



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

Mirror Lake Village LLC
Mirror Lake Village
31000 9th PI SW
Federal Way, WA 98023

RE: Mirror Lake Village License # 2564

Dear Administrator:

This letter addresses Compliance Determination(s) 73272 (Completion Date 02/24/2026) and 71196 (Completion Date 01/15/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/24/2026 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, WAC 388-78A-2130-4, WAC 388-78A-2290-3, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-3-e, WAC 388-78A-2290-4, WAC 388-78A-2290-4-a, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d

The Department staff who did the on-site verification:

Claudia Allis, ALF Licenser
Steven Garrett, LTC Licenser

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

This document was prepared by Residential Care Services for the Locator website.



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 #: 2564	Compliance Determination # 71196
Plan of Correction	Mirror Lake Village	Completion Date
Page 1 of 7	Licensee: Mirror Lake Village LLC	01/15/2026

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 follow-up on 01/12/2026 of:

Mirror Lake Village
31000 9th PI SW
Federal Way, WA 98023

This document references the following SOD dated: 01/15/2026

The following sample was selected for review during the unannounced on-site visit: 9 of 83 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

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2564	Compliance Determination # 71196
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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,

Residential Care Services

01/26/2026

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)

1/27/2026

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.

(4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in 2 of 9 residents (Resident 1 and Resident 3) service agreements a plan to monitor and address interventions to meet the current needs. This failure placed Resident 1 and Resident 3 at risk for unmet care needs and potential harm.

Findings included:

Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 11/13/2025. Resident 1 and Resident 3 were included in the initial citation dated 11/13/2025. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 12/27/2025.

RESIDENT 1

This document was prepared by Residential Care Services for the Locator website.

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Review of Resident 1's records showed the facility admitted Resident 1 on [REDACTED]/2023. The records showed Resident 1 self-administered medications. Resident 1's records showed no documentation of the medications Resident 1 was prescribed. Review of Resident 1's records showed Resident 1 had a diagnosis of [REDACTED]. Facility staff were nurse delegated to check Resident 1's finger-stick blood glucose (blood sugars) checks and to administer injectable insulin due to Resident 1's diagnosis.

Review of Resident 1's demographic 'face sheet', undated, showed documentation of Resident 1's diagnoses which included: [REDACTED]

and [REDACTED]

Review of Resident 1's Service Plan Report (equivalent to the Negotiated Service Agreement), dated 10/14/2025, showed no documentation that provided instructions for the care staff to monitor Resident 1 for signs and symptoms related to depressive disorders, generalized anxiety disorders, diabetes (low blood sugar and high blood sugar), and possible stroke (an interruption of blood flow in the brain). The plan showed no instructions for staff about behaviorally based supportive actions to take when Resident 1 exhibited signs and symptoms of depression and anxiety. There was no documentation that provided the care staff with guidance about the possible side effects from daily use of diabetic medication.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. The records showed Resident 3 received medication assistance services from facility staff to order prescription medications. Review of Resident 3's service plan dated 10/16/2025 showed documentation that Resident 3 was assessed as safe for self-medication.

Review of Resident 3's demographic 'face sheet', undated, showed documentation of Resident 3's diagnoses which included: [REDACTED]

and [REDACTED]

Review of Resident 3's service plan dated 10/16/2025 showed that Resident 3 was prescribed the following medications: 20 mg of Lisinopril (to treat high blood pressure), by mouth, for hypertension (elevated blood pressure); 25 mg of Hydroxyzine (to treat anxiety, 1 tablet 3 times daily, every 8 hours, as needed, by mouth, for anxiety); 300 mg of Bupropion extended release (to treat depression), daily at 3:00 PM, by mouth, for major depressive disorder; 300 mg of Gabapentin (to treat pain from nerve damage) give 1 capsule twice daily, at 7:00 AM and 7:00 PM, by mouth, for chronic pain (weakness, numbness, and pain); and, 81 mg of Aspirin (to reduce pain and prevent

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01/15/2026

blood clots) give 1 tablet, 1 time daily at 7:30 AM, by mouth, to reduce the risk of blood clots which potentially cause strokes.

Review of Resident 3's Service Plan, dated 10/16/2025, showed no documentation that provided the care staff with instructions to monitor Resident 3 for signs and symptoms related to hypertension, anxiety, depressive disorder, and pain. The plan showed no instructions for staff behaviorally based supportive actions to take when Resident 3 exhibited signs and symptoms of anxiety and depression. There was no documentation that provided the care staff with guidance about side effects from Lisinopril, Hydroxyzine, Bupropion, Gabapentin, Aspirin. The plan showed no guidance or instructions for care staff to monitor signs and symptoms of anxiety, depression, hypertension, chronic pain, and increased bruising and bleeding.

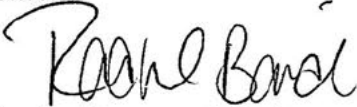
During an interview on 01/08/2026 at 1:55 PM, Staff A, Executive Director, stated that the facility utilized an electronic documentation system. Staff A stated that they were unaware the comprehensive elements required in resident service plans had not been completed.

This is an uncorrected deficiency cited on 11/13/2025 for subsections (3)(a)(b).

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 1/27/2026.

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


Administrator (or Representative)

Date 1/27/2026

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the

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family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 9 sampled residents (Resident 1 and Resident 3) had a written plan for family assistance with medication management. This failure placed Resident 1 and Resident 3 at risk for unmet care needs.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received an initial citation for this regulation on 11/13/2025. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 12/27/2025.

Review of the facility's undated Disclosure of Services document showed the facility permitted family assistance with residents' medication services. During an interview on 01/08/2026 at 11:45 PM, Staff A, Executive Director, stated the facility required residents who receive family medication assistance to provide a plan that would be signed and dated by the resident or legally responsible party and identify the family member who submitted the plan. Staff A stated that the family medication assistance plan would become part of a resident record.

RESIDENT 1

Review of Resident 1's records showed the facility admitted Resident 1 on [REDACTED]/2024. Review of Resident 1's service plan, dated 03/05/2025, showed that Resident 1 was assessed to be independent with their medication management. The document showed that the family assisted by coordinating and ordering Resident 1's medications.

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Review of Resident 1's records showed no documentation of any plan for family assistance with medication management services. The records showed no description of the assistance with Resident 1's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance. The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in effect, or by a representative of the facility, as required.

