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

Kirkland Partners LLC
Madison House
12215 NE 128th St
Kirkland, WA 98034

RE: Madison House License # 2436

Dear Administrator:

This letter addresses Compliance Determination(s) 66942 (Completion Date 10/10/2025) and 62551 (Completion Date 08/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/10/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2690-7-a, WAC 388-78A-2690-7-b, WAC 388-78A-2690-7, WAC 388-78A-2690-9, WAC 388-78A-2900-1, WAC 388-78A-2900-2, WAC 388-78A-2900-3, WAC 388-78A-2900-4, WAC 388-78A-2900-5, WAC 388-78A-2900, WAC 388-78A-3040-5, WAC 388-78A-3040-7-a-iv, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2462-2-b, WAC 388-78A-2474-2-b, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-e, WAC 388-78A-2474-4, WAC 388-78A-2540-1, WAC 388-78A-2170-1

The Department staff who did the on-site verification:
Steven Garrett, LTC Licensor
Claudia Allis, ALF Licensor

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

Sincerely,

Jim 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

Statement of Deficiencies	License #: 2436	Compliance Determination # 62551
Plan of Correction	Madison House	Completion Date
Page 1 of 16	Licensee: Kirkland Partners LLC	08/01/2025

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

The department completed data collection for the unannounced on-site full inspection on 07/22/2025 and 07/25/2025 of:
Madison House
12215 NE 128th St
Kirkland, WA 98034

The following sample was selected for review during the unannounced on-site visit: 9 of 69 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Steven Garrett, LTC 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

08/11/2025
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)

8.12.25
Date

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

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(9) For the purpose of consenting to video electronic monitoring without an audio component, the term "resident" includes the resident's representative.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document the quarterly reevaluation in writing of electronic surveillance for 1 of 1 sampled resident (Resident 5). This failure placed Resident 5 at risk for potential violations of their rights.

Findings included...

Observation on 07/25/2025 at 10:45 AM, showed signage on Resident 5's room that indicated electronic monitoring equipment was present inside the room. Observation showed a video camera mounted inside Resident 5's room on the corner ceiling of their living room area.

Review of Resident 5's records showed the facility admitted Resident 5 on [redacted]/2024. Records showed the electronic monitoring was initiated on [redacted]/2024. Records showed that Resident 5's representative and facility representative signed and dated the consent for electronic monitoring on 03/31/2024. Records showed no documentation of any quarterly review for continued use of electronic monitoring equipment.

During an interview on 07/22/2025 at 10:43 AM, Staff A, Executive Director/Administrator, stated that Resident 5 used electronic monitoring devices in their room. Staff A stated that Resident 5's family installed the electronic monitoring equipment in Resident 5's room.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-15-25 .

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

Administrator (or Representative) — Date: 8-12-25

WAC 388-78A-2900 Retention of approved construction documents. The assisted living facility must retain paper or electronic copies of the following on the assisted living facility premises:

(1) Specification data on materials used in construction, for the life of the product;

(2) Stamped "approved" set of construction documents;

(3) The certificate of occupancy or final inspection granted by the local building official;

(4) The functional program required under WAC 388-78A-2361 ; and

(5) Any approved exemption or alternative methods of compliance issued by the department.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 127 rooms (Apartment [redacted]) was approved by the department for occupancy by residents. This failure placed Resident 10 at risk of safety issues and incomplete service by residing in an apartment not approved for occupancy.

Findings included...

Review of the Department of Social and Health Services "Secure Tracking and Reporting Systems" (STARS) showed a list of all the apartments identified as approved for occupancy by the department. There was no documentation of any approval for the

facility Apartment [redacted].

Review of the facility's Characteristics Roster showed that Resident 10 resided in Apartment [redacted]. The roster showed that Resident 10 received care and services from the assisted living facility staff.

Observation on 07/25/2025 at 12:26 PM, showed that Resident 10 resided in Apartment [redacted].

