STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Edmonds Memory Care, LLC
Cedar Creek Memory Care Community
21006 72nd Ave W
Edmonds, WA 98026

RE: Cedar Creek Memory Care Community License # 2453

Dear Administrator:

This letter addresses Compliance Determination(s) 74496 (Completion Date 03/31/2026) and 70653 (Completion Date 01/27/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/31/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b, WAC 388-78A-2630-1, WAC 388-78A-2430-2-a, WAC 388-78A-2430-2, WAC 388-78A-2430-2-b

The Department staff who did the on-site verification:
Hayley Pinkham, ALF Licensor

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

Sincerely,

Jamie Singer

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Cedar Creek Memory Care Community
Provider Type: Assisted Living Facility
License/Cert.#: 2453
Intake ID: 203909
Compliance Determination #: 70653
Region/Unit #: RCS Region 2 / Unit J
Investigator: Hayley Pinkham
Investigation Date(s): 12/29/2025 through 01/27/2026
Complainant Contact Date(s): 01/27/2026

Allegation(s):

1) The Named Resident's (NRs) legal representative (LR) did not receive the NRs medical records as requested in a timely manner.
2) A nurse at the ALF "bent" a needle during insulin administration and the nurse continued to provide care to the NR after the incident.
3) The NR was experiencing extremes of fluctuating blood sugar checks. The ALF nurse was using the wrong insulin dosage at bedtime, resulting in low blood sugar checks in the morning.
4) The ALF withheld the NRs requested records and the close timing between the LR's complaint regarding the incident with the nurse administering insulin with a "bent" needle raises concern for retaliation or unsafe continuation of care.
5) The ALF repeatedly provided meals that were inappropriate for the NR.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 5 Closed records sample size: 1
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents
Record Reviews:	Medical records Incident investigation

Investigation Summary:

1) The NR no longer resides at the Assisted Living Facility (ALF). Observation and interview with sampled residents showed no voiced concerns for care and/or safety at the ALF. Interview and record review showed the ALF did not provide the requested records to the LR within two working days of the LR's request for the

records. Findings of deficient practice, see Statement of Deficiencies dated 01/27/2026.
2) Interview and record review showed that the report of a bent needle used during insulin administration was investigated and ruled out as not occurring at the ALF. Record review of the investigation showed the ALF determined that the nurse did not provide insulin administration inaccurately. Unable to substantiate allegation.
3) Interview and record review showed the ALF received an order for sliding scale during waking hours and a bedtime insulin order and the order was transcribed inaccurately based on the need to clarify the order. Record review showed the NR did not experience several extremes of low morning blood sugars below normal range. The ALF investigated the medication error and corrected the medication error when it was discovered. Unable to substantiate allegation.
4) Interview and record review showed there was no correlation between the NR not receiving the requested medical records and the event of the allegation of a “bent” needle. The ALF investigated both allegations and ruled out abuse and/or neglect. The ALF took corrective action for the medication error. Unable to substantiate allegation regarding retaliation.
5) Record review showed the NR received a diabetic diet as ordered. Unable to substantiate allegation.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Cedar Creek Memory Care Community
Provider Type: Assisted Living Facility
License/Cert.#: 2453
Intake ID: 206810
Compliance Determination #: 70653
Region/Unit #: RCS Region 2 / Unit J
Investigator: Hayley Pinkham
Investigation Date(s): 12/29/2025 through 01/27/2026
Complainant Contact Date(s): 01/27/2026

Allegation(s):

1) The Named Resident (NR) has lost the ability to walk since being admitted to the Assisted Living Facility (ALF). The NR is having difficulty getting physical therapy (PT).
2) The NR fell at the ALF and sustained a black eye, and a cut above the eyebrow. Upon further inspection the NR was found with bruises on their abdomen. The bruises appeared old.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 5 Closed records sample size: 1
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:

1) Interview and observation showed the NR needed physical assist to stand and the NR required a wheelchair for transport. The NR denied care concerns and reported staff treated them with respect. Interview and record review showed the NR was ambulatory prior to hospitalization and the NR returned from the hospital after an extended period in a weakened condition. The NR had orders for PT, but insurance

denied PT. The ALF is working with the insurance company to provide PT benefits to the NR. No findings of deficient practice.
2) Observation of the NR showed there was evidence of a few small pale-yellow discolorations on the abdomen. Interview showed that the NR denied any abuse and/or neglect at the ALF. Record review showed the NR was in the hospital for an extended period and the bruises were identified and investigated upon his return to the ALF. No findings of deficient practice. Interview and record review showed that the NR was hospitalized for unstable behaviors and inappropriate actions toward other residents. Findings for deficient practice. The ALF failed to notify the department and the local police department for resident to resident altercations. See Statement of Deficiency dated 01/27/2026