During an interview on 01/08/2026 at 10:47 AM, Resident 1 stated that they ordered and managed their own medications with help from their family. Resident 1 stated that they kept their medications secured in their room.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. Review of Resident 3's assessment, dated 09/24/2025, showed documentation that Resident 3 was assessed to be independent with their medication management. The assessment dated 09/24/2025 showed no documentation of a family medication assistance plan.

On 01/08/2026 at 11:05 review of Resident 3's records showed no description of the assistance with Resident 3's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance. The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in effect, or by a representative of the facility, as required.

During an interview on 01/08/2026 at 11:45 AM, Resident 3 stated that the facility ordered the medications. During an interview on 01/08/2026 at 11:48 AM, Resident 3 stated that the facility delivered the medication unit dose "bubble pack cards" to their room for Resident 3 to store and manage. Resident 3 stated that they took the medications according to the instructions printed on the package labels. Resident 3 stated that they kept their medications secured in their room.

During an interview on 01/08/2025 at 10:05 AM, Staff A stated that the facility was using a new electronic documentation system. Staff N, Health and Wellness Director for Assisted Living stated that they thought that the electronic documentation system met the requirements for the family medication assistance agreement.

During an interview on 01/08/2026 at 2:00 PM, Staff A, Executive Director, stated that they were aware of the family plan requirements for family assistance with resident medication services. Staff A stated that they were unaware that Resident 1 and Resident 3 did not have written plans for family assistance with medication services, as required.

This is an uncorrected deficiency cited on 11/13/2025.

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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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 1/27/2026.

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



Administrator (or Representative)

1/27/2026

Date



Residential Care Services Investigation Summary Report

Provider/Facility: Mirror Lake Village
License/Cert.#: 2564

Provider Type: Assisted Living Facility

Compliance Determination #: 67420

Intake ID: 199917

Investigator: Steven Garrett

Region/Unit #: RCS Region 2 / Unit D

Investigation Date(s): 10/22/2025 through 11/13/2025

Complainant Contact Date(s):

Allegation(s):

- 1) Residents are not receiving medications as ordered.
- 2) Residents are not receiving the care and services as agreed upon.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 9 Closed records sample size: 0
Observations:	Facility environment, medication carts, resident to staff interactions, medication administration.
Interviews:	Executive Director, Health Services Director, Medication Technicians, Resident Representatives
Record Reviews:	Facility Medication services policies, facility disclosure of services, medication administration records

Investigation Summary:

Failed practice found.

1) During the full licensing inspection conducted on 10/22/2025 through 10/27/2025, on-site facility investigation found facility failed practice related to medication services. This finding of failed facility practice was cited in the Statement of Deficiencies, with a completion date of 11/13/2025, under Washington Administration Chapter 388-78A-2210 - Medication services.

2)

Failed facility practice found.

2) During the full licensing inspection conducted on 10/22/2025 through 10/27/2025, on-site facility investigation found facility failed practice related to quality of care and services related to insufficient staff to provide safe medication services. This finding of failed facility practice was cited in the Statement of Deficiencies, with a completion date of 11/13/2025, under Washington Administration Chapter 388-78A-2210 - Medication services.

Conclusion / Action:

- ☒ 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

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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 the unannounced on-site full inspection and complaint investigation on 10/22/2025 and 10/28/2025 of:

Mirror Lake Village
31000 9th PI SW
Federal Way, WA 98023

This document references the following complaint numbers: 199917.

The following sample was selected for review during the unannounced on-site visit: 9 of 88 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Steven Garrett, LTC Licenser
Claudia Allis, ALF Licenser

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

This document was prepared by Residential Care Services for the Locator website.

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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.

Jim Sherman
Residential Care Services

11-24-2025

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.

Rachul Band

Administrator (or Representative)

11/24/2025

Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 9 sampled residents (Resident 2, Resident 4, and Resident 7) or their representative, and a facility representative signed their Service Plan (equivalent to the negotiated service agreement), at least annually. This failure placed Resident 2, Resident 4, and Resident 7 at risk of being uninformed about their assessed care and services and having unmet care needs.

Findings included...

RESIDENT 2

Review of Resident 2's information document showed the facility admitted Resident 2 on [REDACTED]/2025. Review of Resident 2's Service Plans showed no signatures by resident, resident's representative, or facility staff since Resident 2's admission.

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RESIDENT 4

Review of Resident 4's information document showed the facility admitted Resident 4 on [REDACTED]/2022. Review of Resident 4's Service Plans showed no signatures by resident, resident's representative, or facility staff since Resident 4's admission.

RESIDENT 7

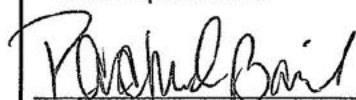
Review of Resident 7's information document showed the facility admitted Resident 7 on [REDACTED]/2023. Review of Resident 7's Service Plans showed no signatures by resident, resident's representative, or facility staff since Resident 7's admission.

During an interview on 10/28/2025 at 2:20 PM, Staff A, Executive Director/Administrator, stated that they were aware the Service Plans required signatures from the facility staff, residents, or the resident's representatives at least annually. Staff A stated that they were aware some of Service Plans were not signed and dated by facility staff, residents, or their representatives, as required.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 12/28/2025.

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



Administrator (or Representative)

11/24/2025

Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement infection control policies and requirements to protect residents from infectious illnesses. This failure

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placed all 88 residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

During an interview on 10/22/2025 at 10:10 AM, Staff A, Executive Director/Administrator, and Staff N, Director of Wellness, stated that they were aware of the Respiratory Protection Program (RPP) requirements. Staff A and Staff N stated that Staff N was the RPP administrator and trained to conduct fit-testing of N95 respirators for staff who might be required to wear a N95 respirator.

Review of the facility's policy titled, "Respirator Program Template for COVID-19 Prevention", dated 01/05/2023, showed that facility staff used respirators to protect against transmission of the SARS-COV-2 virus and other airborne diseases. The policy showed that all employees designated to use N95 respirators would be medically evaluated and fit-tested before they are allowed to use the respirator.

Review of the facility's RPP documents showed no documentation of any staff fit testing for any of the facility provided N95 respirators.

During an interview on 10/24/2025 at 9:30 AM, Staff N stated that they were unaware that there was no documentation of staff fit-testing for N95 respirators.

