 days of employment. The job descriptions showed that staff were required to successfully complete other state-required education / certification classes according to statue.

Review of Resident 1, Resident 6, and Resident 7's records showed each resident with a diagnosis of [redacted].

STAFF B
Review of the facility's employee roster showed that the facility hired Staff B, Medication Technician (unlicensed staff who dispense medications), on 01/16/2025.

Review of the facility's caregiver schedules showed that from 04/28/2025 through 07/03/2025, Staff B worked 43 shifts in the facility, providing care and services to residents.

Review of Staff B's employee record showed that as of 07/03/2025, 169 days after hire, there was no documentation that showed Staff B completed the facility orientation as required.

STAFF D
Review of the facility's employee roster showed that the facility hired Staff D, Medication Technician, on 02/28/2025.

Review of the facility's staff schedules showed that from 04/28/2025 through 07/03/2025, Staff D worked in 37 shifts in the facility, providing care and services to residents.

Review of Staff D's employee record showed that as of 07/03/2025, 126 days after hire, there was no documentation that showed Staff D completed facility orientation, first aid, and the Washington state Department of Social and Health Services (DSHS) approved mental health specialty training, as required.

During an interview on 07/03/2025 at 11:30 AM, Staff U, Assistant Administrator, stated that they were unable to find any further records for Staff B and Staff D.

STAFF F
Review of Staff F's employee records showed the facility hired Staff F as a Medication Technician on 03/14/2023. The records showed Staff F maintained an active Nursing Assistant Certified (NAC) credential. The records showed documentation Staff F completed five of the required 12 hours of continuing education training from their June 2024 birthday to their June 2025 birthday. The records showed no documentation that Staff F completed their first aid training.

Review of the facility Care Staff schedules from 4/28/2025 through 07/04/2025, showed Staff F worked five shifts per week in the facility, providing care and services to residents. The schedules showed Staff F worked 21 shifts past their June birthday without completion of the continuing education training requirements.

Observations on 07/02/2025 at 10:00 AM, and on 07/03/2025 at 8:02 AM, showed Staff F dispensed medications and provided care and services to residents.

During an interview on 07/02/2025 at 10:30 AM, Staff U stated that they were unable to locate any additional training documentation for Staff F.

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 8/12/25

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

Administrator (or Representative) — 7-15-25 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:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

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

This requirement was not met as evidenced by:

STAFF F
Review of Staff F's employee records showed the facility hired Staff F as a Medication Technician on 03/14/2023. The records showed Staff F maintained an active Nursing Assistant Certified (NAC) credential. The records showed documentation Staff F completed five of the required 12 hours of continuing education training from their June 2024 birthday to their June 2025 birthday. The records showed no documentation that Staff F completed their first aid training.

Review of the facility Care Staff schedules from 4/28/2025 through 07/04/2025, showed Staff F worked five shifts per week in the facility, providing care and services to residents. The schedules showed Staff F worked 21 shifts past their June birthday without completion of the continuing education training requirements.

Observations on 07/02/2025 at 10:00 AM, and on 07/03/2025 at 8:02 AM, showed Staff F dispensed medications and provided care and services to residents.

During an interview on 07/02/2025 at 10:30 AM, Staff U stated that they were unable to locate any additional training documentation for Staff F.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) 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:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(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 interview and record review, the facility failed to ensure that 2 of 4 newly hired staff (Staff N and Staff P) completed tuberculosis (TB) testing upon hire. This failure placed all 46 residents at risk of contracting tuberculosis, a contagious illness.

Findings included…

Review of the facility's policy titled, "Employee Health Screening and TB", dated 2022, showed Staff would conform to the TB requirements for the state.

Review of the facility's Medication Technician job description, dated 02/01/2018, showed Medication Technicians provided direct care to residents.

Staff N
Review of Staff N's employee records showed the facility hired Staff N as Receptionist on 05/23/2025. The records showed Staff N had a history of a negative TB blood test in the previous 12 months. The records showed that on 02/24/2025, Staff N previously completed a QuantiFERON (blood test for TB) with negative results. The records showed no documentation that Staff N completed a TB one test, as required.

Staff P
Review of Staff P's employee records showed the facility hired Staff P as the Activities Director Receptionist on 05/05/2025. The records showed Staff P had a history of a negative TB blood test in the previous 12 months. The records showed that on 04/25/2025, Staff P completed a QuantiFERON test with negative results. The records showed no documentation that Staff P completed a TB one test, as required.

