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

US Alliance Holden of Bellevue Tenant, LLC
The Watermark at Bellevue
121 112th Ave NE
Bellevue, WA 98004

RE: The Watermark at Bellevue License # 2626

Dear Administrator:

This letter addresses Compliance Determination(s) 75835 (Completion Date 04/15/2026) and 72283 (Completion Date 02/13/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/15/2026 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-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2305-1, WAC 246-215-02310-5, WAC 388-78A-2474-2-e, WAC 388-112A-0611-1-a-iii, WAC 388-78A-2320-2-b, WAC 388-78A-2320-2-e, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2090-1-a, WAC 388-78A-2090-6-e

The Department staff who did the on-site verification:
Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit D

Residential Care Services

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

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

The department completed data collection for the unannounced on-site full inspection on 02/02/2026 and 02/05/2026 of:

The Watermark at Bellevue
121 112th Ave NE
Bellevue, WA 98004

The following sample was selected for review during the unannounced on-site visit: 9 of 93 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

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

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

Jim Sherman
Residential Care Services

02-24-2026
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)

3/5/2026.
Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 11 sampled staff (Staff D) for tuberculosis (TB) within three days of hire as required and failed to perform a second TB test one to three weeks after the first test for 1 of 1 sampled staff (Staff A) for TB. This failure placed 93 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's policy titled, "Risk Management – Associates TB Testing for Associates" dated 10/18/2024 showed that the staff were required to complete a one-step TB test within three days of their first paid shift. The policy showed a second-step TB test was to be followed within one to three weeks after the first test if the initial TB test results were negative for TB.

ONE-STEP TB TEST

STAFF D
Review of the facility's Employee Roster showed that the facility hired Staff D,

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-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to test 1 of 11 sampled staff (Staff D) for tuberculosis (TB) within three days of hire as required and failed to perform a second TB test one to three weeks after the first test for 1 of 1 sampled staff (Staff A) for TB. This failure placed 93 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included…

Review of the facility's policy titled, "Risk Management – Associates TB Testing for Associates" dated 10/18/2024 showed that the staff were required to complete a one-step TB test within three days of their first paid shift. The policy showed a second-step TB test was to be followed within one to three weeks after the first test if the initial TB test results were negative for TB.

ONE-STEP TB TEST

STAFF D
Review of the facility's Employee Roster showed that the facility hired Staff D,

Medication Technician (unlicensed staff who dispense medications), on 10/03/2025.

Review of Staff D's employee records showed that Staff D was administered an initial one-step TB test on 10/08/2025 eight days after hire.

During an interview on 02/05/2025 at 1:30 PM, Staff T, Human Resource Director, stated that Staff D's TB test was done late and not within the required time frame.

TWO-STEP TB TEST

STAFF A
Review of the facility's Employee Roster showed that the facility hired Staff A, Executive Director for the Assisted Living" on 02/15/2024.

Review of Staff A's employee records showed that Staff A was administered a one-step TB test on 02/16/2024 and read on 02/19/2024 with negative results. A second-step TB test was administered on 02/21/2024 two days after the first TB test. The second-step TB test was read on 02/23/2024 and showed a negative result of 5 millimeters (mm). Staff A's employee records showed a Chest X-Ray report dated 03/07/2024 that showed that there was no active TB.

During an interview on 02/04/2026 at 11:00 AM, Staff A, Executive Director for the Assisted Living facility, stated that they were not sure why the nurse at the time of their hire administered a second-step TB test so close to the one-step TB test instead of the required one to three weeks apart. Staff A stated that the nurse at the time acknowledged the second-step TB results of 5mm was within the negative parameters "but out of an abundance of caution" elected to have Staff A complete an X-Ray exam to rule out active TB.

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, The Watermark at Bellevue is or will be in compliance with this law and / or regulation on (Date) 3/30/2026.

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

Administrator (or Representative) Date 3/5/2026.

Medication Technician (unlicensed staff who dispense medications), on 10/03/2025.

Review of Staff D's employee records showed that Staff D was administered an initial one-step TB test on 10/08/2025 eight days after hire.

