STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Kirkland Memory Care LLC
Jefferson House Memory Care Community
12217 NE 128th Street
Kirkland, WA 98034

RE: Jefferson House Memory Care Community License # 2548

Dear Administrator:

This letter addresses Compliance Determination(s) 77727 (Completion Date 05/21/2026) and 74388 (Completion Date 03/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/21/2026 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-2130-3, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b

The Department staff who did the on-site verification:
Claudia Allis, ALF Licensor
Steven Garrett, LTC 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
HOME AND COMMUNITY LIVING 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 03/18/2026 of:
Jefferson House Memory Care Community
12217 NE 128th Street
Kirkland, WA 98034

This document references the following SOD dated: 03/26/2026

The following sample was selected for review during the unannounced on-site visit: 11 of 52 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, Home and Community Living 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.

Residential Care Services — 04/02/2026 Date

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

Administrator (or Representative) — 4/3/2026 Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 11 residents (Resident 7 and Resident 10) service agreements were updated to meet current and changing needs and to include care staff instructions and interventions. This placed Resident 7 and Resident 10 at risk for unmet needs and a decreased quality of life.

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 01/20/2026 that included findings for Resident 7. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 03/06/2026.

RESIDENT 7
Review of the facility's Resident Face Sheet and Emergency Information document showed the facility admitted Resident 7 on [redacted]2025 with dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of

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 _____

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 11 residents (Resident 7 and Resident 10) service agreements were updated to meet current and changing needs and to include care staff instructions and interventions. This placed Resident 7 and Resident 10 at risk for unmet needs and a decreased quality of life.

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 01/20/2026 that included findings for Resident 7. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 03/06/2026.

RESIDENT 7
Review of the facility's Resident Face Sheet and Emergency Information document showed the facility admitted Resident 7 on [redacted]/2025 with dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of

Resident 7's records showed that the facility updated Resident 7's assessment and service plan (equivalent to the negotiated service agreement) on 02/05/2026. Review of the assessment and service plan showed that Resident 7 required reminders, redirection, and orientation to person, place, time and situation. The assessment and service plan showed documentation that Resident 7 had poor self-safety awareness, episodes of agitation, paranoia, and exit-seeking behavior.

Review of Resident 7's records for October 2025 through January 2026 showed documentation that Resident 7 had chased staff with their walking cane (10/07/2025). Documentation showed that Resident 7 used their walking cane to shatter the building window (10/07/2025). Documentation showed that Resident 7 had verbalized suicidal ideation with a plan on 10/09/2025 and 10/21/2025. Documentation showed that on 12/09/2025 Resident 7 accessed a caregiver's purse, emptied the contents and took cash and items.

A review of Resident 7's records showed documentation that Resident 7's service plan had been updated on 02/05/2026. The updated service plan documented no guidance or instructions for staff when observing behaviors or suicidal ideation, actions or interventions to take, and when and whom to report Resident 7's behaviors and agitation.

A review of the service plan showed no documentation of the potential side effects of multiple medications prescribed and documented in Resident 7's Medication Administration Records (MAR) for October 2025 through January 2026. Medications prescribed include: Seroquel (an oral prescription medication primarily used to treat mental health conditions), 25 milligrams (mg), bid (twice a day), by mouth, for agitation; Sertraline (an anti-depressant used to help maintain mental balance and improve mood), 150 mg, by mouth, one time a day; and, Trazadone (used to treat depression and insomnia), 50 mg, by mouth, one time per day at bedtime.

Review of Resident 7's records showed the Service Plan, dated 02/05/2026, showed no documentation that Resident 7's Service Plan had been updated with the potential side effects of Seroquel (drowsiness, dry mouth, dizziness, constipation, increased appetite, and sore throat); Sertraline (nausea, diarrhea, dry mouth, and fatigue); and Trazadone (dizziness, confusion, unusual weakness, blurred vision, and fatigue) and no instructions to caregivers to monitor signs of side effects and when and whom to report the observed side effects.

RESIDENT 10
Review of Resident 10's records showed the facility admitted Resident 10 on [redacted]/2026. The records showed the facility completed a preadmission assessment on 03/04/2026. Review of the preadmission assessment showed no documentation of Resident 10's diagnoses or list of current prescribed medications. Review of Resident 10's records showed the facility updated Resident 10's assessment and service plan on [redacted]/2026. Review of the updated assessment and service plan showed that Resident 10 required full assistance with medication management services from facility staff. Review of the updated assessment and service plan showed no documentation of

Resident 10's diagnoses or current list of prescribed medications. The service plan showed no documentation that provided the care staff with guidance to monitor Resident 10 for signs and symptoms related to Resident 10's diagnoses. Review of the service plan showed no documentation that provided care staff with guidance about monitoring for possible side effects from any of Resident 10's prescribed medications. The service plan did not show directions to staff on what interventions to use or actions to take before administering, as needed, medication for agitation/psychosis.