Observation on 07/01/2025 at 10:00 and 2:00 PM showed Staff P provided various activities for residents. Observation on 07/03/2025 at 10:00 AM showed Staff P decorated the facility for the Fourth of July.

During an interview on 06/30/2025 at 3:45 PM, Staff U, Assistant Administrator, stated that they did not realize that a TB one was required when someone took a TB blood test. Staff U stated they thought blood tests were like chest x-rays for TB and were only required to be done once.

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 8-12-25.

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

Administrator (or Representative) — Date: 7-15-25

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 pet (Pet 1) received regular veterinary examinations and were veterinarian certified to be free of disease transmittable to humans. This failure placed all 46 residents at risk of contracting illnesses spread by pets.

Findings included...

Review of the facility's undated "Disclosure of Services" showed the facility allowed pets to reside in the facility. The disclosure showed the pets must have regular veterinarian examinations and must be certified by a veterinarian to be free of diseases transmittable to humans.

PET 1
Review of the facility's pet records showed no record Pet 1 received a regular veterinary examination. The records showed no veterinarian certification Pet 1 was free of diseases transmittable to humans.

Observations on 07/01/2025 at 11:56 AM, showed Pet 1 in the dining room with Resident 9. Observations throughout the full inspection from 06/30/2025 at 9:00 AM through 07/03/2025 at 1:15 PM, showed Pet 1 with Resident 9 in the main floor halls.

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, PETERS CREEK RETIREMENT COMMUNITY 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-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 pet (Pet 1) received regular veterinary examinations and were veterinarian certified to be free of disease transmittable to humans. This failure placed all 46 residents at risk of contracting illnesses spread by pets.

Findings included…

Review of the facility's undated "Disclosure of Services" showed the facility allowed pets to reside in the facility. The disclosure showed the pets must have regular veterinarian examinations and must be certified by a veterinarian to be free of diseases transmittable to humans.

PET 1
Review of the facility's pet records showed no record Pet 1 received a regular veterinary examination. The records showed no veterinarian certification Pet 1 was free of diseases transmittable to humans.

Observations on 07/01/2025 at 11:58 AM, showed Pet 1 in the dining room with Resident 9. Observations throughout the full inspection from 06/30/2025 at 9:00 AM through 07/03/2025 at 1:15 PM, showed Pet 1 with Resident 9 in the main floor halls

and lobby.

During an interview on 07/02/2025 at 10:15 AM, Staff V, Receptionist, stated that they handled the pet records. Staff V stated that they asked residents for their current pet records. Staff V stated that they did not specifically ask for the exam or vet certification that showed the pet was free of diseases transmittable to humans.

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7-15-25.

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

Administrator (or Representative) — Date: 7-15-25

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, and component parts safe, sanitary, and in good repair.

(4) Providing door hardware to ensure:

(b) Residents cannot become locked in storage rooms, closets, or other rooms or areas not intended for resident access.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 1 of 1 Memory Care Courtyards (MC Courtyard) was clean and safe for resident use. These failures placed all 12 memory care residents at risk of injury from unsafe or unsanitary conditions when in the courtyard.

Findings included...

Observations of the memory care unit on 06/30/2025 at 11:27 AM and on 07/01/2025 at 9:15 AM, showed the courtyard was located outside of the dining room. Observation

and lobby.

During an interview on 07/02/2025 at 10:15 AM, Staff V, Receptionist, stated that they handled the pet records. Staff V stated that they asked residents for their current pet records. Staff V stated that they did not specifically ask for the exam or vet certification that showed the pet was free of diseases transmittable to humans.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, and component parts safe, sanitary, and in good repair.

(4) Providing door hardware to ensure:

(b) Residents cannot become locked in storage rooms, closets, or other rooms or areas not intended for resident access.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 1 of 1 Memory Care Courtyards (MC Courtyard) was clean and safe for resident use. These failures placed all 12 memory care residents at risk of injury from unsafe or unsanitary conditions when in the courtyard.