During an interview on 02/05/2025 at 1:30 PM, Staff T, Human Resource Director, stated that Staff D's TB test was done late and not within the required time frame.

TWO-STEP TB TEST

STAFF A
Review of the facility's Employee Roster showed that the facility hired Staff A, Executive Director for the Assisted Living" on 02/15/2024.

Review of Staff A's employee records showed that Staff A was administered a one-step TB test on 02/16/2024 and read on 02/19/2024 with negative results. A second-step TB test was administered on 02/21/2024 two days after the first TB test. The second-step TB test was read on 02/23/2024 and showed a negative result of 5 millimeters (mm). Staff A's employee records showed a Chest X-Ray report dated 03/07/2024 that showed that there was no active TB.

During an interview on 02/04/2026 at 11:00 AM, Staff A, Executive Director for the Assisted Living facility, stated that they were not sure why the nurse at the time of their hire administered a second-step TB test so close to the one-step TB test instead of the required one to three weeks apart. Staff A stated that the nurse at the time acknowledged the second-step TB results of 5mm was within the negative parameters "but out of an abundance of caution" elected to have Staff A complete an X-Ray exam to rule out active TB.

Plan/Attestation Statement

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_____ _____
Administrator (or Representative) Date

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(5) After handling soiled equipment or utensils;

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow proper sanitation procedures for 1 of 1 kitchen (Main Kitchen). This failure placed 93 residents at risk of consuming contaminated food and contracting food borne illnesses.

Findings included…

Review of the facility's "Infection Control Policy" dated 03/07/2022 showed that "policies, procedures and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment".

Review of the facility personnel files showed that the facility hired Staff O, Dishwasher, on 09/25/2025.

Observation on 02/03/2026 at 12:17 PM – 12:42 PM, showed Staff O worked in the dishwasher area of the main facility kitchen. Observation showed Staff O completed tasks that included dirty dishes and clean dishes. Observation showed Staff O wore gloves and removed food debris from dirty dishes with a scrub brush and a sprayer. Observation showed Staff O placed the dirty dishes in a dishwasher rack on the dirty side of the commercial dishwasher before the rack was inserted into the dishwasher to be cleaned and sanitized. Observation showed Staff O removed the dishwasher rack from the clean side of the dishwasher and proceeded to remove the clean dishes and utensils from the dishwasher rack and put them away. Observation showed Staff O did not change gloves or wash their hands in between the handling of the dirty and clean dishes.

Observation on 02/04/2026 at 12:30 – 1:00 PM, showed Staff O changed tasks from handling dirty dishes to handling clean dishes without washing their hands or changing their gloves. Observation showed Staff O removed food debris from the dirty dishes, then placed the dirty dishes and utensils in a dishwashing rack and inserted the rack into the commercial dishwasher. Observation showed Staff O removed the dishwasher rack on the clean side. Observation showed Staff O then removed the clean utensil, dishes, and pots and pans from the clean dish rack and put them away on various wired

shelves in the kitchen. Staff O was observed repeatedly changing tasks from dirty dishes to clean dishes without changing their gloves or washing their hands.

During an observation and interview on 02/04/2026 at 12:38 PM, Staff S, Executive Chef, stated that they observed Staff O failed to change gloves or wash hands between dirty dishes and clean dishes.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 3/5/2026

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:

(iii) A certified nursing assistant;

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled staff (Staff E) completed the Continuing Education (CE) training approved by the Department of Social and Health Services (DSHS) between their 2024 and 2025 birthdays. This failure placed the 93 Assisted Living residents at risk for receiving improper care from untrained staff persons.

shelves in the kitchen. Staff O was observed repeatedly changing tasks from dirty dishes to clean dishes without changing their gloves or washing their hands.

During an observation and interview on 02/04/2026 at 12:38 PM, Staff S, Executive Chef, stated that they observed Staff O failed to change gloves or wash hands between dirty dishes and clean dishes.

