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

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

RE: Everett Heritage Court License # 2612

Dear Administrator:

This letter addresses Compliance Determination(s) 70876 (Completion Date 01/05/2026) and 67680 (Completion Date 11/04/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/05/2026 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-2170-1

The Department staff who did the on-site verification:
Steven Kindle, Nursing Consultant Institutional
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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Everett Heritage Court
Provider Type: Assisted Living Facility

License/Cert.#: 2612
Intake ID: 196298
Compliance Determination #: 67680
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 10/23/2025 through 11/04/2025
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) went missing.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Activities Staff to resident interactions Resident to resident interactions secured exit doors Traffic Roads
Interviews:	Residents Identified resident Nursing staff Maintenance staff
Record Reviews:	Incident investigation Facility policies Assessments Care plan

Investigation Summary:
The facility failed to ensure the safety of the Named Resident (NR) when a secured exit door was remained unlocked. The NR was believed to have exited the unlocked door and went missing. The facility failed to follow their policy when it did not conduct a regular elopement drills as defined by their policy. The facility Health and Wellness Director stated they were to do a monthly elopement drills. Failed practices were identified and the facility was issued citations for noncompliance with WAC 388-78A-2170 (1). Required assisted living facility services.

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

Conclusion / Action:

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

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 10/23/2025 of:

Everett Heritage Court
4230 Colby Ave
Everett, WA 98203

This document references the following complaint number(s): 196298

The following sample was selected for review during the unannounced on-site visit: 2 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 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 #: 2612	Compliance Determination # 67680
Plan of Correction	Everett Heritage Court	Completion Date
Page 2 of 4	Licensee: Greenlake Management Everett, LLC	11/04/2025

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

Jim Sherman
Residential Care Services

11-04-2025
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)

11/5/2025
Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to ensure the safety and well-being for 1 of 1 resident (Resident 1) who left the facility unsupervised through an unlocked memory care unit secured exit door. This failure resulted in Resident 1 going missing and placed Resident 1 at risk of harm, injury and abuse.

Findings included...

Review of facility policy dated titled "Elopement- Prevention for Memory care" and 02/15/2024 showed the memory care community was designed and maintained to prevent elopements.

Resident 1

Review of face sheet showed Resident 1 moved to the facility on [redacted]/2025 with multiple diagnoses including [redacted].

Review of Move in Assessment dated 07/24/2025 showed Resident 1 was assessed

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

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

11-04-2025
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)

Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to ensure the safety and well-being for 1 of 1 resident (Resident 1) who left the facility unsupervised through an unlocked memory care unit secured exit door. This failure resulted in Resident 1 going missing and placed Resident 1 at risk of harm, injury and abuse.

Findings included...

Review of facility policy dated titled "Elopement- Prevention for Memory care" and 02/15/2024 showed the memory care community was designed and maintained to prevent elopements.

Resident 1

Review of face sheet showed Resident 1 moved to the facility on [redacted]/2025 with multiple diagnoses including [redacted].

Review of Move in Assessment dated [redacted]/2025 showed Resident 1 was assessed

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

having elopement potential.

Review of Service Plan (SP) dated 08/24/2025 showed Resident 1 had Severe cognitive Impairment. Resident 1 was frequently disoriented and required frequent supervision and oversight from the staff. Staff were to maintain Resident 1 in common areas when awake. The SP showed Resident 1 had extensive wandering behavior issues. Resident 1 wanders outside and leaves immediate area. Resident 1 had history of leaving immediate area, getting lost, or being combative about returning. Staff would try and keep Resident 1 in common areas.

Review of facility Occurrence Report (Report) dated 09/25/2025 showed Resident 1 was discovered missing on 09/25/2025 at 5:00 PM. The report showed Resident 1 was found by the Police on a nearby cemetery at 6:50 PM and returned to the facility. The report showed a door was unlocked.

Observation on 10/23/2025 at 12:41 PM showed the facility had a memory care unit secured exit door (equipped with an alarm system and opened with the use of a key) located on the first floor of the building past the fireplace and by the hallway. The door, when opened, exits on the side of the building and leads to a multi-lane street. The door was equipped with two alarm systems. One was wired which was built in with the door and a secondary battery-operated alarm system. Both alarms were engaged and activated by a physical key. The alarms were engaged when the doors were locked and disarmed when unlocked and opened with a key.

On 10/23/2025 at 11:27 AM, Staff B, Health and Wellness Director, stated that they honestly believed Resident 1 exited the secured exit door located at the first-floor hallway near the fireplace. Staff A stated that the door was used by staff as an exit to throw trash outside in their dumpster. Staff A stated they believed the door was unlocked and the alarm did not activate.