Findings included…

Observations of the memory care unit on 06/30/2025 at 11:27 AM and on 07/01/2025 at 9:15 AM, showed the courtyard was located outside of the dining room. Observation

showed residents were present in the dining room. Observation showed the doors to the courtyard from the dining room were unlocked. Observation of the courtyard showed an uncovered garbage can on the courtyard, near the entrance to the dining room. The garbage can's contents included used incontinence products (supplies designed to manage urinary or bowel leakage), used disposable gloves, and thin flexible plastic film. Observation showed a lockable outdoor resin storage box sat in the courtyard. The box was mostly empty. The box was large enough for a human to fit inside. There was no padlock on the box and the box was unlocked.

During an interview on 06/30/2025 at 11:27 AM, Staff W, Facilities Director, stated that they were unaware of the unsafe and unsanitary conditions for the memory care residents due to the resident-accessible garbage and unsecured storage box in the memory care courtyard.

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7-15-25

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

Administrator (or Representative) — Date: 7-15-25

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

(1) The residents' characteristics and needs;

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

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 memory care housekeeping utility carts (Cart 1), that stored hazardous chemicals, was

showed residents were present in the dining room. Observation showed the doors to the courtyard from the dining room were unlocked. Observation of the courtyard showed an uncovered garbage can on the courtyard, near the entrance to the dining room. The garbage can's contents included used incontinence products (supplies designed to manage urinary or bowel leakage), used disposable gloves, and thin flexible plastic film. Observation showed a lockable outdoor resin storage box sat in the courtyard. The box was mostly empty. The box was large enough for a human to fit inside. There was no padlock on the box and the box was unlocked.

During an interview on 06/30/2025 at 11:27 AM, Staff W, Facilities Director, stated that they were unaware of the unsafe and unsanitary conditions for the memory care residents due to the resident-accessible garbage and unsecured storage box in the memory care courtyard.

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

(1) The residents' characteristics and needs;

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

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 memory care housekeeping utility carts (Cart 1), that stored hazardous chemicals, was

locked while unattended. This failure placed all 12 residents at risk of injury from contact with or possible ingestion of the hazardous chemicals.

Findings included...

Review of the facility's policy titled, "Guidelines for Dementia Residents on Restricted Items", dated 02/01/2018, showed a "yes" answer to any of these four questions should prevent the item from being accessible: does the product contain a warning label?; could the product or item be a danger to any resident?; would you prevent a small child from playing unattended with the item?; and, could the item be more safely provided or stored by the community?

Observation on 06/30/2025 at 11:12 AM, showed an unattended, unlocked, and open housekeeper's cart in the hall of the memory care unit. Observation showed the upper compartment of the cart contained disinfectant wipes and pump and aerosol sprays. The items showed caution labels with warnings that the products should be kept out of reach of children, may be harmful if swallowed, do not spray towards face and eyes, may cause eye irritation, and seek medical attention as needed.

During an interview on 06/30/2025 at 11:17 AM, Staff W, Facilities Director, stated that they supervised the housekeepers. Staff W stated that the housekeeping cart should be either under the housekeeper's control or locked.

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7-15-25 .

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

Administrator (or Representative) 7-15-25 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

locked while unattended. This failure placed all 12 residents at risk of injury from contact with or possible ingestion of the hazardous chemicals.

Findings included…

Review of the facility's policy titled, "Guidelines for Dementia Residents on Restricted Items", dated 02/01/2018, showed a "yes" answer to any of these four questions should prevent the item from being accessible: does the product contain a warning label?; could the product or item be a danger to any resident?; would you prevent a small child from playing unattended with the item?; and, could the item be more safely provided or stored by the community?

Observation on 06/30/2025 at 11:12 AM, showed an unattended, unlocked, and open housekeeper's cart in the hall of the memory care unit. Observation showed the upper compartment of the cart contained disinfectant wipes and pump and aerosol sprays. The items showed caution labels with warnings that the products should be kept out of reach of children, may be harmful if swallowed, do not spray towards face and eyes, may cause eye irritation, and seek medical attention as needed.

During an interview on 06/30/2025 at 11:17 AM, Staff W, Facilities Director, stated that they supervised the housekeepers. Staff W stated that the housekeeping cart should be either under the housekeeper's control or locked.