Review of Resident 10's March 2026 MAR showed that Resident 10 received 5 mg of Escitalopram (an oral prescription medication primarily used to treat major depressive disorder and generalized anxiety disorder) once a day, by mouth; 50mg of Quetiapine (an oral prescription medication primarily used to treat schizophrenia, bipolar disorder, and depressive disorder) once daily in the afternoon, 100mg once daily at 2:00 PM, 150mg once daily at bedtime, and 25mg every 6 hours as needed for agitation/psychosis (mental state characterized by a disconnect from reality, featuring hallucinations, delusions, and disorganized thinking), by mouth; and 20mg of Xarelto (an oral prescription medication used as a blood thinner that treats and prevents blood clots in the veins, legs, and lungs, and reduces risk of blood flow interruption) once a day, by mouth.

During an interview on 03/18/2026 at 2:16 PM, Staff H, Regional Director of Operations/Executive Director, stated that when an assessment and service plan were completed for residents, the service plan should include documentation of the individualized care and services needs for each resident. Staff H stated that the current documentation in Resident 7 and Resident 10's service plans did not provide information and instructions for care staff to provide the necessary care and services for resident care. During an interview on 03/18/2026 at 2:16 PM, Staff H stated that when a significant change in a resident's condition occurred, the service plan should be updated to provide care staff with instructions to meet the resident's current care needs.

This is an uncorrected deficiency previously cited on 01/20/2026 for subsections (3)(a)(b).

Statement of Deficiencies	License #: 2548	Compliance Determination #74388
Plan of Correction	Jefferson House Memory Care Community	Completion Date
Page 5 of 5	Licensee: Kirkland Memory Care LLC	03/26/2026

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 5/10/2026.

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

H. [signature]
Administrator (or Representative)

4/3/2026
Date

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, Jefferson House Memory Care 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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING 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 and complaint investigation on 01/05/2026 and 01/08/2026 of:

Jefferson House Memory Care Community
12217 NE 128th Street
Kirkland, WA 98034

This document references the following complaint numbers: 206203.

The following sample was selected for review during the unannounced on-site visit: 7 of 45 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Jane Hermano, NCI
Steven Garrett, LTC Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2548	Compliance Determination # 70896
Plan of Correction	Jefferson House Memory Care Community	Completion Date
Page 2 of 16	Licensee: Kirkland Memory Care LLC	01/20/2026

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

Jim Sherman
Residential Care Services

01-28-2026
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.

H. Kim
Administrator (or Representative)

2/2/2026
Date

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a documented pre-admission assessment for 4 of 6 residents (Resident 1, Resident 4, Resident 6, and Resident 7) admitted to the assisted living facility. This failure placed Resident 1, Resident 4, Resident 6, and Resident 7 at risk for admission to a facility that was unable to meet resident needs and to have a decreased quality of life.

Findings included...

RESIDENT 1
Review of Resident 1's information document showed the facility admitted Resident 1 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 1 was dated [redacted]/2025, the day that Resident 1 moved into the facility. Review of Resident 1's records showed no documentation of an assessment completed prior to Resident 1's non-emergent move into the facility.

RESIDENT 4
Review of Resident 4's information document showed the facility admitted Resident 4 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 4 was dated [redacted]/2025, the day that Resident 4 moved into the facility. Review of Resident 4's records showed no documentation of an assessment completed prior to Resident 4's non-emergent move into the facility.

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

01-28-2026
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)

Date

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a documented pre-admission assessment for 4 of 6 residents (Resident 1, Resident 4, Resident 6, and Resident 7) admitted to the assisted living facility. This failure placed Resident 1, Resident 4, Resident 6, and Resident 7 at risk for admission to a facility that was unable to meet resident needs and to have a decreased quality of life.

Findings included...

RESIDENT 1
Review of Resident 1's information document showed the facility admitted Resident 1 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 1 was dated [redacted]/2025, the day that Resident 1 moved into the facility. Review of Resident 1's records showed no documentation of an assessment completed prior to Resident 1's non-emergent move into the facility.