On 10/23/2025 at 12:20 PM, Staff C, Med tech, stated that Resident 1 was discovered missing when it was dinner time. Staff A stated that they did not know Resident 1 was an elopement risk, but they knew Resident 1 wanders around and within the facility. Staff C stated that Resident 1 exited the secured door by the hallway. Staff A stated they did not hear any alarm being activated. Staff C stated that they checked the exit door at around 2:30 PM during the day and before the incident.

On 10/23/2025 at 12:26 PM, Staff D, Caregiver, stated that Resident 1 wanders and staff needed to stay with them when not in bed. Staff D stated that they did not know Resident 1 was an elopement risk. Staff D stated that they believed Resident 1 does not have exit-seeking behavior but wanders and would go around other residents' room pushing doors.

On 10/23/2025 at 12:31 PM, Staff E, Caregiver, stated that they were assigned with

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

Statement of Deficiencies	License #: 2612	Compliance Determination # 67680
Plan of Correction	Everett Heritage Court	Completion Date
Page 4 of 4	Licensee: Greenlake Management Everett, LLC	11/04/2025

Resident 1 at the time of the incident. Staff E stated that Resident 1 wanders and walks around the hallway. Staff E stated that Resident 1 showed exit-seeking behavior and would go push doors including other residents' doors. Staff E stated that before the incident, they went to check the secured exit door at 3:00 PM. Staff E stated that they did not check the door anymore after 3:09 PM. Staff E stated that after they checked the secured exit door, they were at the Dining Room with Resident 1 seated with other residents. Staff E stated that they stood up and left Resident 1 to get juice. Staff E stated they noticed that Resident 1 stood up and walked away from the chair. Staff E stated that they did not follow Resident 1 because they thought Resident 1 would just go walk in the hallway as they would usually do. Staff E stated they noticed Resident 1 was missing around 4:45 PM when they were looking for them for dinner.

On 10/23/2025 at 12:53 PM, Staff G, Caregiver, stated that they were the ones that discovered the secured exit door lights were not blinking. Staff G stated that when the secured exit door lights were not blinking or off, it meant the secured exit door was unlocked. Staff G stated that they observed Resident 1 pushing doors.

On 10/23/20205 at 12:39 PM, Staff F, Maintenance Director, stated that the secured exit door was equipped with two alarm systems. One was the wired and built in alarm and secondary and battery-operated alarm systems purposely installed by the facility as a backup alarm. Staff F stated that when the door was pushed both alarms would be activated. Staff F stated that to disable the alarms, the Care staff would have to use a key to open the door. Staff F stated that when the exit door was engaged and alarmed, there would be blinking lights seen. Staff F stated that when the exit door was unlocked, the blinking lights disappeared.

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) 12/19/2025

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

Administrator (or Representative) Susie Day Date 11/5/2025

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

Resident 1 at the time of the incident. Staff E stated that Resident 1 wanders and walks around the hallway. Staff E stated that Resident 1 showed exit-seeking behavior and would go push doors including other residents' doors. Staff E stated that before the incident, they went to check the secured exit door at 3:00 PM. Staff E stated that they did not check the door anymore after 3:00 PM. Staff E stated that after they checked the secured exit door, they were at the Dining Room with Resident 1 seated with other residents. Staff E stated that they stood up and left Resident 1 to get juice. Staff E stated they noticed that Resident 1 stood up and walked away from the chair. Staff E stated that they did not follow Resident 1 because they thought Resident 1 would just go walk in the hallway as they would usually do. Staff E stated they noticed Resident 1 was missing around 4:45 PM when they were looking for them for dinner.

On 10/23/2025 at 12:53 PM, Staff G, Caregiver, stated that they were the ones that discovered the secured exit door lights were not blinking. Staff G stated that when the secured exit door lights were not blinking or off, it meant the secured exit door was unlocked. Staff G stated that they observed Resident 1 pushing doors.

On 10/23/20205 at 12:39 PM, Staff F, Maintenance Director, stated that the secured exit door was equipped with two alarm systems. One was the wired and built in alarm and secondary and battery-operated alarm systems purposely installed by the facility as a backup alarm. Staff F stated that when the door was pushed both alarms would be activated. Staff F stated that to disable the alarms, the Care staff would have to use a key to open the door. Staff F stated that when the exit door was engaged and alarmed, there would be blinking lights seen. Staff F stated that when the exit door was unlocked, the blinking lights disappeared.

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

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