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, PETERS CREEK RETIREMENT COMMUNITY 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-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 5 of 15 sampled staff (Staff E, Staff O, Staff R, Staff S, and Staff T) completed an initial skin test for Tuberculosis (TB), within three days of hire, as required. The facility failed to ensure Staff E, Staff R, Staff S, and Staff T completed a second skin test one to three weeks after the initial skin test. These failures placed all 46 residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings included…

Review of the facility's document titled "Employee Health Screening and TB", dated 2022, showed that all employees must demonstrate they are free of communicable disease. The policy showed that employees need to conform to the state licensing requirements. The policy showed that all employees were to have a baseline two-step skin test initiated within three days of hire.

Review of the facility's Medication Technician and the Resident Caregiver job descriptions, dated 02/01/2018, showed Medication Technicians and Resident Caregivers provided direct resident care.

STAFF E
Review of Staff E's employee records showed the facility rehired Staff E as a Medication Technician on 09/24/2024. The records showed that on 10/17/2024, Staff E completed a TB skin test, with negative results, 23 days after hire. There was no documentation that showed Staff E completed a second TB skin test when rehired.

Review of the facility's Care Staff schedules from 04/28/2025 through 07/04/2025, showed Staff E worked five shifts per week in the facility, providing care and services to residents.

STAFF O
Review of the facility's Employee Roster showed the facility hired Staff O, Caregiver, on 06/09/2025. Review of Staff O's employee records showed a one-step positive TB skin test was done on 06/13/2025, five days after hire. A negative chest X-ray for TB was completed on 06/16/2025.

Review of the facility's Care Staff schedules from 06/09/2025 through 07/03/2025, showed Staff O worked eight days in the facility, providing care and services to residents.

Staff R
Review of the facility's Employee Roster showed the facility hired Staff R, Cook, on 03/04/2025. Review of Staff R's employee records showed Staff R completed a one-step

TB skin test with negative results on 03/17/2025, 14 days after hire. The record showed no documentation that a second-step TB test was completed.

STAFF S
Review of the facility's Employee Roster showed the facility hired Staff S, Caregiver, on 02/17/2025. Review of Staff S's employee records showed Staff S completed a one-step TB skin test with negative results on 03/14/2025, 26 days after hire. The record showed no documentation that a second-step TB test was completed.

Review of the facility's Care Staff schedules from 04/27/2025 through 07/03/2025 showed Staff O worked 16 days in the facility, providing care and services to residents.

STAFF T
Review of the facility's Employee Roster showed the facility hired Staff T, Cook/Server, on 12/30/2024. Review of Staff T's employee records showed Staff T completed a one-step TB test with negative results on 02/25/2025, 58 days after hire. The records showed that a second-step TB test was completed on 03/20/2025, 23 days after the one-step was completed, two days past the required 21 days for completion.

During an interview on 06/30/2025 at 2:54 PM, Staff U, Assistant Administrator, stated that they were aware several of the staff's TB tests were done late and incomplete.

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 8-12-25.

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

Administrator (or Representative) — Date: 7-15-25

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 3

TB skin test with negative results on 03/17/2025, 14 days after hire. The record showed no documentation that a second-step TB test was completed.

STAFF S
Review of the facility's Employee Roster showed the facility hired Staff S, Caregiver, on 02/17/2025. Review of Staff S's employee records showed Staff S completed a one-step TB skin test with negative results on 03/14/2025, 26 days after hire. The record showed no documentation that a second-step TB test was completed.

Review of the facility's Care Staff schedules from 04/27/2025 through 07/03/2025 showed Staff O worked 16 days in the facility, providing care and services to residents.

STAFF T
Review of the facility's Employee Roster showed the facility hired Staff T, Cook/Server, on 12/30/2024. Review of Staff T's employee records showed Staff T completed a one-step TB test with negative results on 02/25/2025, 58 days after hire. The records showed that a second-step TB test was completed on 03/20/2025, 23 days after the one-step was completed, two days past the required 21 days for completion.

During an interview on 06/30/2025 at 2:54 PM, Staff U, Assistant Administrator, stated that they were aware several of the staff's TB tests were done late and incomplete.

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, PETERS CREEK RETIREMENT COMMUNITY 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-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 3

resident's (Resident 8) medical device was secured and safely installed for use. This failure placed Resident 8 at risk for potential entrapment and injury.

Findings included...

