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

Sunrise Senior Living Management Inc
Sunrise of Issaquah
23599 SE Issaquah Fall City Rd
Issaquah, WA 98029

RE: Sunrise of Issaquah License # 2543

Dear Administrator:

This letter addresses Compliance Determination(s) 69767 (Completion Date 12/09/2025) and 66135 (Completion Date 10/09/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/09/2025 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-2371-3, WAC 388-78A-2371-2, WAC 388-78A-2371-1

The Department staff who did the on-site verification:
Deborah Corlis, Complaint Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sunrise of Issaquah
Provider Type: Assisted Living Facility
License/Cert.#: 2543
Compliance Determination #: 66135
Intake ID: 194870
Investigator: Deborah Corlis
Region/Unit #: RCS Region 2 / Unit D
Investigation Date(s): 09/24/2025 through 10/09/2025
Complainant Contact Date(s):

Allegation(s):
Failed to investigate an incident.

Investigation Methods:

Sample:	Total residents: 86 Resident sample size: 1 Closed records sample size: 0
Observations:	Facility environment, common areas, resident to staff interactions, resident to resident interactions, third and fourth floor balconies, Named Resident (NR).
Interviews:	Senior Executive Director, Resident Care Director, Registered Nurse, Lead Care Manager, NR, family/Power of Attorney.
Record Reviews:	Characteristic Roster, face sheet, progress notes, staff statements, hospital visit summary, service plan, Abuse and Neglect Policy.

Investigation Summary:
The Assisted Living Facility failed to investigate circumstances when NR was found on the third-floor outdoor balcony, in a squatting position having last been seen on the fourth floor. Failed practice identified. See statement of deficiency.

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

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 complaint investigation on 09/24/2025 of:

Sunrise of Issaquah
23599 SE Issaquah Fall City Rd
Issaquah, WA 98029

This document references the following complaint number(s): 194870

The following sample was selected for review during the unannounced on-site visit: 1 of 86 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Deborah Corlis, Complaint Investigator

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 #: 2543	Compliance Determination # 66135
Plan of Correction	Sunrise of Issaquah	Completion Date
Page 2 of 3	Licensee: Sunrise Senior Living Management Inc	10/09/2025

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.

Jim Sherman
Residential Care Services

10-13-2025
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.

Irene P Pandujar
Administrator (or Representative)

10/22/2025
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document an investigation to determine circumstances of one resident (Resident 1) being found on the third-floor outdoor balcony, in a squatting position, having last been seen on the fourth floor. This failure placed Resident 1 at risk for repeated incidents and injury.

Resident 1's face sheet, dated 09/24/2025 showed Resident 1 moved to facility on [redacted] 2025, was diagnosed with [redacted] and resided in an apartment on the fourth floor.

Facility observed on 09/30/2025 at 10:05 AM showed multi story building on a steep hillside with separate secured memory care units and outdoor balconies on third and fourth floors.
Record review of Service Plan dated 09/18/2025 showed on page 10, elopement/safety the goal was for Resident 1's needs to be assessed, understood and anticipated in relationship to what may be causing my exit seeking behavior. Interventions included

observation of Resident 1's location in the community.

In an interview on 09/29/2025 at 1:01 PM, collateral contact 1 (CC 1), stated that Resident 1 fell from the fourth-floor balcony to the third-floor balcony while attempting to exit seek.
Record review of document titled Statement of Event, dated 09/15/2025 showed Staff A, Lead Care Manager heard a thud and found Resident 1 squatting on the third-floor balcony.

Record review of document titled Statement of Event, dated 09/14/2025 showed Staff B, Care Manager, could not locate Resident 1 on the fourth floor and started searching for them. Resident 1 was then returned to the fourth floor by third floor care staff.

In an interview on 09/30/2025 at 9:40 AM, Staff C (Senior Executive Director) stated that they don't know how Resident 1 got onto the third-floor balcony. It is possible they followed family off the unit, or they could have accessed the code and came through the stairwell, we just don't know what happened.

Review of facility records found no documented incident or investigation into circumstances and additional prevention measures regarding Resident 1 being found on the third-floor balcony.

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, Sunrise of Issaquah is or will be in compliance with this law and / or regulation on (Date) 10/22/2025.

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

Administrator (or Representative) Irene P Landeyer Date 10/22/2025