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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Plan of Correction	Cedar Creek Memory Care Community	Completion Date
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 12/29/2025 of:

Cedar Creek Memory Care Community
21006 72nd Ave W
Edmonds, WA 98026

This document references the following complaint number(s): 203909, 206810

The following sample was selected for review during the unannounced on-site visit: 5 of 57 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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

Jennie Seiger
Residential Care Services

2/11/2026
Date

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

Administrator (or Representative)

2/24/2026
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify law enforcement or the department's Complaint Resolution Unit (hotline) for incidents of physical and sexual abuse when 1 of 1 resident (Resident 2) hit and inappropriately touched 2 of 2 known residents (Resident 3 and Resident 4). This failure may have contributed to a delay in investigation by law enforcement and the Department.

Findings included...

NOTE: Revised Code of Washington (RCW) 74.34.035-Reports—Mandated and permissive—Contents—Confidentiality. When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department. (2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

NOTE: Washington Administrative Code (WAC) 388-78A-2020 - Definitions: "Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.

NOTE: Washington Administrative Code (WAC) 388-78A-2020 - Definitions: "Sexual abuse" means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment.

Record review of the ALF's policy, "Abuse, Neglect, and Exploitation," dated 06/01/2024, showed resident abuse, neglect, and exploitation are prohibited. Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in the policy. Staff will immediately make a report to the hotline, when there is reason to suspect that sexual assault has occurred. Mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

Resident 2
Record review of an undated admission record showed the ALF admitted Resident 2 to the Memory Care Unit (MCU) on [redacted]/2025 with a diagnosis of [redacted]. Resident 2's Negotiated Service Agreement (NSA), dated 11/19/2025, showed Resident 2 was independent for ambulation with a "hiking stick." The NSA stated Resident 2 had a history of inappropriate sexual behavior and physical aggression or violence.

Resident 3
Record review of an undated admission record showed the ALF admitted Resident 3 to the MCU on [redacted]/2023 with diagnosis of [redacted]. Resident 2's NSA, updated on 06/29/2025, showed Resident 3 required stand-by assist for ambulation with a front-wheeled walker and had wandering behaviors.

Resident 4
Record review of an undated admission record showed the ALF admitted Resident 4 to the MCU on [redacted]/2023 with a diagnosis of [redacted]. Resident 4's NSA, updated on 08/21/2025, showed Resident 4 was independent with ambulation and had wandering behaviors.

Record review of a Progress Note (PN), dated 11/07/2025 during the evening shift, showed Staff C (Registered Nurse, RN) documented that Resident 2 was witnessed raising their cane and threatening to hit Resident 3 on the top of their head. Staff B documented Resident 2 stopped when Resident 3, strongly told them, "No."

Record review of a PN, dated 11/16/2025 during the day shift, showed Staff D (RN) documented Resident 2 was walking in the dining room when they suddenly hit the head of Resident 3.

Record review of a PN, dated 11/18/2025 during the day shift, showed Staff E (RN) documented Resident 2 showed inappropriate behavior with a female resident when Resident 2 was trying to reach the female resident's "private area." The PN did not identify the female resident.

Record review of a PN, dated 11/19/2025 during the day shift, showed Staff E documented that Resident 2 was holding a female resident's hand. Staff E documented when a caregiver tried to separate the residents, Resident 2 became upset and the caregiver witnessed Resident 2 attempt to hit Resident 3. The PN did not identify the female resident.

Record review of a PN, dated 11/20/2025 during the day shift, showed Staff F (RN) documented Resident 2, made inappropriate sexual comments to the caregivers during morning care. Staff F documented Resident 2 was approaching female residents, "trying to hug and kiss them." The PN did not identify the female resident(s).

Record review of a PN, dated 11/20/2025 during day shift, showed Staff B (Director of Resident Services) documented Resident 2 was found sitting with their hand under Resident 4's shirt. Staff B redirected and removed Resident 2 away from Resident 4.

Record review of a PN, dated 11/20/2025 during evening shift, showed Staff C documented Resident 2, "gets very angry" with staff for separating them from female residents and Resident 2, "does not believe [they are] doing anything wrong." The PN did not identify the female resident(s).

Record review of a PN, dated 11/21/2025 during evening shift, Staff C documented Resident 2 continued to make advances at female residents and Resident 2 disrupts other residents during mealtime. The PN did not identify the female resident(s).

Record review of a PN, dated 11/22/2025 during evening shift, Staff G (Licensed Practical Nurse) documented Resident 2 was separated from female residents, "multiple times this shift." The PN did not identify the female residents.