During an interview on 07/22/2025 at 3:10 PM, Staff A, Executive Director/Administrator, stated that Resident 10 resided in Apartment [redacted]. Staff A stated that Resident 10 received care and services from the staff. Staff A stated that they thought all apartments on the facility's Characteristics Roster were approved by the Department for occupancy by residents. Staff A stated that they were unaware that Apartment [redacted] was not one of the apartments listed as approved for occupancy.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-15-25.

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

Administrator (or Representative) 8-12-25 Date

WAC 388-78A-3040 Laundry.

(5) The assisted living facility must ventilate laundry rooms and areas to the outside of the assisted living facility, including areas or rooms where soiled laundry is held for processing by off site commercial laundry services.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(iv) Mechanical ventilation to the outside of the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide

ventilation fans in 2 of 4 laundry rooms (first floor laundry room, and second floor laundry room) for proper air flow and ventilation to the outside of the facility. This failure placed all 69 residents at risk of potential respiratory illness from improper air circulation in the building, and diminished quality of life.

Findings included...

Note: per WAC 388-78A-2900 Retention of approved construction documents. The assisted living facility must retain paper or electronic copies of the following on the assisted living facility premises: (2) Stamped "approved" set of construction documents; (5) Any approved exemption or alternative methods of compliance issued by the department.

Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed there was no documentation in the Assisted Living Facility (ALF) exemptions/comments section of any exemptions or alternatives to ALF's building requirements.

Observation on 07/22/2025 at 1:34 PM, showed that in two laundry rooms (first floor laundry room, and second floor laundry room), used by residents and staff for processing resident's laundry, had no mechanical ventilation fans to move the air to the outside of the building. During an interview at this time, Staff G, Physical Plant Director, and Staff H, Physical Plant Assistant, stated that they were aware of the ventilation requirements. Staff G and Staff H stated that they were unaware that there was no ventilation systems in these two laundry rooms.

During an interview on 07/22/2025 at 3:10 PM, Staff A, Executive Director/Administrator, stated that the first-floor laundry room and second floor laundry room were part of a facility remodel project which began around 2018. Staff A stated that they thought the first and second floor laundry rooms were approved by the Department's Construction Review Services. Staff A stated that they were unaware there was no ventilation systems in the first and second floor laundry rooms.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-16-25 .

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

Administrator (or Representative) 8-12-25 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 3 of 9 sampled residents (Resident 3, Resident 4, and Resident 6) assessments that included the required full assessment components. This failure placed Resident 3, Resident 4, and Resident 6 at risk of harm from unidentified care needs and changes in condition.

Findings included...

RESIDENT 3
Review of Resident 3's records showed the facility admitted Resident 3 on [redacted]/2025. Records showed Resident 3 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 3's assessment, dated 06/18/2025, showed no documentation of Resident 3's [redacted] diagnosis with the care assistance needed related to the disease. The assessment showed no documentation of Resident 3 current prescribed medications.

RESIDENT 4
Review of Resident 4's records showed the facility admitted Resident 4 on [redacted]/2024. The records showed Resident 4 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 4's assessment, dated 04/29/2025 showed no documentation of Resident 4's signs and symptoms related to major depression. The assessment showed no documentation of Resident 4's signs and symptoms related to generalized anxiety. The assessment showed Resident 4 smoked cigarettes. There was no documentation that showed the facility completed a smoking assessment for Resident 4. The records showed no listing of Resident 4 current prescribed medications.

RESIDENT 6
Review of Resident 6's records showed the facility admitted Resident 6 on [redacted]/2021. The records showed Resident 6 admitted with diagnoses of [redacted] and [redacted].

Review of the facility's undated characteristic roster showed that Resident 6 used a medical device. During an interview at this time, Staff A, Executive Director, stated that Resident 6 had a colostomy (a surgical opening in the abdomen fitted with a collection bag to allow fecal waste to leave the body).