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

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled staff (Staff E) completed the Continuing Education (CE) training approved by the Department of Social and Health Services (DSHS) between their 2024 and 2025 birthdays. This failure placed the 93 Assisted Living residents at risk for receiving improper care from untrained staff persons.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 93 residents received Assisted Living services.

STAFF E
Review of the facility's undated employee list showed the facility hired Staff E, Lead Medication Asst. Technician, on 07/01/2023. Review of the facility's employee schedule showed Staff E provided personal care to the residents in the facility in January 2026.

Review of Staff E's employee records showed Staff E held an active Nursing Assistant Certification (NAC). The records showed Staff E's NAC was first issued on 05/12/2010. The records showed documentation that Staff E completed 5.5 hours of the required 12 hours of CE training approved by the DSHS, from their 2024 birthday to May 2025 birthday.

During an interview on 02/05/2026 at 2:45 PM, Staff T, Human Resources Director, stated that they were unaware Staff E completed the CE courses that were not approved by the DSHS. Staff T stated Staff E did not complete the required 12 hours of CE training between their 2024 and 2025 birthdays.

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, The Watermark at Bellevue is or will be in compliance with this law and / or regulation on (Date) 3/30/2026.

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

Administrator (or Representative) Date 3/5/2026.

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

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

Findings included…

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 93 residents received Assisted Living services.

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Review of the facility's undated employee list showed the facility hired Staff E, Lead Medication Asst. Technician, on 07/01/2023. Review of the facility's employee schedule showed Staff E provided personal care to the residents in the facility in January 2026.

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During an interview on 02/05/2026 at 2:45 PM, Staff T, Human Resources Director, stated that they were unaware Staff E completed the CE courses that were not approved by the DSHS. Staff T stated Staff E did not complete the required 12 hours of CE training between their 2024 and 2025 birthdays.

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-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to properly implement oxygen therapy through the Nurse Delegation (ND) services for 1 of 1 sampled resident (Resident 9). This failure placed Resident 9 at risk for treatment errors and potential medical complications.

Findings included…

Review of the facility's document titled "Health Services Registered Nurse Delegation-Washington", dated 01/20/2026, showed that the facility provided nurse delegation services in accordance with the Washington Administrative Code (WAC). The document listed that the Unlicensed Assistive Personnel (unlicensed staff who perform delegated nursing tasks when properly trained and supervised) was responsible for following RN instructions exactly and performing only delegated tasks for the specified resident.

Review of the facility's policy titled "Oxygen/Automatic Positive Airway Pressure (APAP)/Bilevel Positive Airway Pressure (BiPAP)/Continuous Positive Airway Pressure (CPAP)", dated 05/29/2024, showed that the facility staff was responsible to review the provider order and ensure "the equipment settings for the prescribed flow rates, modes, and or settings" for oxygen use.

Review of Resident 9's records showed that the facility admitted Resident 9 in [redacted] 2025 with a medical diagnosis of [redacted]. The records showed a physician order, dated 12/10/2025, of "oxygen (O2) gas, inhale two liters (L) per minute by mouth continuously if needed for dizziness and shortness of breath". The records showed that on 01/19/2026, the facility completed an assessment for Resident 9. The assessment showed that Resident 9 required assistance with oxygen management as ordered by physicians.

Review of Resident 9's Service Plan, dated 01/28/2026, showed that Resident 9 received oxygen management by Care Associates. The Service Plan showed that Resident 9's oxygen management included "tubing change, humidifier change, and oxygen rate settings" as captured on the electronic Medication Administration Record (EMAR)/Treatment Administration Record (TAR).

Review of the facility's ND documents showed that on 09/30/2025 and 12/17/2025, Staff U, Registered Nurse Delegator (RND), delegated Medication Technicians (trained, unlicensed staff who perform delegated nursing tasks) to administer continuous oxygen for Resident 9. The documents showed RND's instructions that instructed delegated staff to "apply oxygen at two liters per minute via nasal cannula continuous". The documents showed that on 12/17/2025, Staff U delegated Staff H, Medication Technician, administered oxygen for Resident 9.

Review of Resident 9's November 2025, December 2025, January 2026, and February 2026 EMARs showed a medical order of "check oxygen saturation every 8 hours and as needed". There was no documentation that showed the oxygen rate setting.