Record review of a PN, dated 12/01/2025 during evening shift, Staff H (Medication Technician) documented a care staff member reported that Resident 2 punched her on the face, "last Saturday" while she was redirecting Resident 2, not to hit another resident. The PN did not identify the other resident.

Record review of an Incident Form (IF), dated 11/16/2025, showed the ALF investigated when Resident 2 hit Resident 3 on the head. The IF did not show that the appropriate agencies had been notified.

Record review of an IF, dated 11/20/2025, showed the ALF investigated when Resident 2 placed his hand under Resident 4 shirt. The IF did not show that the appropriate agencies had been notified.

Review of the Department's Secure Tracking and Reporting System (STARS) database, on 01/27/2026, showed the ALF did not make any facility reports for any of the previously identified resident to resident incidents.

In an interview, on 01/27/2026 at 12:55 PM, Staff A (Administrator) stated Resident 2 had hit other residents and was observed with their hand under Resident 4's shirt. Staff A stated that a resident hitting another resident would be considered physical abuse. Staff A stated that a resident touching another resident under their shirt would be considered sexual abuse. Staff A stated that the ALF notified the residents of the families as part of their response and that the ALF did not report it to any additional parties (including law enforcement and the hotline). Staff A stated that all ALF staff know where to call and make a report and that everyone working is a mandated reporter. Staff A acknowledged that they are "ultimately responsible" for the reporting. Staff A stated they are unsure as to why the incidents were not reported to law enforcement and the hotline.

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, Cedar Creek Memory Care Community is or will be in compliance with this law and / or regulation on (Date) March 20 2026 . 3/13/2026

SB confirmed Amended POC date with Provider on 2/24/2026.

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

Administrator (or Representative) [signature] Date 2/24/2026

WAC 388-78A-2430 Resident review of records.

(2) The assisted living facility must provide to the resident or the resident's representative, photocopies of the records or any portions of the records pertaining to the resident, within two working days of the resident's or resident's representative's request for the records.

(a) For the purposes of this section, "working days" means Monday through Friday, except for legal holidays.

(b) The assisted living facility may charge the resident or the resident's representative a fee not to exceed twenty-five cents per page for the cost of photocopying the resident's record.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide resident records as requested for 1 of 1 resident (Resident 1). This failure resulted in Resident 1's legal representative not knowing how Resident 1's medication needs were being met.

Findings included...

Record review of an undated Face Sheet showed the ALF admitted Resident 1 on [redacted]/2025, with multiple diagnoses.

Record review of Resident 1's Negotiated Service Agreement (NSA), dated 09/23/2025, showed Resident 1 required full assistance with medication management. The NSA showed Resident 1's family and the ALF's nurse were involved in Resident 1's medication management.

Record review of a completed copy of the ALF's, "Medication Administration Records (MARs) Request Form" (RF), dated 10/11/2025, showed the Collateral Contact 1 (CC1 – Resident 1's Legal Representative) requested copies of Resident 1's MARs and related documentation from Staff A (Administrator). The RF showed that CC1 requested:

- All physicians' or nurse practitioner orders regarding insulin (a medication used to manage blood sugar) and diabetic (a condition where an individual's blood sugar is irregular and can have negative impacts on health) management;
- Complete MARs for the period of 09/01/2025 through 10/11/2025; and
- Nursing notes, chart updates, and any incident/error reports related to medication administration during that time.

Record review of an email CC1 sent, on 12/03/2025, to Staff A requesting follow-up on the records request. The email showed CC1 first requested the medical records on 10/11/2025 both by fax and by hand delivery. The email showed Staff A confirmed on 11/25/2025 that the request had been received.

In interview, on 12/29/2025 at 8:27 AM, Collateral Contact 2 (CC2 – Resident 1's Family Member) confirmed CC1 still had not received Resident 1's medical records as requested.

In an interview, on 01/27/2026 at 12:55 PM, Staff A (Administrator) stated that they received the records request on 10/11/2025 and they followed the ALF's policy by

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sending the request to the ALF's attorney. Staff A stated they followed up on the request on 12/08/2025 to see if the requested records had been sent to CC1 and did not receive a response from the ALF's attorney. Staff A acknowledged that they could have sent the records requested and they did not as they expected the ALF attorney to send the requested records to CC1.

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, Cedar Creek Memory Care Community is or will be in compliance with this law and / or regulation on (Date) ~~March 06, 2026~~ 3/13/2026.

SB confirmed Amended POC date with Provider on 2/24/2026

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

Administrator (or Representative) [signature] Date 2/24/2026