During an interview on 10/24/2025 at 1:30 PM, Staff A stated that they were unaware there was no documentation of facility staff fit-testing for N95 respirators. Staff A stated that they were aware that the last staff fit-testing for N95 respirators was in 2024. Staff A stated they were aware of recent facility Covid outbreak in August 2025. Staff A was unaware if staff required to wear N95 respirators were fit-tested for N95 respirators during the August 2025 Covid outbreak.

During an interview on 10/28/2025 at 7:57 AM, Staff I, Medication Tech, stated that they have been employed at the assisted living facility for about a year. Staff I stated that they do not recall being medically cleared or fit-tested for N95 respirator use.

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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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 12/27/25.

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

Administrator (or Representative)


Date: 11/24/25**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.
- (2) For purposes of WAC 388-78A-2481 through 388-78A-2489, "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 6 staff (Staff D) were screened for tuberculosis (TB) within three days of employment. This failure placed all the residents at risk of contracting a serious and contagious respiratory disease.

Findings included...

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

On 10/22/2025, a review of staff records showed from 01/13/2025 through 10/22/2025, Staff D worked at the facility and provided care and services for residents. There was documentation in Staff D's records that showed the facility screened Staff D on 03/26/2025. Staff D was screened for TB 73 days after the date of hire.

During an interview on 10/23/2025 at 2:55 PM, Staff A, Executive Director, confirmed that when Staff D was hired, Staff D was not screened for tuberculosis. Staff A stated that they were aware that testing for tuberculosis was required for all facility staff within three days of employment.

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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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 12/27/25.

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

Administrator (or Representative)

Rachel Bal

Date 11/24/25

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 1 of 6 staff (Staff F). These failures placed all 88 residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included....

Review of facility's undated personnel records showed the facility hired Staff F, Caregiver, on 02/10/2022.

Review of Staff F's records showed documentation that Staff F completed a Washington State Name and Date of Birth background check on 10/04/2022. Review of Staff F's records showed no documentation that Staff F completed a Washington State Name and Date of Birth background check in October 2024. The records showed Staff F's provided direct care to residents for 384 days without a valid Washington State Name and Date of Birth background check.

During an interview on 10/23/2025 at 2:55 PM, Staff A, Executive Director, stated that

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the facility was aware that staff needed Washington State Name and Date of Birth background checks upon hire and then every 2 years.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 11/27/25.

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

Rachel B. Bul

Administrator (or Representative)

11/24/25

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.

(4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in 8 of 9 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 6, Resident 7, Resident 8, and Resident 9) service agreements a plan to monitor and address interventions required to meet the current clinical needs. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 6, Resident 7, Resident 8, and Resident 9 at risk for unmet care needs and potential harm.

RESIDENT 1

Review of Resident 1's records showed the facility admitted Resident 1 on [REDACTED]/2023. The records showed Resident 1 self-administered medications. Resident 1's records showed no documentation of the medications Resident 1 was prescribed. Review of Resident 1's records showed facility staff were nurse delegated to check Resident 1's

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finger-stick blood glucose (blood sugars) checks and to administer injectable insulin.

Review of Resident 1's demographic 'face sheet', undated, showed documentation of Resident 1's diagnoses which included:

[REDACTED] and [REDACTED].

Review of Resident 1's Service Plan Report (equivalent to the Negotiated Service Agreement), dated 10/14/2025, showed no documentation that provided instructions for the care staff to monitor Resident 1 for signs and symptoms related to depressive disorders, generalized anxiety disorders, diabetes (low blood sugar and high blood sugar), and possible stroke (an interruption of blood flow in the brain). The plan showed no instructions for staff about behaviorally based supportive actions to take when Resident 1 exhibited signs and symptoms of depression and anxiety. There was no documentation that provided the care staff with guidance about the possible side effects from daily use of diabetic medication. The plan showed no guidance for care staff to document signs and symptoms of anxiety, depression, and low or high blood sugar symptoms.

RESIDENT 2

Review of Resident 2's record showed the ALF admitted Resident 2 on [REDACTED]/2025 with diagnoses which included [REDACTED] and [REDACTED]. The records showed Resident 1 self-administered medications. Resident 2's records showed no documentation of the medications Resident 2 was prescribed.

Resident 2's service plan, dated 09/28/2025, showed documentation of a fall risk assessment.

Resident 2's service plan, dated 09/28/2025, showed no documentation of a fall prevention plan.

Review of Resident 2's service plan showed no documentation of medications taken by Resident 2.

Review of Resident 2's Service Plan, dated 09/28/2025, showed no documentation that provided the care staff instructions to monitor Resident 2 for signs and symptoms related to hypertension. There was no documentation that provided the care staff with guidance about possible side effects from Resident 2's prescribed medications. The plan showed no guidance or instructions for care staff to report signs and symptoms of elevated blood pressure to the nurse.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. The records showed Resident 3 received medication assistance services from facility staff to order prescription medications. Review of Resident 3's service plan dated 10/16/2025 showed documentation that Resident 3 was assessed as safe for self-medication.

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Review of Resident 3's demographic 'face sheet', undated, showed documentation of Resident 3's diagnoses which included: [REDACTED]

and [REDACTED]

Review of Resident 3's service plan dated [add date] showed that Resident 3 was prescribed the following medications: 20 mg of Lisinopril (medication used to treat high blood pressure), by mouth, for hypertension (elevated blood pressure); 25 mg of Hydroxyzine (medication used to treat anxiety) 1 tablet 3 times daily, every 8 hours, as needed, by mouth, for anxiety (excessive worry that is persistent and out of proportion to actual events or threats); 300 mg of Bupropion extended release (medication used to treat depression), daily at 3:00 PM, by mouth, for major depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities); 300 mg of Gabapentin (medication used to treat pain from nerve damage) give 1 capsule twice daily, at 7:00 AM and 7:00 PM, by mouth, for chronic pain (weakness, numbness, and pain); and, 81 mg of Aspirin (medication to reduce pain and prevent blood clots) give 1 tablet, 1 time daily at 7:30 AM, by mouth, to reduce the risk of blood clots which potentially cause strokes.