Observation inside Resident 9's apartment on 02/04/2026 at 1:28 PM showed Resident 9 sat in a recliner. Observation showed Resident 9 used a nasal cannula (device that delivers oxygen via a tube through the nose) to receive supplementary oxygen. Observation showed the nasal cannula was connected to an oxygen concentrator (a device that generates oxygen), which was placed on the floor in the living area. Observation showed the oxygen concentrator was set to deliver oxygen at two liters per minute. Observation showed Staff H assisted Resident 9 transfer from the recliner to the manual wheelchair. Observation showed that while Resident 9 was seated in the manual wheelchair, Staff H disconnected the nasal cannula from the oxygen concentrator and connected the nasal cannula to a portable oxygen machine. Observation showed the portable oxygen machine was set to deliver oxygen at three liters per minute. Observation showed Staff H maintained the oxygen at three liters per minute and propelled Resident 9 in the wheelchair out of the apartment. Observation showed Staff H did not verify the medical order and Staff H did not verify the oxygen rate setting on the portable oxygen machine.

Observation on 02/04/2025 at 2:10 PM showed Resident 9 was seated in the dining room. Observation showed Staff V, Resident Care Director, verified Resident 9's portable oxygen machine. Staff V confirmed that the oxygen rate of the portable oxygen machine was set at three liters per minute. During an interview at this time, Staff V stated that they did not set the oxygen rate of the portable oxygen machine correctly according to the physician order.

During an interview on 02/05/2026 at 12:47 PM, Staff H stated that Resident 9 used continuous oxygen at two liters per minute. Staff H stated that on 02/04/2026, they assisted Resident 9 with changing the oxygen from the oxygen concentrator inside the unit to the portable oxygen machine when Resident 9 went to the dining room. Staff H stated that yesterday they were unaware the portable oxygen machine was set to deliver oxygen at three liters per minute. Staff H stated that Resident 9 was given oxygen at three liters per minute when the resident was escorted to the dining room yesterday.

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 3/5/2026

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Service Plan for 3 of 9 sampled residents (Resident 1, Resident 3, and Resident 9). This failure placed Resident 1, Resident 3, and Resident 9 at risks for unmet care needs and potential for worsening medically diagnosed conditions.

Findings included...

Review of the facility's policy titled "Oxygen/Automatic Positive Airway Pressure (APAP)/Bilevel Positive Airway Pressure (BiPAP)/Continuous Positive Airway Pressure (CPAP)", dated 05/29/2024, showed that the facility "provided assistance with respiratory care and services according to professional standards of practice". The policy showed that the facility's staff were required to follow the manufacturer's guidelines for the medical equipment utilized for oxygen and CPAP machines (a device that helps a person breathe). The policy showed that the "direct care associates" (caregivers) would be trained in the use of the medical equipment. The policy showed that the facility's staff were responsible to review the provider order and ensure "the equipment settings for the prescribed flow rates, modes, and/or settings". The document showed that the facility staff was responsible to identify interventions for the oxygen use or the CPAP use in the service plan and review for specific tasks.

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-2130 Service agreement planning. The assisted living facility must:

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update the Service Plan for 3 of 9 sampled residents (Resident 1, Resident 3, and Resident 9). This failure placed Resident 1, Resident 3, and Resident 9 at risks for unmet care needs and potential for worsening medically diagnosed conditions.

Findings included…

Review of the facility’s policy titled “Oxygen/Automatic Positive Airway Pressure (APAP)/Bilevel Positive Airway Pressure (BiPAP)/Continuous Positive Airway Pressure (CPAP)”, dated 05/29/2024, showed that the facility “provided assistance with respiratory care and services according to professional standards of practice”. The policy showed that the facility’s staff were required to follow the manufacturer’s guidelines for the medical equipment utilized for oxygen and CPAP machines (a device that helps a person breathe). The policy showed that the “direct care associates” (caregivers) would be trained in the use of the medical equipment. The policy showed that the facility’s staff were responsible to review the provider order and ensure “the equipment settings for the prescribed flow rates, modes, and/or settings”. The document showed that the facility staff was responsible to identify interventions for the oxygen use or the CPAP use in the service plan and review for specific tasks.

