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

12/01/2025

Greenlake Management Everett, LLC
Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

RE: Everett Heritage Court # 2612

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 69141 (Completion Date 12/01/2025) and 61005 (Completion Date 07/21/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/01/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

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

The Department staff who did the On Site verification:

Jodi Condyles, Nursing Consultant Institutional

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: Everett Heritage Court
Provider Type: Assisted Living Facility

License/Cert.#: 2612
Intake ID: 180159
Compliance Determination #: 61005
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 06/12/2025 through 07/21/2025
Complainant Contact Date(s): 06/12/2025

Allegation(s):

1. The Named Resident (NR) did not have a call light or button for three days after they moved in. The emergency call button was not working. The Assisted Living Facility (ALF) staff did not have their pagers with them to respond to residents' calls.
2. The NR was moved to the ALF without being informed that the ALF had a delayed egress.
3. The NR's bed was too short for their height.
4. The ALF failed to contact the case manager and the Power of Attorney (POA) when they made an assessment to increase the NR services.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Residents bed ADL Equipment Emergency call button locations
Interviews:	Identified resident Residents Family members Nursing staff Administrator
Record Reviews:	Facility policies Staff patterns Incident investigation Medical records Care plans Progress notes

Investigation Summary:

1. Named Resident's (NR) prior room had a working emergency call button installed by the side of their bed. NR's new apartment had a working emergency call button installed on the wall by their bed. The ALF staff did not have their pagers with them during the unannounced visit. The ALF staff failed to respond to the emergency call lights when activated. Failed practice was identified. A citation was issued for no compliance with WAC 388-78A-2930 (1) (a) (ii)- Communication system.
2. NR admitted to the Assisted Living Facility (ALF) from the hospital. The NR was aware that they were moved into the ALF temporarily. The NR stated the ALF was not preventing them from moving to another facility. The NR stated their Power of Attorney was looking for another facility where they can transfer.
3. Observation showed the NR original apartment had a hospital bed. The NR stated their bed was fine. The NR was moved to another apartment. The apartment was furnished with a bed. The NR fits in the bed and staff were putting a pillow at the foot part as a support when the NR would stretched their legs.
4. The Assisted Living Facility Nurse made a change of condition assessment without involving the NR's case manager. There were no documentation showing the ALF nurse involved the Resident and their representative when they made a change of condition assessment. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A-2130 (5) (a), (b), (d)- Service agreement planning.

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: Everett Heritage Court
Provider Type: Assisted Living Facility

License/Cert.#: 2612
Intake ID: 185119
Compliance Determination #: 61005
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 06/12/2025 through 07/21/2025
Complainant Contact Date(s): 07/16/2025

Allegation(s):
The Named Resident (NR) eloped from the Assisted Living Facility (ALF).

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 5 Closed records sample size:
Observations:	Residents Activities Resident rooms secured doors alarm system Residents behavior Staff to resident interactions Resident to resident interactions
Interviews:	Residents Family members Nursing staff Administrator
Record Reviews:	Incident investigation Facility policies Assessments care plans progress notes

Investigation Summary:
The NR exited the ALF unnoticed by the ALF staff. The NR was found about 0.8 miles away from the ALF at a hotel. The ALF failed to thoroughly investigated the circumstances of the event, document their findings, determine and implement preventative measures to prevent similar incident from happening. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2371 (1) (2) (3)- Investigations.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 06/12/2025 and 07/15/2025 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 181679, 180159, 183560, 186232, 185119

The following sample was selected for review during the unannounced on-site visit: 5 of 45 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Laurie Anderson
Residential Care Services

07/30/2025
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.

Administrator (or Representative)

8/10/25
Date

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

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to involve the resident, their representative and the case manager in the development of an on-going assessment for 1 of 1 resident (Resident 1), with a change in condition. This failure resulted in Resident 1, their representative, and the case manager being unaware of the changes in Resident 1's care needs.

Findings included...

Review of Resident 1's Face sheet showed the facility admitted Resident 1 on [redacted]/2025.

Review of the facility's policy titled, "Resident Service Plans", dated 02/15/2024, showed residents and responsible parties will be invited and encouraged to discuss changes and participate in the care conferences for the residents.

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

Residential Care Services | Date

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

Administrator (or Representative) | Date

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

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to involve the resident, their representative and the case manager in the development of an on-going assessment for 1 of 1 resident (Resident 1), with a change in condition. This failure resulted in Resident 1, their representative, and the case manager being unaware of the changes in Resident 1's care needs.

Findings included…

Review of Resident 1's Face sheet showed the facility admitted Resident 1 on [redacted]/2025.

Review of the facility's policy titled, "Resident Service Plans", dated 02/15/2024, showed residents and responsible parties will be invited and encouraged to discuss changes and participate in the care conferences for the residents.

Review of Resident 1's assessment, dated [redacted]/2025, showed Resident 1 had occasional poor judgment issues, was able to verbally express pain, needed assistance with mobility with no mention of number of staff assist, needed assistance with bathing and no mention of number of staff assist and had no documentation of a [redacted] diagnosis.