Review of Resident 3's Service Plan, dated 10/16/2025, showed no documentation that provided the care staff instructions to monitor Resident 3 for signs and symptoms related to hypertension, anxiety, depressive disorder, and pain. The plan showed no instructions for staff behaviorally based supportive actions to take when Resident 3 exhibited signs and symptoms of anxiety and depression. There was no documentation that provided the care staff with guidance about possible side effects from Lisinopril, Hydroxyzine, Bupropion, Gabapentin, Aspirin. The plan showed no guidance or instructions for care staff to report signs and symptoms anxiety, depression, hypertension, chronic pain, and increased bruising and bleeding to the nurse.

RESIDENT 4

Review of Resident 4's records showed the facility admitted Resident 4 on [REDACTED]/2022. The records, demographic 'face sheet' showed that Resident 4 was indicated as being assessed to self-medicate, requiring no assistance from facility staff for medication services. Facility staff ordered prescription medications for the resident.

Review of Resident 4's demographic 'face sheet', undated, showed documentation of Resident 4's diagnoses which included: [REDACTED]

and [REDACTED]

A review of Resident 4's face sheet showed that Resident 4 was prescribed the following medications: 50 mg of Hydrochlorothiazide (medication used to treat high blood pressure), by mouth, for hypertension (elevated blood pressure) 1 tablet by mouth, 1

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time per day; 50 mg of Tramadol (medication used to treat moderate to severe pain) 1 tablet 2 times daily, by mouth, as needed, for pain; 100 mg of Bupropion (medication used to treat depression), 4 times daily at 7:00 AM, 12:00 PM, 3:00 PM, and 8:00 PM, by mouth, for major depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities); and 40 mg of Paroxetine (medication used to treat depressive disorders) give 40 mg 1 time daily, major depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities).

Review of Resident 4's Service Plan Report, dated 09/24/2025, showed no documentation that provided the care staff with instructions to monitor Resident 4 for signs and symptoms related to depressive disorder and pain. The plan showed no instructions for staff of behaviorally based supportive actions to take when Resident 4 exhibited signs and symptoms of depression, increased pain, and balance instability. There was no documentation that provided the care staff with guidance about possible side effects from Hydrochlorothiazide, Bupropion, Tramadol, and Paroxetine. The plan showed no guidance or instructions for care staff to report signs and symptoms of increased depression, hypertension, and chronic pain to the nurse.

RESIDENT 6

Review of Resident 6's records showed the facility admitted Resident 6 on [REDACTED]/2025. The records showed Resident 6 was admitted to the facility's secured memory care building with diagnoses including [REDACTED]

and [REDACTED]

[REDACTED]. The records showed Resident 6 received medication assistance and administrative services from facility staff. Resident 6 received assistance with monitoring their blood glucose levels.

Review of Resident 6's August 2025, September 2025, and October 2025 MAR's showed that Resident 6 received 12.5mg of Quetiapine (medication used to improve mood, thoughts, and behaviors) twice daily as needed, by mouth, for agitation; 25 mg of Trazodone (medication used to treat depression) every eight hours as needed, by mouth, for depressive disorder (mental health condition characterized by persistent low mood, loss of interest in daily activities).

Review of Resident 6's Service Plan, dated 10/16/2025, showed no documentation that provided the care staff to monitor Resident 6 for signs and symptoms related to diabetes, depression, and agitation. The plan showed no instructions for staff behaviorally based supportive actions to take when Resident 6 exhibited signs and symptoms of diabetes, depression, and agitation. There was no documentation that provided the care staff with guidance on the use of Quetiapine and Trazodone as needed. The plan showed no guidance or instructions for care staff to report signs and symptoms of diabetes, depression, and agitation to the nurse.

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RESIDENT 7

Review of Resident 7's records showed the facility admitted Resident 7 on [REDACTED]/2023. Records showed Resident 7 was admitted to the facility's secured memory care building with diagnoses including [REDACTED] and [REDACTED]. The records showed Resident 7 received medication assistance and administrative services from facility staff.

Review of Resident 7's August 2025, September 2025, and October 2025 MAR's showed that Resident 7 received 5 mg of Apixaban (medication used as a blood thinner to prevent and treat blood clots) twice daily, by mouth, for atrial fibrillation (a heart rhythm disorder where the heart beats irregularly and rapidly); 7.5 mg of Mirtazapine (medication used to treat depression) once daily, by mouth, for major depressive disorder; 100 mg of Sertraline (medication used to treat depression) once daily, by mouth, for depressive disorder; 12.5 mg of Quetiapine twice daily, by mouth, for agitation; and 100 mg of Gabapentin (medication used to treat nerve pain) three times daily as needed, by mouth, for pain.

Review of Resident 7's Service Plan, dated 09/25/2025, showed no documentation that provided the care staff to monitor Resident 7 for signs and symptoms related to depression, neuropathy, atrial fibrillation, and agitation. The plan showed no instructions for staff behaviorally based supportive actions to take when Resident 7 exhibited signs and symptoms of depression and agitation. There was no documentation that provided the care staff with guidance on the use of Gabapentin as needed for pain. The plan showed no guidance or instructions for care staff to report signs and symptoms related to neuropathy, depression, and agitation to the nurse.

RESIDENT 8

A review of Resident 8's records showed the facility admitted Resident 8 on [REDACTED]/2025. Records showed Resident 8 was admitted to the facility's secured memory care building with diagnoses including [REDACTED] and [REDACTED]. The records showed Resident 8 received medication assistance and administration services from facility staff including blood glucose monitoring and insulin injections.

Review of Resident 8's August 2025, September 2025, and October 2025 MAR's showed that Resident 8 received 20 mg of Duloxetine (medication used to treat depression) once daily, by mouth, for depression; 15 units of Insulin Glargine (medication used to treat high blood glucose levels) once daily at bedtime, subcutaneously, for diabetes; and sliding scale units of Insulin Aspart (medication used to treat high blood glucose levels), four times daily as needed depending on blood glucose levels, subcutaneously, for diabetes.

Review of Resident 8's Service Plan, dated 10/14/2025, showed no documentation that provided the care staff to monitor Resident 8 for signs and symptoms related to diabetes. The plan showed no instructions for staff actions to take when Resident 8 exhibited signs and symptoms of high or low blood glucose levels or signs and symptoms of depression. The plan showed no guidance or instructions for care staff to

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report signs and symptoms related to diabetes and depression to the nurse.