RESIDENT 4
Review of Resident 4's information document showed the facility admitted Resident 4 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 4 was dated [redacted]/2025, the day that Resident 4 moved into the facility. Review of Resident 4's records showed no documentation of an assessment completed prior to Resident 4's non-emergent move into the facility.

Statement of Deficiencies	License #: 2548	Compliance Determination # 70696
Plan of Correction	Jefferson House Memory Care Community	Completion Date
Page 3 of 16	Licensee: Kirkland Memory Care LLC	01/20/2026

RESIDENT 6
Review of Resident 6's information document showed the facility admitted Resident 6 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 6 was dated [redacted]/2025, the day that Resident 6 moved into the facility. Review of Resident 6's records showed no documentation of an assessment completed prior to Resident 6's non-emergent move into the facility.

RESIDENT 7
Review of Resident 7's information document showed the facility admitted Resident 7 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 7 was dated [redacted]/2025, the day that Resident 7 moved into the facility. Review of Resident 7's records showed no documentation of an assessment completed prior to Resident 7's non-emergent move into the facility.

During an interview on 01/08/2026 at 2:55 PM, Staff A, Interim Executive Director, stated that Resident 1, Resident 4, Resident 6, and Resident 7 were not admitted under emergency circumstances. Staff A stated that they were unaware of the requirement to complete and document an assessment prior to admitting residents into the assisted living facility. Staff A stated that they were not aware that Resident 1, Resident 4, Resident 6, and Resident 7 did not have documented completion of pre-admission assessments prior to their move-in to the facility.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026 .

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

[signature] 2/2/2026

Administrator (or Representative) Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

RESIDENT 6
Review of Resident 6's information document showed the facility admitted Resident 6 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 6 was dated [redacted]/2025, the day that Resident 6 moved into the facility. Review of Resident 6's records showed no documentation of an assessment completed prior to Resident 6's non-emergent move into the facility.

RESIDENT 7
Review of Resident 7's information document showed the facility admitted Resident 7 on [redacted]/2025. Review of the facility's initial assessment and service plan for Resident 7 was dated [redacted]/2025, the day that Resident 7 moved into the facility. Review of Resident 7's records showed no documentation of an assessment completed prior to Resident 7's non-emergent move into the facility.

During an interview on 01/08/2026 at 2:55 PM, Staff A, Interim Executive Director, stated that Resident 1, Resident 4, Resident 6, and Resident 7 were not admitted under emergency circumstances. Staff A stated that they were unaware of the requirement to complete and document an assessment prior to admitting residents into the assisted living facility. Staff A stated that they were not aware that Resident 1, Resident 4, Resident 6, and Resident 7 did not have documented completion of pre-admission assessments prior to their move-in to the facility.

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, Jefferson House Memory Care 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-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update in 3 of 7 residents (Resident 1, Resident 3, and Resident 7) service agreements the changing needs of the residents with staff instructions about how to meet the residents' needs. This placed Resident 1, Resident 3, and Resident 7 at risk for not having their needs met and a decreased quality of life.

Findings included...

The facility provides care and services for individuals with [redacted] diagnoses, and [redacted]. The entire facility is a secured memory care unit.

RESIDENT 1
Review of the facility's Resident Face Sheet and Emergency Information showed that the facility admitted Resident 1 on [redacted]/2025 with dementia. Review of Resident 1's records showed that the facility completed an initial assessment and service plan on [redacted]/2025. Review of the assessment and service plan showed that Resident 1 required reminders, redirection, orientation, and wayfinding. The assessment and service plan showed documentation that Resident 1 liked to be 'helpful' with other residents' care.

During an interview on 01/05/2026 at 11:15 AM, Staff A, Interim Executive Director, stated that Resident 1 was involved in a witnessed resident to resident altercation on 12/21/2025. Staff A stated that Resident 1 was evaluated by a primary care provider. Staff A stated that Resident 1 was prescribed an anti-psychotic, Seroquel (an oral prescription medication primarily used to treat schizophrenia and bipolar disorders), 12.5 milligrams (mg), tid (three times a day), by mouth, for agitation.

Review of Resident 1's records from January showed no documentation that staff had increased observations of Resident 1's interactions with other residents, agitation, increased need for redirection.

Review of Resident 1's records showed the Service Plan, dated [redacted]/2025, showed no documentation that Resident 1's Service Plan had been updated with instructions for staff to observe behaviors, respond to behaviors, and when to report Resident 1's behaviors and agitation. The Service Plan showed no documentation of the potential side effects (drowsiness, dry mouth, dizziness, constipation, increased appetite, and sore throat) of Seroquel and to when report the observed side effects to the nurse.