RESIDENT 1
Review of Resident 1's records showed that the facility admitted Resident 1 in [redacted] of 2024 with the medical diagnoses of [redacted] and [redacted]. The records showed that Resident 1 was on hospice care services (end of life care). The records showed that Resident 1 used medical devices.

Observation on 02/03/2026 at 2:30 PM, showed Collateral Contact 1 (CC1), Hospice Registered Nurse, provided wound care to multiple blister wounds located on Resident 1's arms and heels. Observation showed Resident 1 wore heel protectors on both heels to prevent pressure sores. Observation showed Resident 1 laid on a pressure relief overlay air mattress (an air mattress to prevent skin breakdown) that was placed on top of a hospital bed mattress. The air mattress was observed to be deflated by both the Department Licensor and CC1. Observation showed two quarter-length bedrails were attached, one bedrail on each side of the head of the hospital bed.

Observation and interview on 02/03/2026 at 2:30 PM, showed that CC1 bent down to access the air pump for the pressure relieving air mattress underneath Resident 1's hospital bed and discovered the air pump was turned off. CC1 stated that the pressure relief overlay air mattress pump was turned off.

Review of the CC1's hospice care visit notes, dated 02/03/2026 at 2:24 PM, showed that during CC1's visit the "pressure relief overlay noted to be off. Discussed with the facility staff, it appears it could have fallen off the bed and switch was turned off. Reinforced checking it during each interaction in patient (Resident 1's) room (sic)."

Review of Resident 1's Service Plan Report, signed on 11/01/2025, did not show Resident 1 used a pressure relief overlay air mattress and did not provide instructions for the caregivers to ensure the mattress remained inflated. The Service Plan did not show Resident 1 wore heel protectors and used bed rails, and there were no instructions provided to the caregivers.

During an interview on 02/04/2026 at 3:00 PM, Staff W, Resident Care Director-Memory Care, stated acknowledgement that the pressure relief overlay air mattress, heel protectors, and bed rails were not identified on Resident 1's Service Plan. Staff W stated that there were no instructions provided. Staff W stated that Resident 1 was bed bound and did not get out of bed.

RESIDENT 3
Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2025 with the medical diagnoses of [redacted] and [redacted]. The records showed that Resident 3 received hospice care services.

Observation on 02/04/2026 at 2:37 PM, showed Resident 3 laid in a hospital bed on a pressure relief overlay air mattress. Two half-length bedrails were observed, one bedrail on each side of the head of the bed. Observation showed Resident 3 wore heel protectors on both heels. A CPAP machine, with hose and mask connections attached, was placed on top of the nightstand.

Review of Resident 3's records showed a Hospice certification and plan of care, dated 12/13/2025, that showed an order for Resident 3 to use a CPAP machine while asleep.

During an interview on 02/04/2026 at 2:37 PM, Collateral Contact 2 (CC2), Private Caregiver, stated that Resident 3 used the CPAP machine at night.

Review of Resident 3's "Service Plan Report" dated 01/29/2026, did not show Resident 3 used a pressure relieving air mattress, bed rails, or heel protectors. There were no instructions for the caregivers to ensure that the medical devices were used correctly. The service plan report did not show who was responsible to ensure the CPAP was maintained properly. The service plan did not show who placed the mask on Resident 3, who turned on the CPAP machine, who filled the humidifier chamber with distilled water, who rinsed and cleaned the tubing, mask, humidifier chamber, and who changed the air filter when needed.

During an interview on 02/04/2026 at 02:25 PM, Staff V, Resident Care Director-Assisted Living, stated that CC2 managed the CPAP machine. Staff V reviewed Resident 3's current Service Plan Report. Staff V stated that no documentation in Resident 3's Service Plan showed Resident 3 used the medical devices and who managed the CPAP for Resident 3.