Review of Resident 6's assessment records, dated 04/02/2025, showed no documentation the facility no documentation of Resident 6's signs and symptoms related to depression or possible issues related to chronic kidney disease. The assessment showed no documentation Resident 6 had a colostomy. The assessment showed no listing of Resident 6's current prescribed medications.

During an interview on 07/25/2025 at 2:20 PM, Staff A stated that they were unaware of the comprehensive elements of required for resident assessments.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-16-25 .

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

Administrator (or Representative) 8-12-25 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document a plan to monitor and address interventions required to meet the current clinical needs for 3 of 6 residents (Resident 3, Resident 4, and Resident 6). This failure placed Resident 3, Resident 4, and Resident 6 at risk for unmet care needs and potential harm.

RESIDENT 3
Review of Resident 3's records showed the facility admitted Resident 3 on [redacted]/2025. Records showed Resident 3 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 3's Service Plan, dated 03/09/2025, showed no documentation of Resident 3's diagnosis of [redacted]. The plan showed no guidance for staff about the signs and symptoms of multiple sclerosis Resident 3 may exhibit. There were no instructions for care staff to report any changes in Resident 3's baseline functioning.

RESIDENT 4
Review of Resident 4's records showed the facility admitted Resident 4 on [redacted]/2024.

The records showed Resident 4 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 4's Service Plan, dated 04/29/2025, showed no directions for care staff of actions needed when Resident 4 exhibited signs and symptoms of depression. The plan showed no directions for care staff of actions to be taken when Resident 4 exhibited signs and symptoms of anxiety. The plan provided no guidance to staff about how to provide supportive care to Resident 4 when they exhibited signs of depression or anxiety. There were no instructions for care staff to report any changes in Resident 4's baseline functioning.

RESIDENT 6
Review of Resident 6's records showed the facility admitted Resident 6 on [redacted]/2021. The records showed Resident 6 admitted with diagnoses of [redacted] and [redacted].

Review of the facility's undated characteristic roster showed that Resident 6 used a medical device. During an interview at this time, Staff A, Executive Director, stated that Resident 6 had a colostomy (a surgical opening in the abdomen fitted with a collection bag to allow fecal waste to leave the body).

Review of Resident 6's Service Plan, dated 04/02/2025, showed no directions for care staff to monitor for depression or possible issues related to chronic kidney disease. The plan showed no directions for care staff of actions to be taken when Resident 6 exhibited signs and symptoms of depression. The plan provided no guidance about who provided the care needed for Resident 6's colostomy. There were no instructions for care staff to report any changes in Resident 6's baseline functioning.

During an interview on 07/25/2025 at 2:15 PM, Staff A stated that they were unaware of the comprehensive elements required for resident service plans.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-16-25 .

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

Administrator (or Representative) 8-12-25 Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 2 of the 6 staff (Staff A and Staff D) completed a national fingerprint check. This failure placed all 69 residents at risk of potential abuse or neglect by staff with an unknown background.

Findings included...

Review of the facility employee record showed the facility hired Staff A, Executive Director, on 01/02/2024 and Staff D, Resident Aide, on 10/23/2024.

NATIONAL FINGERPRINT BACKGROUND CHECK
Staff A
Review of the facility's staff schedule showed that Staff A worked at the facility providing direct supervision of care and services for residents from 01/02/2024 through 07/25/2025, 569 days. Review of Staff A's personnel records showed no documentation that Staff A completed a national fingerprint background check.

Staff D
Review of the facility's staff schedule showed that Staff D worked at the facility providing direct care and services for residents from 10/23/2024 through 07/25/2025, 275 days. Review of Staff D's personnel records showed no documentation that Staff D completed a national fingerprint background check.

During an interview on 07/25/2025 at 1:50 PM, Staff A stated that they were unaware the facility failed to complete the national fingerprint background checks for Staff A and Staff D when they were hired.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-15-25 .

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

Administrator (or Representative) 8-12-25 Date

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:

(b) Basic;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 6 staff (Staff A, Staff D, and Staff F) completed all required training to perform their job duties and responsibilities. This failure placed all 69 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of the facility's personnel records showed the facility hired Staff A, Executive Director, on 01/02/2024; Staff D, Resident Aide, on 10/23/2024; and Staff F, Medication Tech, on 09/04/2021.