Review of the Department of Health and Social Services (DSHS) document titled Dear Assisted Living Facility Administrator/Provider, dated 02/25/2022, showed that Assisted Living Facility Providers were issued this letter related to the recall of certain bed rails. The letter showed that in December 2021, the United States Consumer Product Safety Commission (CPSC) issued recalls for three brand-specific quarter- and eighth-length bed rails that were commonly used to assist with transferring and positioning of residents. The letter showed that CPSC found these devices can lead to consumer injury or death due to entrapment and asphyxiation. The letter showed that an occupational therapist/physical therapist may be able to find an alternative for transferring and positioning for those who need it.

Review of the facility's policy "Mobility Enablers Policy" dated 02/01/2018, showed that residents who used an assistive device for transfers, positioning, and stability would be assessed by a Licensed Nurse or Physical Therapist. The policy showed the potential risks for the use of a medical device were strangling, suffocating, bodily injury or death when part of a body is caught between the bed rail and the mattress. The policy showed more serious injuries occurred when a resident attempted to climb over the rail. The policy showed that the rails/devices are used to enhance residents' mobility and are not used as a restraint. The policy showed that a resident who wanted the side rail/bed enabler may agree to exchange the current rail with a smaller opening device when available.

RESIDENT 8
Review of the facility's undated Resident Characteristics Roster showed that the facility admitted Resident 8 in [redacted] of 2022. The Characteristics Roster showed that Resident 8 resided in the secured Memory Care unit. The Characteristics Roster showed no documentation that Resident 8 used a medical device (bed enabler).

Review of Resident 8's records showed an order by the Primary Care Provider, dated 12/29/2023, for a quarter side rail.

Review of Resident 8's side-rail use assessment form, dated 06/11/2025, showed no documentation that the bed enabler was safely secured to the bed and there were no gaps that presented entrapment like qualities.

Observation of Resident 8's bed on 06/30/2025 at 11:10 AM, Resident 8 lay in their bed and faced the entry door of the shared room. Observation showed a U-shaped half side rail was secured to the bed two horizontal poles that slid under the mattress. The side rail had two vertical poles with a 12-inch wide by 12-inch-long gap between the poles. Observation showed the gap between the vertical poles presented a potential risk for entrapment.

Observation of Resident 8's bed on 07/01/2025 at 2:20 PM, showed a pillowcase was placed over the U-shaped bed enabler to cover the 12-inch by 12-inch gap between the two vertical poles of the bed enabler.

During an interview on 07/03/2024 at 9:20 AM, Staff H, Director of Nursing, stated they realized that several medical devices (bedrails/enablers) had large gaps that presented the potential for entrapment. Staff H stated that the pillowcase on Resident 8's side rail was not a good solution. Staff H stated that a more appropriate cover designed specifically for bedrails/enablers was ordered. Staff H stated they were surprised Resident 8's resident safety assessment for medical devices did not include language that showed the bed rail/enabler was secured to the bed, there were no gaps in-between the mattress and no gaps between the rails that allowed for entrapment-like qualities.

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, PETERS CREEK RETIREMENT COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 8-12-25

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

Administrator (or Representative) — Date: 7-15-25

Observation of Resident 8's bed on 07/01/2025 at 2:20 PM, showed a pillowcase was placed over the U-shaped bed enabler to cover the 12-inch by 12-inch gap between the two vertical poles of the bed enabler.

During an interview on 07/03/2024 at 9:20 AM, Staff H, Director of Nursing, stated they realized that several medical devices (bedrails/enablers) had large gaps that presented the potential for entrapment. Staff H stated that the pillowcase on Resident 8's side rail was not a good solution. Staff H stated that a more appropriate cover designed specifically for bedrails/enablers was ordered. Staff H stated they were surprised Resident 8's resident safety assessment for medical devices did not include language that showed the bed rail/enabler was secured to the bed, there were no gaps in-between the mattress and no gaps between the rails that allowed for entrapment-like qualities.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) 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

07/10/2025

CRH PETERS CREEK LLC
PETERS CREEK RETIREMENT COMMUNITY
14431 REDMOND WAY
REDMOND, WA 98052

RE: PETERS CREEK RETIREMENT COMMUNITY # 2245

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 07/09/2025 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-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

The facility did not post or make the menus available in the memory care unit (MC) for the residents. During the full inspection, the facility posted the weekly menu in memory care and assigned designated staff to post the menu each week.

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

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

Enclosure