RESIDENT 3
Review of the facility's Resident Face Sheet and Emergency Information showed that the facility admitted Resident 3 on [redacted]/2024 with dementia. Review of Resident 3's records showed that the facility completed an annual assessment on 07/09/2025. Review of the assessment showed that Resident 3 required reminders and cueing to

eat.

During an interview on 01/13/2026 at 5:14 PM, Collateral Contact 1 (CC1, Resident Representative), stated that Resident 3 survived their third stroke in October 2025. CC1 stated that around that time Resident 3 became eligible to receive Hospice services. CC1 stated that Resident 3 required cueing to swallow or process their food.

Review of Resident 3's records in October 2025 showed staff observations that Resident 3 was "pocketing food", where they held the food in their cheeks instead of being swallowed. The records showed that the Hospice Nurse instructed staff to monitor the food texture for Resident 3's chewing ability.

Review of Resident 3's Service Plan, dated 07/23/2025, showed no documentation that Resident 3's chewing and swallowing ability changed. The Service Plan showed no instructions to monitor the food texture. The service plan showed no documentation about the signs of increased swallowing difficulties and when to report the incident to the nurse.

RESIDENT 7
Review of the facility's Resident Face Sheet and Emergency Information showed that the facility admitted Resident 7 on [redacted]/2025 with dementia. Review of Resident 7's records showed that the facility completed an initial assessment and service plan on [redacted]/2025. Review of the assessment and service plan showed that Resident 7 required reminders, redirection, and orientation. The assessment and service plan showed documentation that Resident 7 had poor self-safety awareness, episodes of agitation, paranoia, and exit-seeking.

Review of Resident 7's records for October, November, and December 2025 showed documentation that Resident 7 had chased staff with their cane (10/07/2025). Documentation showed that Resident 7 used their cane to shatter the building window (10/07/2025). Documentation showed that Resident 7 had verbalized suicidal ideations with a plan on 10/09/2025 and 10/21/2025. Documentation showed that on 12/09/2025 Resident 7 accessed a caregiver purse, emptied the contents and took cash and items.

A review of Resident 7's record showed no documentation that Resident 7's service plan had been updated since [redacted]/2025. Review of Resident 7's records showed the Service Plan, dated [redacted]/2025, showed no documentation of instructions for staff to observe behaviors , respond to behaviors, and when to report Resident 7's behaviors and agitation.

A review of the Service Plan showed no documentation of the potential side effects multiple medications prescribed in October 2025 and December 2025.
Medications prescribed include: Seroquel (an oral prescription medication primarily used to trat schizophrenia and bipolar disorders), 25 milligrams (mg), bid (twice a day), by mouth, for agitation; Sertraline (an anti-depressant used to help maintain mental balance and improve mood, 150 milligrams (mg), by mouth, one time a day; and,

Statement of Deficiencies	License #: 2548	Compliance Determination # 70696
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Trazadone (used to treat depression and insomnia), 50 mg, by mouth, one time per day at bedtime.

Review of Resident 7's records showed the Service Plan, dated [redacted]/2025, showed no documentation that Resident 7's Service Plan had been updated with the potential side effects of Seroquel (drowsiness, dry mouth, dizziness, constipation, increased appetite, and sore throat); Sertraline (nausea, diarrhea, dry mouth, and fatigue); and Trazadone (dizziness, confusion, unusual weakness, blurred vision, and fatigue) and to when report the observed side effects to the nurse.

During an interview on 01/14/2026 at 1:16 PM, Staff H, Regional Director of Operations, stated that when a significant change in a resident's condition occurred, the service plan had not been updated for Resident1, Resident3, and Resident 7. During an interview on 01/14/2026 at 1:16 PM, Staff H stated that when a significant change in a resident's condition occurred, the service plan should be updated to provide care staff with instructions to meet the resident's current care needs.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026 .

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

H-Lin — Administrator (or Representative)

2/2/2026 — Date

WAC 246-215-02115 Duties Person in charge (FDA Food Code 2-103.11). The person in charge shall ensure that:

(3) employees and other persons such as delivery and maintenance persons and pesticide applicators entering the food preparation, food storage, and warewashing areas comply with this chapter;

WAC 246-215-04545 Equipment Mechanical warewashing equipment, wash solution temperature (FDA Food Code 4-501.110).

(1) The temperature of the wash solution in spray-type warewashers that use hot water to sanitize may not be less than:

(a) For a stationary rack, single temperature machine, 165 F (74 C);

(b) For a stationary rack, dual temperature machine, 150 F (66 C);

(c) For a single tank, conveyor, dual temperature machine, 160 F (71 C);

(d) For a multitank, conveyor, multitemperature machine, 150 F (66 C).

