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

05/20/2026

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 letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 77341 (Completion Date 05/20/2026) and 72801 (Completion Date 03/16/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/20/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

The Department staff who did the On Site verification:
Wesler Dumecquias, Community 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: Jefferson House Memory Care Community
Provider Type: Assisted Living Facility
License/Cert.#: 2548
Intake ID: 210769
Compliance Determination #: 72801
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 02/11/2026 through 03/16/2026
Complainant Contact Date(s): 02/02/2026, 02/04/2026, 02/11/2026

Allegation(s):
The Named Resident (NR) had pressure sores on their heels.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 6 Closed records sample size: 1
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms ADL's
Interviews:	Identified resident Nursing staff Residents Family members Administrator Collateral contacts
Record Reviews:	Medical records Incident investigation Facility policies Staff training records Staff patterns care plans Assessments progress notes Emails Med list Home health notes

Investigation Summary:
The facility staff identified a skin issue and reported it to their supervisors. Care

staff observed the NR using their heels for mobility while in their wheelchair. The facility Licensed Nurses conducted an assessment and evaluation. The staff called 911, and paramedics arrived. After the paramedics consulted with the resident's primary care physician, they transported the NR to the hospital for further evaluation and treatment. The hospital found that the NR had stage 3 and stage 4 pressure injuries on both of their heels. The NR was prescribed booties to relieve pressure on their heels. The facility failed to perform a change of condition assessment or update the care plan to reflect the NR current needs due to the significant wounds on their heels. Failed practice were identified, and a citation was issued.

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: Jefferson House Memory Care Community
License/Cert.#: 2548
Compliance Determination #: 72801
Investigator: Wesler Dumecquias
Provider Type: Assisted Living Facility
Intake ID: 214247
Region/Unit #: RCS Region 2 / Unit D
Investigation Date(s): 02/11/2026 through 03/16/2026
Complainant Contact Date(s): 03/03/2026

Allegation(s):

1. The Named Resident (NR) had a pressure wound on their right buttocks.
2. The NR's inflatable seat for their tilt-in-space wheelchair had been deflated couple times and the air pump had been missing.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 6 Closed records sample size: 1
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members collateral contacts
Record Reviews:	Medical records Incident investigation Facility policies Staff training records Staff patterns care plans Assessments progress notes Emails Med list Home health notes Photos

Investigation Summary:

1. The facility staff discovered an open area on the NR's buttocks during routine care. The licensed nurse assessed the area, administered wound care, notified all relevant parties, and requested a referral to the primary care physician for a home health care agency. The facility placed the NR on alert charting and monitoring. However, a change of condition assessment was not conducted regarding the pressure wound, which resulted in the need for a practitioner's intervention to address the skin issue. Failed practice was identified, and a citation was issued.
2. The facility staff worked with the family of the NR to obtain a new wheelchair cushion, which was delivered by the family. Observations indicated that the facility staff stored the wheelchair cushion's air pump in the NR's locked closet. The facility did not perform a medical device assessment regarding the safe use of a tilt-in-space wheelchair, including instructions on how staff would ensure that the air cushion was properly installed and maintained. Failed practice was identified, and a citation was issued.

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
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 2548	Compliance Determination # 72801
Plan of Correction	Jefferson House Memory Care Community	Completion Date
Page 1 of 5	Licensee: Kirkland Memory Care LLC	03/16/2026

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 02/11/2026 and 03/11/2026 of:

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

This document references the following complaint number(s): 210769, 211502, 214247, 215879

The following sample was selected for review during the unannounced on-site visit: 6 of 45 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

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 # 72801
Plan of Correction	Jefferson House Memory Care Community	Completion Date
Page 2 of 5	Licensee: Kirkland Memory Care LLC	03/16/2026

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

03-19-2026
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. Lin
Administrator (or Representative)

3/23/2026
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to obtain adequate information to determine and assess the safe use of equipment for 1 of 1 resident (Resident 1) who utilized a Hoyer (mechanical) lift for transfers and a Tilt-in-space wheelchair. Additionally, the facility did not conduct change of condition assessments for 2 of 2 residents (Resident 1 and 2) who had pressure injuries. These failures may have contributed in the development of skin issues and placed Residents 1 and 2 at risk for harm and unmet care needs.