Review of Resident 1's change of condition assessment, dated 06/11/2025, showed Resident 1 had frequent poor judgment issues, pain was observed through facial grimacing, needed two to three staff for mobility, refused to be turned, needed two to three staff assistance with bathing and was diagnosed with [redacted].

Review of Resident 1's Service Plan, dated 06/11/2025, showed Resident 1 need two to three staff assistance for mobility and bathing due to their left side paralysis, had frequent poor judgment issues, may resist care often and refused showers.

Review of Resident 1's progress notes and available records showed no documentation that Resident 1 and their Power of Attorney (POA) were involved in the development of the assessment. There was no documentation that showed Resident 1 and the POA were made aware of the changes in Resident 1's care needs.

On 06/12/2025 at 10:33 AM, Collateral Contact 1 (CC1, resident representative) stated that the ALF completed an assessment when Resident 1 moved into the facility in [redacted] 2025. CC1 stated that they planned to move Resident 1 to another facility and discovered the facility completed another assessment for Resident 1. The new assessment increased Resident 1's care needs and resulted in the new facility denying Resident 1's admission. CC1 stated that the ALF never communicated with Resident 1's case manager and the POA when the facility completed Resident 1's change of condition assessment.

On 06/12/2025 at 1:22 PM, Resident 1 stated that they were unaware of any updated assessment. Resident 1 stated that they were not asked if their care needs changed or increased.

On 07/09/2025 at 12:19 PM, Collateral Contact 2 (CC2, POA) stated that they were unaware an updated assessment was completed. CC2 stated that they were not involved in any discussion about any changes in Resident 1's care needs or any assessment that was completed.

On 06/12/2025 at 1:49 PM Staff B, Health and Wellness Director, stated that they completed a change of condition assessment because Resident 1 needed two to three staff assistance with mobility, bathing and transferring especially when Resident 1 was in pain and uncooperative with the staff. Staff A stated that the Department of Social

Health and Services (DSHS) was not involved in the change of condition assessment. Staff A stated they were unaware they needed to involve the DSHS case manager in the change of condition assessment.

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, Everett Heritage Court is or will be in compliance with this law and / or regulation on (Date) 8/11/2025

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

Administrator (or Representative) — Date 8/10/25

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff responded to 2 of 2 residents' (Resident 1 and Resident 2) calls when they activated their emergency pull cords in their rooms. This failure placed Resident 1 and Resident 2 at risk for unmet care needs.

Findings included...

Review of the facility's undated policy titled, "Resident Call System Response Policy", showed staff must respond to all alarms promptly. Residents shall not be left without timely assistance. Each alarm must be investigated to determine the nature and urgency of the need.

Resident 1
Review of the face sheet showed the facility admitted Resident 1 on [redacted]2025.

On 06/12/2025 at 1:22 PM, Resident 1 stated that they needed to urinate. Resident 1 stated that they used a urinal. Resident 1 stated that they needed staff assistance to

Health and Services (DSHS) was not involved in the change of condition assessment. Staff A stated they were unaware they needed to involve the DSHS case manager in the change of condition assessment.

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, Everett Heritage Court is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff responded to 2 of 2 residents' (Resident 1 and Resident 2) calls when they activated their emergency pull cords in their rooms. This failure placed Resident 1 and Resident 2 at risk for unmet care needs.

Findings included…

Review of the facility's undated policy titled, "Resident Call System Response Policy", showed staff must respond to all alarms promptly. Residents shall not be left without timely assistance. Each alarm must be investigated to determine the nature and urgency of the need.

Resident 1
Review of the face sheet showed the facility admitted Resident 1 on [redacted]/2025.

On 06/12/2025 at 1:22 PM, Resident 1 stated that they needed to urinate. Resident 1 stated that they used a urinal. Resident 1 stated that they needed staff assistance to

put them in their bed to comfortably use the urinal. Resident 1 stated that there were many times when they called for help, and staff did not respond to their call. Resident 1 stated that there was a time when they sat in their urine for a long time because staff never responded to hand them their urinal.

On 06/12/2025 at 1:25 PM, observation showed Resident 1 activated their call light. Observation showed no staff responded to the call light request. Observation showed staff only responded when the state investigator personally informed Staff D that Resident 1 needed to urinate and needed to be transferred to their bed first.

On 06/12/2025 at 1:31 PM, Staff C, Med tech, stated that when a resident pulled their emergency pull cord for help, the call activated the staff's pagers. The staff then responded immediately unless they were helping another resident. When staff were busy with another resident, staff needed to ask for help from other staff members. Staff C stated that they only had two pagers. One pager was for the Med tech and the other pager was for a Caregiver. Staff C stated that they did not have their pager with them. Staff C stated that they left the pager at their medication cart when they went to use the bathroom. Staff C stated that the pagers were supposed to always be in the possession of the staff.

On 06/12/2025 at 1:32 PM, observation showed Staff C looked for their pager. Staff C came out from the medication room with their pager.

On 06/12/2025 at 1:34 PM, Staff D, caregiver, stated that they did not have their pager with them. Staff D stated that they forgot to get the pager from their breakroom. Staff D stated that the pagers' battery was dead. Staff D stated that there were not enough pagers for all the staff. Staff D stated that there were only two pagers available for the bottom floor staff.