BASIC TRAINING
STAFF A
Review of the facility's personnel records showed no documentation that Staff A completed the required 70-hour basic training.

STAFF F
Review of the facility's personnel records showed no documentation that Staff F completed the required 70-hour basic training.

During an interview on 07/25/2025 at 1:55 PM, Staff A stated that they were unaware that they were required to complete the 70-hour basic training. Staff A stated that they were unaware that Staff F had not completed the 70-hour basic training requirement.

SPECIALTY TRAINING
A review of the facility's disclosure of services showed the facility provides care and services to residents with dementia and mental health.

Review of the facility's personnel records showed no documentation that Staff D completed the required specialty training for dementia and mental health.

During an interview on 07/25/2025 at 1:55 PM, Staff A stated that they were unaware that Staff D had not completed the required specialty training requirements.

CONTINUING EDUCATION
STAFF F
Review of the facility's personnel records showed no documentation that Staff F completed the required 12 hours of continuing education training between their 08/15/2023 birthday and their 08/15/2024 birthday.

During an interview on 07/25/2025 at 1:55 PM, Staff A stated that they were unaware that Staff F had not completed the 12 hours of continuing education training requirement.

HOME CARE AIDE CERTIFICATION
STAFF A
Review of the facility's undated personnel records showed Staff A provided direct supervision of care and services for residents for 569 days since their date of hire. Review of the facility's undated personnel records showed no documentation that Staff A completed the basic training requirements for long-term care workers. The review of Staff A's personnel records showed no documentation that Staff A completed the Home Care Aide certification (HCA).

STAFF F
Review of the facility's undated personnel records showed Staff F provided care and services for residents 1451 days since their date of hire. Review of personnel records showed no documentation that Staff F completed the basic training requirements for long-term care workers. The records showed Staff F's Washington Department of Health credential as a Nursing Assistant Registered expired on 08/15/2025. Review of Staff F's personnel records showed no documentation that Staff F completed the Home Care Aide certification (HCA).

During an interview on 07/25/2025 at 1:55 PM, Staff A stated that they were unaware that they were required to complete the Home Care Aide certification. Staff A stated that there was no designee of the facility to cover for when the administrator was unavailable. Staff A stated that they were unaware that Staff F had not completed the required Home Care Aide certification.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-16-25 .

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

Administrator (or Representative) Date 8/12/25

WAC 388-78A-2540 Administrator requirements. The licensee must ensure the assisted living facility administrator:

(1) Meets the training requirements under chapter 388-112A WAC; and

This requirement was not met as evidenced by:

Based on record review and interview, the licensee failed to ensure 1 of 1 sampled staff (Staff A) met the Washington State qualifications and requirements to be an assisted living facility administrator. This failure placed all 69 residents at risk for unmet care needs by untrained and unqualified staff.

Findings included...

Review of the facility's undated personnel records showed no documentation that Staff A, Executive Director, completed the basic training requirements for long-term care workers. The records showed no documentation that Staff A had completed the Home

Care Aide certification (HCA).

During an interview on 07/25/2025 at 2:10 PM, Staff A stated that they had not completed the 70-hour basic training requirement. Staff A stated that they did not have any certification or credentials as a Home Care Aide. Staff A stated that they were unaware that they did not meet the qualifications for the administrator position upon hire.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-15-25 .

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

Administrator (or Representative) Date 8-12-25

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 9 residents (Resident 1, Resident 2, Resident 3, Resident 6, and Resident 9) medical devices were safe and free of entrapment hazards. This failure placed Resident 1, Resident 2, Resident 3, Resident 6, and Resident 9 at risk of potential harm or death from use of unsafe medical equipment.

Findings included...

RESIDENT 1
Review of Resident 1's records showed the facility admitted Resident 1 on [redacted]/2025.