RESIDENT 9

Review of Resident 9's records showed the facility admitted Resident 9 on [REDACTED]/2025. Records showed Resident 9 was admitted to the facility's secured memory care building with diagnoses including [REDACTED] and [REDACTED]. The records showed Resident 9 received medication assistance and administrative services from facility staff.

Review of Resident 9's August 2025, September 2025, and October 2025 MAR's showed that Resident 9 received 20 mg of Citalopram (medication used to treat depression) once daily, by mouth, for depression; and 12.5 mg of Quetiapine once daily at bedtime, by mouth, for dementia.

Review of Resident 9's Service Plan, dated 09/23/2025, showed no documentation that provided the care staff to monitor Resident 9 for signs and symptoms related to dementia and depression. The plan showed Resident 9 had current and historical issues with anxiety. There were no instructions for staff to monitor or behaviorally supportive actions to take when Resident 9 exhibited signs and symptoms of anxiety. The plan showed no guidance or instructions for care staff to report signs and symptoms related to dementia, depression, or anxiety to the nurse.

During an interview on 10/27/2025 at 1:55 PM, Staff A, Executive Director, stated that the facility utilized an electronic documentation system. Staff A stated that they were unaware the comprehensive elements required in resident service plans had not been completed.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 11/27/25.

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

[Signature]
Administrator (or Representative)

11/24/25
Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

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(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

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

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to provide 6 of 9 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 8) with a copy of the facility's policy for acceptance of Medicaid as a payment source. The facility failed to ensure the residents, or the residents representative acknowledged the facility policy on Medicaid as a payment source with a signature and date. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 8 at risk of being discharged and unable to reside in the facility on state Medicaid assistance as a payment source.

Findings included...

Review of the Department of Social and Health Services "Secure Tracking and Reporting Systems" (STARS) showed a list of the facility's current Medicaid contracts. Review showed the facility had contracts under Assisted Living Services (ALS), Enhanced Adult Residential Care (EARC), and Specialized Dementia Care (SDC).

Review of the facility's undated Disclosure of Services document showed the facility provided assistance with activities of daily living (ADL's). The document showed that the facility accepted Medicaid as a payment source under their ALS and EARC contracts.

During an interview on 10/22/2025 at 10:10 AM, Staff A, Executive Director/Administrator, stated that the facility accepted Medicaid as a payment source. Staff A stated that the facility had state Medicaid contracts under ALS, EARC, and SDC.

RESIDENT 1

Review of Resident 1's records showed the facility admitted Resident 1 on [REDACTED]/2024. The records showed no documentation of any acknowledgment by Resident 1 or their representative that they received the facility's policy on accepting Medicaid as a payment source. The records showed no signature or date by the resident or the resident's representative that acknowledged they received a copy of the facility's Medicaid policy.

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 on [REDACTED]/2025. The records showed no documentation of any acknowledgment by Resident 2 or their representative that they received the facility's policy on accepting Medicaid as a

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payment source. The records showed no signature or date by the resident or the resident's representative that acknowledged they received a copy of the facility's Medicaid policy.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. The records showed no documentation of any acknowledgement by Resident 3 or their representative that they received the facility's policy on accepting Medicaid as a payment source. The records showed no signature or date by the resident or the resident's representative that acknowledged they received a copy of the facility's Medicaid policy.

RESIDENT 4

Review of Resident 4's records showed the facility admitted Resident 4 on [REDACTED]/2022. The records showed no documentation of any acknowledgement by Resident 4 or their representative that they received the facility's policy on accepting Medicaid as a payment source. The records showed no signature or date by the resident or the resident's representative that acknowledged they received a copy of the facility's Medicaid policy.

RESIDENT 5

Review of Resident 5's records showed the facility admitted Resident 5 on [REDACTED]/2024. The records showed no documentation of any acknowledgement by Resident 5 or their representative that they received the facility's policy on accepting Medicaid as a payment source. The records showed no signature or date by the resident or the resident's representative that acknowledged they received a copy of the facility's Medicaid policy.

RESIDENT 8

Review of Resident 8's records showed the facility admitted Resident 8 on [REDACTED]/2025. The records showed no documentation of any acknowledgement by Resident 8 or their representative that they received the facility's policy on accepting Medicaid as a payment source. The records showed no signature or date by the resident or the resident's representative that acknowledged they received a copy of the facility's Medicaid policy.

During an interview on 10/28/2025 at 2:20 PM, Staff A stated that they were aware of the requirement for residents or the residents' representatives to acknowledge receipt of the facility's Medicaid policy with signatures and dates. Staff A stated they were unaware that Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 8 did not have documentation acknowledging receiving the facility's Medicaid policy.

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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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 12/27/25.

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

Rachel Bui
Administrator (or Representative)

11/24/25
Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 9 sampled residents (Resident 1, Resident 2, and Resident 3) had a written plan for family assistance with medication management. This failure placed Resident 1, Resident 2, and Resident 3 at risk for unmet care needs.

Findings included...

Review of the facility's undated Disclosure of Services document showed the facility permitted family assistance with residents' medication services. During an interview on 10/27/2025 at 1:45 PM, Staff A, Executive Director, stated the facility required residents who receive family medication assistance to provide a plan that would be signed and dated by the resident or legally responsible party and identify the family member who submitted the plan. Staff A stated that the family medication assistance plan would become part of a resident record.

RESIDENT 1

Review of Resident 1's records showed the facility admitted Resident 1 on [REDACTED] 2024. Review of Resident 1's service plan, dated 03/05/2025, showed that Resident 1 was assessed to be independent with their medication management. The document showed that the family assisted by coordinating and ordering Resident 1's medications.

Review of Resident 1's records showed no documentation of any family plan for assistance with medication management services. The records showed no list of family members involved with the medication assistance services, no description of the assistance with Resident 1's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance. The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in effect, or by a representative of the facility, as required.

During an interview on 10/27/2025 at 10:47 AM, Resident 1 stated that they ordered and managed their own medications with help from their family. Resident 1 stated that they kept their medications secured in their room.

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 on [REDACTED] 2025. Review of Resident 2's assessment, dated 09/08/2025, showed no documentation that Resident 2 was assessed to be independent with their medication management. Review of Resident 2's service plan, dated 09/24/2025, showed no documentation that Resident 2 was assessed to be independent with their medication management. Resident 2's assessment, dated 09/08/2025, and service plan, dated 09/24/2025, showed no documentation of how Resident 2 would obtain medications. The documents did not show how the family would assist Resident 2 to coordinate, order, and manage Resident 2's medications.