On 06/12/2025 at 1:37 PM, observation showed Staff D went to the breakroom and obtained their pager. Observation showed staff tried to turn the pager on and there was no power. Staff D left the area and returned with a working pager. During an interview at this time, Staff D stated that they replaced the battery.

Resident 2
Review of the face sheet showed the facility admitted Resident 2 on [redacted]/2023.

On 07/15/2025 at 2:32 PM, Resident 2 stated that they frequently used the pull cord and called for help. Resident 2 stated that staff often did not come and respond to their request for help.

On 07/15/2025 at 2:34 PM, observation showed Resident 2's emergency pull cord worked. Observation showed staff did not respond for over 36 minutes and not until the

state investigator (SI) informed staff that Resident 2 need assistance.

Resident 3
Review of the face sheet showed the facility admitted Resident 3 on [redacted]/2025.

On 07/15/2025 at 2:44 PM, Resident 3 stated that they did not know if their pull cord worked because they no longer used it. Resident 3 stated that the staff do not come when they pull their pull cord. Resident 3 stated that felt lucky if staff responded.

On 07/15/2025 at 2:45 PM, the state investigator pulled Resident 3's emergency pull cord. There were two beeps and then a steady light came on. No staff responded for over 33 minutes and not until the state investigator informed staff that Resident 3 required assistance.

On 07/15/2025 at 3:18 PM, Staff A, Executive Director stated that they cleared the pagers, and they were working. Staff A stated that Resident 2 and Resident 3 were independent in their care needs and would not use their emergency pull cords for help anyway.

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, Everett Heritage Court is or will be in compliance with this law and / or regulation on (Date) 9/1/2025.

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

Administrator (or Representative) — Date: 8/10/2025

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:

state investigator (SI) informed staff that Resident 2 need assistance.

Resident 3
Review of the face sheet showed the facility admitted Resident 3 on [redacted]/2025.

On 07/15/2025 at 2:44 PM, Resident 3 stated that they did not know if their pull cord worked because they no longer used it. Resident 3 stated that the staff do not come when they pull their pull cord. Resident 3 stated that felt lucky if staff responded.

On 07/15/2025 at 2:45 PM, the state investigator pulled Resident 3's emergency pull cord. There were two beeps and then a steady light came on. No staff responded for over 33 minutes and not until the state investigator informed staff that Resident 3 required assistance.

On 07/15/2025 at 3:18 PM, Staff A, Executive Director stated that they cleared the pagers, and they were working. Staff A stated that Resident 2 and Resident 3 were independent in their care needs and would not use their emergency pull cords for help anyway.

Plan/Attestation Statement

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

_____ _____
Administrator (or Representative) Date

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 facility failed to document the findings and actions from the facility's investigation when 1 of 1 resident (Resident 1) left the facility unnoticed and unsupervised. This failure placed Resident 1 at risk for harm and injury, and potential abuse.

Findings included…

Review of the facility's policy titled, "Incident Investigation and Reporting", dated 02/15/2024, showed the facility would ensure the safety and well-being of their residents. The investigations would include who, what, when, why and how. The facility would document and implement ongoing preventative measures.

Review of policy titled, "Incident Investigation and Reporting" dated 02/15/2024 showed the ALF would ensure the safety and well-being of their residents. The investigations would include who, what, when, why and how. The ALF would document and implement ongoing preventative measures.

Review of an undated Face sheet showed the facility admitted Resident 1 on [redacted]/2025 with multiple diagnoses including [redacted] and [redacted]

Review of the facility's document titled "Occurrence Report" dated 06/30/2025 showed Resident 1 left the facility without awareness.

Review of Resident 1's Progress notes dated 06/30/2025 showed Resident 1 was found in a hotel which was about 0.8 miles away from the ALF.

On 07/15/2025 at 1:47 PM, Staff B, Health and Wellness Director, stated that they were unable to determine how Resident 1 left the facility. Staff B stated that since they were unable to determine how Resident 1 got out of the building, they ruled out neglect.

On 07/15/2025 at 1:55 PM, when asked where the documentation was that showed the facility conducted a thorough investigation and showed they ruled out neglect, Staff B would not answer the question.

On 07/15/2025 at 1:57 PM, Staff A, Executive Director stated that the facility was not neglectful because they were unable to determine how Resident 1 was able to leave the facility. Staff A stated that they suspected Resident 1 used the back door. When asked where the facility investigation was that showed they conducted a thorough

investigation, Staff A would not answer.

This is a recurring citation previously cited on 07/22/2024 for subsections (1), (2), (3), and (4) and on 06/01/2023 for subsections (1), (2), and (3).

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, Everett Heritage Court is or will be in compliance with this law and / or regulation on (Date) 9/1/2025

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

Administrator (or Representative) — Date: 8/10/25

investigation, Staff A would not answer.

This is a recurring citation previously cited on 07/22/2024 for subsections (1), (2), (3), and (4) and on 06/01/2023 for subsections (1), (2), and (3).

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date