Observation of Resident 1's apartment on 07/25/2025 at 1:10 PM, showed a bed cane/hand bar attached at the middle of the bed, along the left side. The bed cane measured approximately 10 inches wide with a nine-inch gap between the vertical rail bars. The gap between the vertical bars presented the potential for entrapment.

During an interview on 07/25/2925 at 1:10 PM, Resident 1 stated that they were injured at a different facility because of an entrapment incident while they used the bed rail. Resident 1 stated that they used the bed rail for re-positioning while in bed and "to steady myself and to keep from falling." Resident 1 stated that they were not aware that there were ways to minimize the risk of entrapment.

RESIDENT 2
Review of Resident 2's Face Sheet, showed the facility admitted Resident 2 on [redacted]/2024.

Observation of Resident 2's apartment on 07/24/2025 at 1:30 PM, showed half side rails were attached at the head of the bed, along both the right and left side. The bed rails were in the raised position and measured approximately 30 inches wide with a five-inch gap between vertical rail bars. The gap between the vertical bars presented the potential for entrapment.

Review of Resident 2's assessment, dated 05/08/2025, showed that Resident 2 required facility care staff assistance with transfers from their wheelchair to the bed and from the bed to their wheelchair. The assessment showed Resident 2 used half bed rails for positioning.

RESIDENT 3
Review of Resident 3's records showed the facility admitted Resident 3 on [redacted]/2025.

Observation of Resident 3's apartment on 07/25/2025 at 1:20 PM showed a bed cane/hand bar attached at the middle of the bed, along the right side. The bed cane measured approximately 10 inches wide with a nine-inch gap between the vertical rail bars. The gap between the vertical bars presented the potential for entrapment.

During an interview on 07/25/2025 at 1:20 PM Resident 3 stated that they needed the bed rail for re-positioning while in bed and to help them move to stand up. Resident 3 stated that they were not aware that there were ways to minimize the risk of entrapment.

RESIDENT 6
Review of Resident 6's records showed the facility admitted Resident 6 on [redacted]/2021. Review of the undated facility characteristic roster showed Resident 6 used a medical device.

Observation of Resident 6's apartment on 07/25/2025 at 12:50 PM showed half side rails were attached at the head of the bed, along both the right and left side. The bed rails were in the raised position and measured approximately 30 inches wide with a five-inch gap between vertical rail bars. The gap between the vertical bars presented the

potential for entrapment.

During an interview on 07/25/2025 at 12:50 PM Resident 6 stated that they needed the bed rail for re-positioning while in bed and to help them move to stand up. Resident 6 stated that they needed staff assistance to raise and lower the bedrails.

RESIDENT 9
Review of Resident 9's Face Sheet showed the facility admitted Resident 9 on [redacted]/2023.

Review of Resident 9's assessment, dated 06/18/2025, showed that Resident 9 used a bed cane/hand bar for positioning.

Observation on 07/25/2025 at 1:14 PM, showed a bed cane/hand bar attached at the head of the bed, along the right side. The bed cane measured approximately 10 inches wide with a nine-inch gap between the vertical rail bars. The gap between the vertical bars presented the potential for entrapment.

During an interview on 07/24/2025 at 11:30 AM, Staff A, Executive Director/Administrator, stated that they were aware several residents used bed rails. Staff A stated that they were unaware the gap between the vertical bars on the bed rails presented the potential for entrapment.

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, Madison House is or will be in compliance with this law and / or regulation on (Date) 9-15-25 .

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

Administrator (or Representative) — Date: 8-12-25

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

08/11/2025

Kirkland Partners LLC
Madison House
12215 NE 128th St
Kirkland, WA 98034

RE: Madison House # 2436

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 08/01/2025 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-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

Review of the facility's resident records showed that one resident did not have the Medicaid policy acknowledgement documentation on a separate form, signed and dated by the resident. During the licensing visit, the facility obtained the resident's signature and date on the facility's Medicaid payment policy, to meet regulatory requirements.

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