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The records showed no list of family members involved with the medication assistance services, no description of the assistance to be provided with Resident 2's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. Review of Resident 3's assessment, dated 09/24/2025, showed documentation that Resident 3 was assessed to be independent with their medication management. The assessment dated 09/24/2025 showed no documentation of a family medication assistance plan.

On 10/23/2025 at 11:05 review of Resident 3's records showed no documentation of a list of family members involved with Resident 3's medication assistance services, no description of the assistance with Resident 3's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance. The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in effect, or by a representative of the facility, as required.

During an interview on 10/27/2025 at 11:45 AM, Resident 3 stated that the facility ordered the medications. During an interview on 10/27/2025 at 11:48 AM, Resident 3 stated that the facility delivered the medication unit dose "bubble pack cards" to their room for Resident 3 to store and manage. Resident 3 stated that they took the medications according to the instructions printed on the package labels. Resident 3 stated that they kept their medications secured in their room.

During an interview on 10/27/2025 at 2:35 PM, Staff A, Executive Director, stated that they were aware of the family plan requirements for family assistance with resident medication services. Staff A stated that they were unaware that Resident 1, Resident 2, and Resident 3 did not have written plans for family assistance with medication services, as required.

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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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 11/27/25.

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

Administrator (or Representative)



Date: 11/24/25

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 2 of 9 residents (Resident 2 and Resident 3) admitted to the assisted living facility. This failure placed Resident 2 and Resident 3 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 2

Review of Resident 2's information document showed the facility admitted Resident 2 on [REDACTED]/2025. Review of the facility's initial assessment and service plan for Resident 2 was dated [REDACTED]/2025, 45 days after Resident 2 moved into the facility. Review of Resident 2's records showed no documentation of an assessment completed prior to Resident 2's move into the facility.

RESIDENT 3

Review of Resident 3's information document showed the facility admitted Resident 3 on [REDACTED]/2025. Review of the facility's initial assessment and service plan for Resident 3 was dated [REDACTED]/2025, 5 days after Resident 3 moved into the facility. Review of Resident 3's records showed no documentation of an assessment completed prior to Resident 3's move into the facility.

During an interview on 10/27/2025 at 2:35 PM, Staff A, Executive Director, stated that Resident 2 and Resident 3 were not admitted under emergency circumstances. Staff A

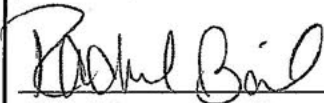
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stated that they were aware of the requirement to complete and document an assessment prior to admitting residents into the assisted living facility. Staff A stated that they were unaware that Resident 2 and Resident 3 did not have documented completion of pre-admission assessments prior to their move-in to the facility.

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)

11/24/25
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:

Based on interview and record review, the Assisted Living Facility (ALF) failed to investigate and address an unwitnessed fall that resulted in an injury for 1 of residents (Resident 2). This failure placed Resident 2 at risk of additional harm, unmanaged pain, and additional falls.

Findings included...

Review of Resident 2's record showed the ALF admitted Resident 2 on [REDACTED]/2025 with multiple diagnoses. Resident 2's assessment, dated 09/28/2025, showed Resident 2 had a recent history of 1 – 2 falls. Resident 2's service plan, dated 09/28/2025, showed documentation of a fall risk assessment. Resident 2's service plan, dated 09/28/2025, showed no documentation of a fall prevention plan. Review of Resident 2's assessment and service plan showed no documentation of medications taken by Resident 2.

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Review of Resident 2's progress notes, dated 09/15/2025 at 6:42 AM, showed facility staff documented that they found Resident 2's room and observed Resident 2 on the floor in their room. Staff documented that Resident 2 had a head injury, a skin tear on their right arm, and generalized body pain. Staff documented that Resident 2 reported they had "passed out" and fallen.

Review of an incident report dated 09/15/2025 showed documentation that Resident 2 was assessed by emergency medical services and transported to a medical facility for evaluation and treatment.

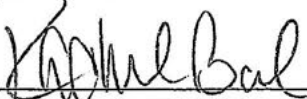
During an interview on 10/24/2025 at 11:40 AM, Staff A, Executive Director, stated that no documentation of additional progress notes from 09/16/2025 through 10/22/2025 was found. During an interview on 10/24/2025 at 11:40 AM, Staff A, Executive Director, stated that no documentation of alert progress notes was found. Staff A stated that there was documentation of an assessment and service plan found following Resident 2's unwitnessed fall, dated 09/28/2025, 13 days after the date of injury on 09/15/2025. Staff A stated that there was no documentation in Resident 2's record to show when Resident 2 had returned to the facility. Staff A stated that there was no documentation in Resident 2's record to show a record of discharge instructions when Resident 2 had returned to the facility.

During an interview, on 10/24/2025 at 11:35 AM, Staff A stated that they were unaware of Resident 2's fall. Staff A stated that they were aware that unwitnessed falls with injury required investigation, follow-up, assessment, and service plan updates. Staff A stated that they were unaware that Resident 2's assessment and service plan did not have documentation of the medications that Resident 2 was self-administering.

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, Mirror Lake Village is or will be in compliance with this law and / or regulation on (Date) 12/27/25.

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


Administrator (or Representative)

11/24/25
Date

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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;

(9) employees are properly maintaining the temperatures of time/temperature control for safety food during hot and cold holding through daily oversight of the employees' routine monitoring of food temperatures;

(11) employees are properly sanitizing cleaned multiuse equipment and utensils before they are reused, through routine monitoring of solution temperature and exposure time for hot water sanitizing, and chemical concentration, pH, temperature, and exposure time for chemical sanitizing;

(16) Written procedures and plans, such as a clean-up plan for vomit and diarrhea, where specified by this chapter and as developed by the food establishment to ensure active managerial control, are maintained and implemented as required.

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 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;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

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. The facility failed to ensure 2 of 11 kitchen staff (Staff G and Staff M) obtained current Washington State food worker cards. This failure placed all 88 residents at risk of potential foodborne illnesses.

Findings included...

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Note: per 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.

Review of the facility's Characteristics Roster showed the facility provided assistance with activities of daily living (ADL) including meal service to 88 residents.