Trazadone (used to treat depression and insomnia), 50 mg, by mouth, one time per day at bedtime.

Review of Resident 7's records showed the Service Plan, dated [redacted]/2025, showed no documentation that Resident 7's Service Plan had been updated with the potential side effects of Seroquel (drowsiness, dry mouth, dizziness, constipation, increased appetite, and sore throat); Sertraline (nausea, diarrhea, dry mouth, and fatigue); and Trazadone (dizziness, confusion, unusual weakness, blurred vision, and fatigue) and to when report the observed side effects to the nurse.

During an interview on 01/14/2026 at 1:16 PM, Staff H, Regional Director of Operations, stated that when a significant change in a resident's condition occurred, the service plan had not been updated for Resident1, Resident3, and Resident 7. During an interview on 01/14/2026 at 1:16 PM, Staff H stated that when a significant change in a resident's condition occurred, the service plan should be updated to provide care staff with instructions to meet the resident's current care needs.

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, Jefferson House Memory Care 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 246-215-02115 Duties Person in charge (FDA Food Code 2-103.11). The person in charge shall ensure that:

(3) employees and other persons such as delivery and maintenance persons and pesticide applicators entering the food preparation, food storage, and warewashing areas comply with this chapter;

WAC 246-215-04545 Equipment Mechanical warewashing equipment, wash solution temperature (FDA Food Code 4-501.110).

(1) The temperature of the wash solution in spray-type warewashers that use hot water to sanitize may not be less than:

(a) For a stationary rack, single temperature machine, 165 F (74 C);

(b) For a stationary rack, dual temperature machine, 150 F (66 C);

(c) For a single tank, conveyor, dual temperature machine, 160 F (71 C);

(d) For a multitank, conveyor, multitemperature machine, 150 F (66 C).

(2) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 F (49 C).

WAC 246-215-04575 Equipment Warewashing equipment, determining chemical sanitizer concentration (FDA Food Code 4-501.116). Concentration of the sanitizing solution must be accurately determined by using a test kit or other device.

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 facility failed to ensure safe food practices were followed in 1 of 1 kitchen (main kitchen) that provided meal preparation and services to all residents. This failure placed 45 residents at risk of potential foodborne illnesses.

Findings included...

Review of the facility's Characteristics Roster showed the facility provided assistance with activities of daily living (ADL) including meal service to 45 residents.

SANITIZING SOLUTION

Observation in the main kitchen on 01/08/2026 at 11:10 AM, showed four red buckets filled with sanitizing solution were placed throughout the kitchen area. Observation showed kitchen staff utilizing cloths soaked in sanitizing solution to wipe down food preparation areas as well as food and dinnerware transport carts. Observation showed no documentation log for staff to utilize in monitoring sanitizing solution effectiveness or when sanitizing solution was added or changed in the buckets.

During an interview on 01/07/2026 at 12:55 PM, Staff G, Culinary Director, stated that they oversaw kitchen operations in the facility's main kitchen. Staff G stated that the kitchen utilized pre-mixed sanitizing solution from their chemical/cleaning supply vendor and had no test strips to test sanitizing solution effectiveness. Staff G stated that there was no written schedule for staff to check the effectiveness of the sanitizing solution or change the sanitizing solution in the buckets. Staff G stated that there was no log used to document the effectiveness of the sanitizing solution or when the sanitizing solution was changed.

DISHWASHER TEMPERATURE MONITORING

Statement of Deficiencies	License #: 2548	Compliance Determination # 70896
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Observation in the main kitchen on 01/08/2026 at 11:30 AM, showed staff used an automated dishwashing machine to clean dirty dishware. Observation showed no documentation log for staff to utilize in monitoring kitchen dishwasher wash and rinse cycle temperatures.

During an interview on 01/07/2026 at 1:00 PM, Staff G stated that the kitchen dishwasher utilized chemical and hot water for cleaning and sanitizing dirty dishware. Staff G stated there was no schedule for staff to document the kitchen dishwasher wash and rinse temperatures. Staff G stated that there was no standard procedure or log used to document the kitchen dishwasher wash and rinse cycle temperatures.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026 .

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

H. Yuan — Administrator (or Representative)

2/2/2026 — Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a Washington State Name and Date of Birth Background check for 2 of 6 staff (Staff E and Staff F). These failures placed all 45 residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included....