Findings included...
Note: WAC 388-78A-2090 Full assessment topics.
(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.
(6) Significant known behaviors or symptoms of the individual causing concern or

requiring special care, including:
(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

Review of facility policy titled "Negotiated Service Agreement" (NSA) and "Resident Assessments" dated 12/01/2024 and 06/01/2025 respectively showed an assessment was to be completed and updated as frequently as necessary to ensure they reflect current resident care needs and preferences. The information from an assessment was to be used to develop an appropriate plan of care and an individualized Negotiated Service Agreement were to be used to plan for and meet residents' needs using an interdisciplinary approach. The policy showed the NSA and resident assessments would be updated every six months and whenever there was a significant change in residents' status.

Resident 1

Record review of the face sheet showed Resident 1 was admitted to the facility on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

Medical Devices

Observation on 02/11/2026 at 2:50 PM, showed a Hoyer lift device (a mechanical, hydraulic, or electric device with a sling used to safely transfer individuals with limited mobility between surfaces—such as bed to wheelchair, commode, or floor) was in Resident 1's room near their bed.

Record review of Resident 1's Service plan dated 07/13/2025 showed Resident 1 needed a Hoyer lift device for transfers and wheel chair for mobility.

On 02/11/2026, at 3:45 PM, observation showed Resident 1 had a Tilt-in-space wheelchair (a wheelchair that reclines the seat while keeping the user's hips, knees, and ankles at fixed angles, providing crucial pressure relief, improved posture, and comfort without causing shear) with inflatable pressure relief air bubble cushion seat (to prevent and treat pressure injuries, sores, and ulcers by providing deep immersion and consistent, low-pressure, even weight distribution). Observation showed one side of the air bubble cushion was deflated.

Record review of Resident 1's Assessment dated 12/30/2025 did not indicate any assessment was completed regarding the safe use of the Hoyer lift and the tilt-in- space wheelchair as medical devices. Additionally, the assessment did not contain any information or directions to staff regarding the need for and use of the inflatable pressure relief air bubble cushion.

In an interview on 02/11/2026, at 1:49 PM, Staff B, Director of Resident Services (DRS), stated that they were unaware of the requirement for an assessment related to the use of the Hoyer lift, and the tilt-in-space wheelchair with inflatable pressure relief air bubble cushion as a medical device.

Skin Change of Condition (COC)

Resident 1

Record review of a wound care order dated 01/12/2026 showed Resident 1 had an unstageable pressure injury (a full thickness wound where the base is covered by slough (yellow, tan, gray, green, or brown) or eschar (tan, brown, or black). The actual depth cannot be determined until this dead tissue is removed, though it is usually a Stage 3 or 4 injury) on their right buttock.

Record review of Resident 1's Assessment dated 12/30/2025 showed it was the most current assessment at the time of the department's visit. The record showed "scheduled Reassessment" as the reason for the assessment. There was no COC assessment to reflect the current needs of Resident 1 because of the pressure injury.

Resident 2

Record review of the face sheet showed Resident 2 was admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted].
Record review of Resident 2's assessment dated 09/22/2025 showed they used a wheelchair for mobility.

In an interview on 02/11/2026 at 3:35 PM, Staff F, Medication Technician, stated that the care staff informed them on 01/07/2026 that Resident 2 had a wound on their heel. Staff F stated that they went to check the wound and subsequently informed Staff B, the DRS, about the issue.

Record review of an after-visit summary, dated 01/29/2026 showed Resident 2 was seen at the hospital. Resident 2 was diagnosed and treated for a [redacted] and a [redacted]

Record review of Resident 2's assessment showed the latest assessment for Resident 2 was dated 09/22/2025. There was no COC assessment that was made to reflect the current needs of Resident 2 because of the pressure injury.

Record review of Resident 2's service plan (SP) dated 09/22/2025 was the most current service plan at the time of the visit. The SP was not updated to reflect the current needs and instructions to staff of Resident 2 because of the pressure injuries.

During an interview on 03/11/2026 at 1:48 PM, Staff B, DRS stated that an assessment for a change of condition (COC) was typically conducted when there were at least two increases in a resident's care and services. Staff B stated that in the case of Resident 2, a COC assessment should have been conducted due to pressure injuries on their heels. Staff B explained that they were unable to conduct this assessment at the time because they were new and in the middle of a staffing transition. Staff B added that they completed the assessment immediately after the visit from the state investigator. Additionally, Staff B was uncertain whether a COC assessment had been conducted for Resident 1's pressure injury on their buttocks.

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) 4/30/2026 .

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

H. [illegible] 3/23/2026

Administrator (or Representative) Date