SANITIZING SOLUTION

Observation in the main kitchen on 10/23/2025 at 9:35 AM, showed six red and green buckets filled with sanitizing solution were placed throughout the kitchen area. 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 10/22/2025 at 12:00 PM, Staff G, Director of Dining Services, stated that the kitchen had no test strips to test sanitizing solution effectiveness. Staff G stated that there was no 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.

FOOD AND DISHWASHER TEMPERATURE MONITORING

Observation in the main kitchen on 10/23/2025 at 11:10 AM, showed Staff G prepared food for lunch service. Observation showed Staff G placing pans of food removed from oven onto the hot-hold stations. Staff G prepared lunch entrée items for transport to the residents in the secured memory care building. Observation showed staff cleaning dirty dish items using the kitchen dishwasher.

Review of the kitchen records showed incomplete documentation of when staff monitored food cooking temperatures or the dishwasher wash and rinse temperatures. Review showed the last documentation of the dishwasher wash/rinse temperatures was in August 2025. There was no documentation for monitoring the dishwasher wash/rinse temperatures for September 2025 or October 2025. Review showed incomplete food temperature monitoring logs with missing entries for 10/18/2025 and 10/19/2025 dinner meal food temperatures.

During an interview on 10/23/2025 at 9:35 AM, Staff G stated they expect staff to monitor food temperatures at the beginning, middle and end of each meal service. Staff G stated they were aware of the requirements for monitoring and documentation of food temperatures and dishwasher wash/rinse temperatures. Staff G stated they were aware that food and dishwasher temperature monitoring logs were incomplete and inconsistent.

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CLEANING/MAINTENANCE OF ICE MAKER

Observation in the main kitchen on 10/23/2025 at 11:10 AM, showed staff used equipment, including the ice maker, to prepare meals for facility residents.

Review of kitchen records showed no documentation or schedule of when staff cleaned the kitchen ice maker.

During an interview on 10/23/2025 at 9:45 AM, Staff G stated that the kitchen staff do not routinely clean the ice maker. Staff G stated that there was no scheduled cleaning process or log to document the cleaning of the ice maker. Staff G stated that they understood the maintenance staff maintained and cleaned the ice maker.

During an interview on 10/24/2025 at 9:15 AM, Staff H, Director of Maintenance, stated that the maintenance staff do not clean or maintain the ice maker. Staff H stated that they were unaware of any scheduled cleaning and maintenance of the kitchen ice maker.

FOOD WORKER CARDS

Observation on 10/23/2025 at 11:10 AM, showed Staff G prepared food for lunch service. Staff M, Server, assisted with preparing food for lunch service for residents residing in the secured memory care building. Observation showed Staff M loaded food items onto the transport cart for lunch service in the secured memory care building. Staff M brought the transport cart with food for lunch service to the secured memory care building 1st floor servery kitchen. Observation showed Staff M unloaded food items from transport cart, plate food items for residents lunch service, and serve plated meals to residents in the 1st floor secured memory care dining area.

Review of kitchen/dining staff records showed no Washington State food worker card documentation for Staff G or Staff M.

During an interview on 10/23/2025 at 9:50 AM, Staff G stated that they were aware of the food worker card requirements. Staff G stated that they were unaware Staff M did not have a food worker card. Staff G stated that they were unaware they needed their own Washington State food worker card in addition to their current training documents.

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Administrator (or Representative)

*Rachel Bel*Date 11/24/25**WAC 388-110-220 Enhanced adult residential care service standards.**

(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(c) Develop and implement policies and procedures:

(iii) To obtain consultative resources to address behavioral issues for residents. The contractor must include a plan that identifies the professional (i.e., clinical psychologist, psychiatrist, psychiatric nurse practitioner, or other behavioral specialist familiar with care of persons with dementia with complex or severe problems) who will provide the consultation, and when and how the consultation will be utilized.

(g) Provide daily activities consistent with the functional abilities, interests, habits and preferences of the individual residents. The contractor must support the participation of residents and the resident council, if there is one, in the development of recreational and activity programs that reflect the needs and choices of residents. On a daily basis, the contractor must provide residents access to:

(ii) Individual activities, in which a staff person or volunteer engages the resident in a planned and/or spontaneous activity of interest. Activities may include personal care activities that provide opportunities for purposeful and positive interactions; and

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the assisted living facility residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to have identified consultative resources available to provide the required behavioral support services and daily resident-centered individualized activities for 1 of

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1 Medicaid Contracts (Enhanced Adult Residential Care-Specialized Dementia Care (EARC-SDC)). This failure placed residents with an EARC-SDC contract as a payor source at risk for a decreased quality of life.

Findings included...

Review of the Department of Social and Health Services "Secure Tracking and Reporting Systems" (STARS) showed a list of the facility's current Medicaid contracts. Review showed the facility obtained the EARC-SDC contract in May 2024.

Review of the Washington Administrative Code (WAC) 388-110-020 showed the definition of EARC-SDC services as follows: Enhanced adult residential care-specialized dementia care services is a package of services, including specialized dementia care assessment and care planning, personal care services, intermittent nursing services, medication administration services, specialized environmental features and accommodations, and activity programming.

Review of facility untitled documents showed the ALF provided care funded by the EARC-SDC contract to eleven residents with different levels of cognitive impairments and behavioral issues in four separate floors of the assisted living and secured memory care buildings.

During an interview on 10/24/2025 at 1:43 PM, Staff A, Executive Director/Administrator, stated they were aware the facility had residents receiving care and services paid for by their EARC-SDC contract. Staff A stated that they were unaware of the requirements to identify consultative behavioral health providers and provide resident-specific daily individualized resident activities.

Review of Service Plans (equivalent to the negotiated service agreement) for the eleven residents receiving care and services under the EARC-SDC contract showed no documentation of identified behavioral health professionals for consultative services. The Service Plans showed no documentation of resident-specific individualized activities. There was no documentation of directions for staff to engage residents in planned or spontaneous activities of interest.

Observations conducted by Residential Care Services staff on 10/22/2025, 10/23/2025, 10/24/2025, and 10/28/2025 (observations conducted on each date occurred between 10:00 AM and 3:00 PM) showed no individualized resident activities were being provided by staff for residents funded by EARC-SDC contract.

During an interview on 10/28/2025 at 10:40 AM, Staff K, Medication Tech, stated that they provide care and services to residents in the secured memory care building. Staff K stated that the activities for residents in memory care are not designed for individualized, resident-specific engagement.