Observation in the main kitchen on 01/08/2026 at 11:30 AM, showed staff used an automated dishwashing machine to clean dirty dishware. Observation showed no documentation log for staff to utilize in monitoring kitchen dishwasher wash and rinse cycle temperatures.

During an interview on 01/07/2026 at 1:00 PM, Staff G stated that the kitchen dishwasher utilized chemical and hot water for cleaning and sanitizing dirty dishware. Staff G stated there was no schedule for staff to document the kitchen dishwasher wash and rinse temperatures. Staff G stated that there was no standard procedure or log used to document the kitchen dishwasher wash and rinse cycle temperatures.

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, Jefferson House Memory Care 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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(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete a Washington State Name and Date of Birth Background check for 2 of 6 staff (Staff E and Staff F). These failures placed all 45 residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included....

Review of the facility's Characteristics Roster showed the facility provided assisted living services to 45 residents.

Review of facility's undated personnel records showed the facility hired Staff E, Medication Technician, on 03/22/2023.
Review of facility's undated personnel records showed the facility hired Staff F, Medication Technician, on 08/19/2021.

Review of Staff E's records showed documentation that Staff E completed a Washington State Name and Date of Birth background check on 03/22/2023. Review of Staff E's records showed no documentation that Staff E completed a Washington State Name and Date of Birth background check in March 2025 when it expired. The records showed Staff E provided direct care to residents for 293 days without a valid Washington State Name and Date of Birth background check.

Review of Staff F's records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 08/19/2021. Review of Staff F's records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 06/12/2024. The records showed Staff F's provided direct care to residents for 299 days without a valid Washington State Name and Date of Birth background check. Review of Staff F's records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 06/12/2024.

During an interview on 01/08/2026 at 2:55 PM, Staff A, Interim Executive Director, stated that the facility was aware that staff needed Washington State Name and Date of Birth background checks upon hire and then every 2 years.

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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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026.

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

Administrator (or Representative) — Date: 2/2/2026

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 1 of 6 staff (Staff E) completed all required training to perform their job duties and responsibilities. This failure placed 45 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of the facility's Characteristics Roster showed the facility provided assisted living services to 45 residents.

Review of facility's undated personnel records showed the facility hired Staff E, Medication Technician on 03/23/2023.

CPR and first aid
Review of Staff E's undated personnel records showed Staff E provided direct care for residents from 03/23/2023 through 01/08/2026. There was documentation in Staff E's records that showed Staff E's required cardio-pulmonary resuscitation and first aid training expired on 09/16/2025.

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, Jefferson House Memory Care 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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(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 1 of 6 staff (Staff E) completed all required training to perform their job duties and responsibilities. This failure placed 45 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of the facility's Characteristics Roster showed the facility provided assisted living services to 45 residents.

Review of facility's undated personnel records showed the facility hired Staff E, Medication Technician on 03/23/2023.

CPR and first aid
Review of Staff E's undated personnel records showed Staff E provided direct care for residents from 03/23/2023 through 01/08/2026. There was documentation in Staff E's records that showed Staff E's required cardio-pulmonary resuscitation and first aid training expired on 09/16/2025.

Statement of Deficiencies	License #: 2548	Compliance Determination # 70696
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Continuing Education
Review of Staff E's undated personnel records showed Staff E provided direct care for residents from 03/23/2023 through 01/08/2026. There was no documentation in Staff E's records that showed Staff E completed the required 12 hours of continuing education between their birthdays, 05/04/2024 and 05/04/2025.

During an interview on 01/08/2026 at 2:25 PM, Staff A, Interim Executive Director, stated that they were unaware Staff E had not completed the required cardio-pulmonary resuscitation and first aid training. During an interview on 01/08/2026 at 2:30 PM, Staff A stated that they were unaware Staff E had not completed the required 12 hours of continuing education requirements.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026 .

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

H. Lin — Administrator (or Representative)

2/2/2026 — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 6 staff (Staff B and Staff D) were screened for tuberculosis (TB) within three days of employment. This failure placed residents at risk of contracting an airborne and contagious respiratory disease.

Findings included...

Review of facility's personnel records showed the facility hired Staff B, Caregiver, on 03/05/2025and Staff D, Caregiver, on 01/13/2025.

Continuing Education
Review of Staff E's undated personnel records showed Staff E provided direct care for residents from 03/23/2023 through 01/08/2026. There was no documentation in Staff E's records that showed Staff E completed the required 12 hours of continuing education between their birthdays, 05/04/2024 and 05/04/2025.