During an interview on 10/28/2025 at 12:06 PM, Staff L, Director of Life Enrichment, stated that they were unaware of any individualized, resident-specific designed activities for staff engagement. Staff L stated that they were unaware of any Service Plans that developed planned or spontaneous activities with individual residents.

Plan/Attestation Statement

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WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to have a system in place to ensure water was available from 6 of 6 hot water tanks (Tank 1, Tank 2, Tank 3, Tank 4, Tank 5, and Tank 6) identified in the disaster manual as part of the emergency water supply, was readily accessible for residents in an emergency. This failure placed the 88 residents at risk for dehydration or other health and hygiene issues secondary to a lack of safe, emergency water.

Findings included...

Review of the facility's Characteristics Roster showed the facility provided care and services to 88 residents.

Review of the facility's disaster manual plan showed that emergency drinking water consisted of one quart of drinking water per person, per day, for three days. The plan identified the facility's six hot water tanks as part of the emergency potable water supply.

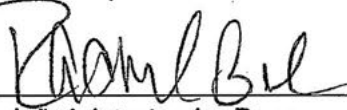
Observation on 10/22/2025 at 1:35 PM, showed six hot water tanks located on the facility. Each water tank had a valve with no handle located at the bottom of each tank. Observation showed no device or equipment available to turn on the valve to provide access to the water. Observations showed no hoses or containers available to collect the emergency water when drained from the tanks. Observation showed no instructions on how to access the water in the hot water tanks during an emergency.

During an interview on 10/22/2025 at 2:45 PM, Staff H, Director of Maintenance, stated that the hot water tanks were designated as part of the emergency water supply. Staff H stated that they were aware there was not a device available to turn the hot water tank valve, no hose available to access the hot water tank water, and no bucket to collect the water. Staff H stated that they were aware there were no instructions for staff on how to collect water from the hot water tanks for emergency water access.

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WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their

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medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

- (a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and
- (b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 facility policy for safe medication delivery system was implemented. These failures placed residents at risk of negative health impacts.

Findings included...

ADMINISTRATION OF MEDICATIONS

Review of the facility's Characteristics Roster showed the facility provided care and services to 88 residents. The roster showed the facility provided medication assistance and administration services to 76 residents.

Review of the facility Nurse Delegation records, undated binders, showed that residents who resided in the secured Memory Care unit received all medications, to include oral (by mouth) medications (routine, as needed, and time sensitive medications) and injectables from facility staff, medication technicians, who had received training.

Time-sensitive medications (also known as time-critical medications) must be taken at a specific time or within a narrow time frame (commonly defined as 30 minutes before or after the scheduled dose) to maintain their effectiveness and prevent serious patient harm. Some examples of time-sensitive medications are as follows: medications for Parkinson's Disease; Insulin and other diabetic medications; seizure medications; anticoagulants (prevent blood clotting; certain antibiotics and antivirals; and steroids. (The Pharmaceutical Journal)

Review of facility policy document titled "Medication Service", dated 04/01/2017 showed residents that receive medication assistance must have all medication(s) centrally stored together for each resident either in the medication cart or Wellness Center. Review showed all medications for residents will be kept together but will be physically separated from other residents' medications. The policy showed that all medications will be assisted with or administered at the designated times. Medications may not be given more than one hour before or one hour after the designated time.

During an interview on 10/24/2025 at 11:30 AM, Staff I stated that they administered time-sensitive medications to residents who resided in the secure memory unit that

resided on the first and second floor. During an interview on 10/24/2025 at 11:45 AM, Staff I stated that they were responsible for doing finger-stick blood glucose monitoring for insulin dependent residents before the residents were able to receive breakfast.

Observation on 10/28/2025, between 6:53 AM and 9:30 AM, showed Staff I, Medication Tech, prepared, assisted, and administered medications to residents in the secured memory care building on the first and second floors. Staff I provided both oral and injectable medications to residents. Observation showed Staff I utilized the facilities electronic medication administration record (MAR) system to provide medications due for residents at 7 AM and 8 AM dosing times. Observation showed Staff I obtained blood glucose monitoring readings for residents requiring sliding scale doses of insulin depending on their blood glucose readings. Observation on 10/28/2025 at 9:27 AM, showed Staff I was assisting with caregivers with oversight of residents on the first floor of the secured memory care building.

During an interview on 10/28/2025 at 9:30 AM, Staff I stated that they had not completed passing all residents medications due between 7 AM and 8 AM per the residents MAR's.

During an interview on 10/28/2025 at 2:50 PM, Staff A, Executive Director, stated they were unaware that resident medications were not being administered according to residents primary-care providers and the facility "Medication Service" policy.

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Date 11/24/25

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess 1 of 9 residents (Resident 4) medical devices (half side bed rails) for their ability to safely use the side rails. This failure placed Resident 4 at risk of potential injury and/or entrapment from use of unsafe medical equipment.

Findings included...

Note : WAC 388-78A-2090(6)(e) Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(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.

RESIDENT 4

On 10/24/2025 at 1:20 PM, a review of Resident 4's records showed the facility admitted Resident 4 on [REDACTED]/2022. Review of Resident 4's demographic record, Resident Face Sheet, showed Resident 4 was admitted with a diagnosis of [REDACTED]

and [REDACTED]

On 10/24/2025 at 1:20 PM, a review of Resident 4's assessment dated 09/24/2025, did not show documentation the resident used side rails or that the side rails were assessed for safety.

Observation on 10/24/2025 at 2:50 PM, showed half side rails attached at the head of the bed, along both the right and left side of the bed. The bed rails were in the raised position and measured approximately 30 inches wide with a five-inch gap between vertical rail bars.

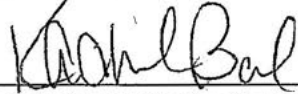
During an interview on 10/24/2025 at 2:50 PM with Resident 4, Resident 4 stated that they needed the bed rails for re-positioning while in bed and "to steady myself and to keep from falling." Resident 4 stated that they could not raise and lower the side rails without staff assistance. Resident 4 stated that they were not aware that there were ways to minimize the risk of entrapment.

During an interview on 10/27/2025 at 2:55 PM, Staff A, Executive Director, stated that they were aware of the entrapment risks of side rails. Staff A stated that they were unaware that Resident 4 did not have an assessment for the safe use of positioning aids.

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