During an interview on 01/08/2026 at 2:25 PM, Staff A, Interim Executive Director, stated that they were unaware Staff E had not completed the required cardio-pulmonary resuscitation and first aid training. During an interview on 01/08/2026 at 2:30 PM, Staff A stated that they were unaware Staff E had not completed the required 12 hours of continuing education requirements.

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, Jefferson House Memory Care 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-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 6 staff (Staff B and Staff D) were screened for tuberculosis (TB) within three days of employment. This failure placed residents at risk of contracting an airborne and contagious respiratory disease.

Findings included...

Review of facility's personnel records showed the facility hired Staff B, Caregiver, on 03/05/2025and Staff D, Caregiver, on 01/13/2025.

Review of staff records showed from 03/05/2025 through 01/08/2026, Staff B worked at the facility. Staff B provided care and services for residents. There was no documentation in Staff B's records that showed the facility screened Staff B for TB within three days of employment.

Review of staff records showed from 01/13/2025 through 01/08/2026, Staff D worked at the facility. Staff D provided care and services for residents. There was no documentation in Staff D's records that showed the facility screened Staff D for TB within three days of employment.

During an interview on 01/08/2026 at 2:10 PM, Staff A, Interim Executive Director, stated that when Staff B and Staff D were hired, they were not screened for tuberculosis.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026.

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

H. Lin — Administrator (or Representative)

2/2/2026 — Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

WAC 388-78A-2410-1 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(8) Medical and nursing services provided by the assisted living facility for a resident, including:

Review of staff records showed from 03/05/2025 through 01/08/2026, Staff B worked at the facility. Staff B provided care and services for residents. There was no documentation in Staff B's records that showed the facility screened Staff B for TB within three days of employment.

Review of staff records showed from 01/13/2025 through 01/08/2026, Staff D worked at the facility. Staff D provided care and services for residents. There was no documentation in Staff D's records that showed the facility screened Staff D for TB within three days of employment.

During an interview on 01/08/2026 at 2:10 PM, Staff A, Interim Executive Director, stated that when Staff B and Staff D were hired, they were not screened for tuberculosis.

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, Jefferson House Memory Care 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-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

WAC 388-78A-2410-1 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(8) Medical and nursing services provided by the assisted living facility for a resident, including:

(b) A record of any nursing treatments, including the signature or initials of the person providing them.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a safe nursing services when a non-licensed staff flushed a urinary catheter of 1 of 4 sampled residents (Resident 3). This failure placed Resident 3 at risk of unsafe or improper treatment by receiving nursing services from unqualified staff.

Findings included...

Review of the facility's undated Disclosure of Services showed that the facility provided intermittent nursing services. The disclosure showed that the nurse delegation services was limited to diabetic management, non-routine ostomy care, tube feeding, and other nursing services depending on complexity of the resident's needs.

Review of the facility's policy titled, "WA GP15-Nurse Delegation", dated 06/01/2025, showed that the delegation process was implemented in accordance with the State requirements. The policy showed the Registered Nurse was responsible to assess and determine whether or not a delegation of a task of nursing care could be safely done.

Review of Resident 3's records showed that the facility admitted Resident 3 on [redacted]/2024 with a diagnosis of [redacted]. The records showed on 09/30/2025, that Resident 3 was certified for hospice services. The records showed that the hospice plan of care included Resident 3's management of indwelling urinary catheter (a tube left inside the bladder to drain urine into a bag).

Review of Resident 3's January 2026 Medication Administration Record (MAR) showed a physician's order to irrigate or flush the indwelling catheter of 60 to 120 cubic centimeter (cc) of sterile saline water, one time weekly or as needed for catheter obstruction. The MAR showed Staff I, Medication Technician, signed off when the catheter was flushed.

Review of Resident 3's service plan, dated 07/23/2025, showed no documentation that Resident 3 received nurse delegation services for flushing of indwelling catheter.

Review of Staff H, Regional Director of Operations' electronic mail (email), dated 01/16/2026, stated that Resident 3's flushing of catheter was a nursing service performed only by a licensed nurse. In the email, dated 01/20/2026, Staff H stated that Staff I did not complete the catheter flush and that the task was completed by a licensed nurse. Staff H stated that the licensed nurse signed off while Staff I was logged in with their name and credentials on the same computer. Staff H stated that Staff I was

aware that they should not sign off on the tasks they did not complete.

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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026 .

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

H. Lin — Administrator (or Representative)

2/2/2026 — Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that 1 of 4 residents (Resident 5) and their family representative were given opportunity to exercise their rights over rearranging Resident 5's occupied room. This failure placed Resident 5 at risk of emotional distress and a diminished quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights. (5) A resident has the right to: (b) Receive notice before the resident's room or roommate in the facility is changed.

Observation by a Department Licensor on 01/08/2026 at 12:20 PM, showed two secured locked memory care units on the second floor and third floor. The second-floor memory care unit had 27 residents, all with symptoms associated with dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and impaired cognition. Observation showed Resident 5's room contained two beds, one of which was used by Resident 5 and the other was unused. Observation showed that Resident 5 was outside of their room, and self-propelling their wheelchair in the dining room.

During an interview on 01/12/2026 at 1:15 PM, Collateral Contact 2 (CC2, family representative and power of attorney), stated that they visited Resident 5 on December

aware that they should not sign off on the tasks they did not complete.

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, Jefferson House Memory Care 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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(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that 1 of 4 residents (Resident 5) and their family representative were given opportunity to exercise their rights over rearranging Resident 5's occupied room. This failure placed Resident 5 at risk of emotional distress and a diminished quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights. (5) A resident has the right to: (b) Receive notice before the resident's room or roommate in the facility is changed.

Observation by a Department Licensor on 01/08/2026 at 12:20 PM, showed two secured locked memory care units on the second floor and third floor. The second-floor memory care unit had 27 residents, all with symptoms associated with dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and impaired cognition. Observation showed Resident 5's room contained two beds, one of which was used by Resident 5 and the other was unused. Observation showed that Resident 5 was outside of their room, and self-propelling their wheelchair in the dining room.

During an interview on 01/12/2026 at 1:15 PM, Collateral Contact 2 (CC2, family representative and power of attorney), stated that they visited Resident 5 on December

28, 2025. CC2 stated that Resident 5's personal furniture of side tables, lounge chair, and an area rug were moved to one side of the room to make space for another bed. CC2 stated that Resident 5's communication board that was mounted on the wall was left on the floor. CC2 stated that the facility did not provide a verbal or written notice before any change in the room or room assignment. CC2 stated that the placement of an additional bed and the furniture that was pushed against the wall created a tight space for Resident 5 to safely move around the room. CC2 stated that the staff was unable to explain why the room was rearranged.

Review of the legal document, titled "General Durable Power of Attorney...", dated 2015 signed by Resident 5 and CC2, showed Resident 5 appointed CC2 as their "Attorney-in-Fact," a trusted person granted authority by Resident 5 as power of attorney. The legal document showed that CC2 had the right to make decisions and give informed consent on Resident 5's behalf.

Review of Resident 5's assessment, dated 05/05/2025, showed Resident 5 was blind in one eye with a limited peripheral vision in their good eye. Resident 5 was assessed with sadness and frequent crying. The assessed needs showed interventions to ensure Resident 5's room was clutter-free, and frequent redirection to manage Resident 5's emotional behaviors.

During an interview on 01/14/2026 at 2:01 PM, Staff A, Interim Executive Director, stated that Resident 5 occupied a semi-private room. Staff A stated that the facility followed through the process of notifying the family representative before Residents 5's furniture was rearranged. Staff A stated that they would provide the date and time when the call was made. Staff A stated that the verbal notification was not documented. The facility staff was unable to provide any documentation showing the date and time of the call.

Review of Staff H, Regional Director of Operations' electronic mail (email), dated 01/16/2026, stated that CC2 was verbally notified when CC2 was in the building visiting Resident 5. In the email, Staff H stated that Staff A discussed Resident 5's furniture that was on the shared side of the room. The facility staff then moved the furniture and rearranged the room.

Statement of Deficiencies	License #: 2548	Compliance Determination # 70896
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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, Jefferson House Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/6/2026 .

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

H. Lim 2/2/2026

Administrator (or Representative) Date

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
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Kirkland Memory Care LLC
Jefferson House Memory Care Community
12217 NE 128th Street
Kirkland, WA 98034

RE: Jefferson House Memory Care Community # 2548

Dear Administrator:

This document references the following complaint numbers 206203.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 01/20/2026 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:

James Sherman, 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 calendar days of Last Date of Data Collection (01/20/2026), no later than 03/06/2026 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-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department; and

The facility failed to post the most recent full inspection report in a clearly visible area of the facility. During the inspection, facility staff located and placed the most recent full inspection report next to the first floor elevator to meet the regulatory requirements. This deficiency was corrected by the exit conference.

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 You can make an IDR request and find directions on the IDR web page at:

https://www.dshs.wa.gov/altsa/idr

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

Enclosure