RESIDENT 9
Review of Resident 9's records showed that the facility admitted Resident 9 in [redacted] 2025 with a medical diagnosis of [redacted]. The records showed a physician order, dated 12/10/2025, of "oxygen (O2) gas, inhale two liters (L) per minute by mouth continuously if needed for dizziness and shortness of breath". The records showed that on 01/19/2026, the facility completed an assessment for Resident 9. The assessment showed that Resident 9 required assistance with oxygen management as ordered by physicians.

Review of Resident 9's Service Plan, dated 01/28/2026, showed that Resident 9 received oxygen management by Care Associates. The Service Plan showed that Resident 9's oxygen management included "tubing change, humidifier change, and oxygen rate settings as captured on the electronic Medication Administration Record (EMAR)/Treatment Administration Record (TAR)".

Review of Resident 9's November 2025, December 2025, January 2026, and February

2026 EMARs showed a medical order of "check oxygen saturation every 8 hours and as needed". There was no documentation that showed the order and instructions for "tubing change, humidifier change, and oxygen rate setting", as indicated in the resident's Service Plan.

During an interview on 02/04/2026 at 3:00 PM, Staff V stated that the facility's system showed Resident 9's most recent service plan was completed on 01/19/2026. Staff V stated that there was no oxygen rate setting documented on Resident 9's service plan.

Staff H, Medication Technician, failed to verify the oxygen flow rate on the portable oxygen machine. Refer to Washington Administrative Code (WAC) 388-78A-2320(2)(b)(e) in this report.

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, The Watermark at Bellevue is or will be in compliance with this law and / or regulation on (Date) 3/30/2026.

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

Administrator (or Representative) 3/5/2026 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 6 sampled residents (Resident 1, Resident 4, Resident 5, Resident 6, and Resident 7) with a medical device were assessed for their ability to safely use the medical devices. The facility failed to ensure 1 of 1 sampled resident's (Resident 8) wound was assessed. The

2026 EMARs showed a medical order of “check oxygen saturation every 8 hours and as needed”. There was no documentation that showed the order and instructions for “tubing change, humidifier change, and oxygen rate setting”, as indicated in the resident’s Service Plan.

During an interview on 02/04/2026 at 3:00 PM, Staff V stated that the facility’s system showed Resident 9’s most recent service plan was completed on 01/19/2026. Staff V stated that there was no oxygen rate setting documented on Resident 9’s service plan.

Staff H, Medication Technician, failed to verify the oxygen flow rate on the portable oxygen machine. Refer to Washington Administrative Code (WAC) 388-78A-2320(2)(b)(e) in this report.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 5 of 6 sampled residents (Resident 1, Resident 4, Resident 5, Resident 6, and Resident 7) with a medical device were assessed for their ability to safely use the medical devices. The facility failed to ensure 1 of 1 sampled resident’s (Resident 8) wound was assessed. The

facility failed to ensure 1 of 1 sampled resident (Resident 9) with a medical diagnosis of [redacted] was assessed. These failures placed Resident 1, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9 at risk for possible injury and unmet care needs.

Findings included…

Note: Washington Administrative Code (WAC) 388-78A-2090, 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.

Review of the facility's "Risk Management – Residents Bedside Mobility Device", dated 06/01/2023, showed that the facility did not permit bedside rails without a physician's order. The document showed that the bedside rails must be included in the resident's care plan. The document showed that the facility was responsible to document the order in the resident records, complete a safety review, and obtain the consent from the resident or power of attorney prior for approval, ordering, or installation of the bedside mobility device. The document showed that the facility was responsible for evaluating the bedside rail quarterly.

MEDICAL DEVICES
RESIDENT 1
Review of the facility's "Resident Characteristic Roster" dated 01/20/2026 showed the facility admitted Resident 1 in [redacted] of 2024 with a diagnosis of [redacted] and [redacted]. The Resident characteristic Roster showed that Resident 1 was on Hospice care services (end of life care). The Resident Characteristic Roster showed that Resident 1 used medical devices.

Observation on 02/03/2026 at 2:30 PM, showed Resident 1 laid in a hospital bed with two half-length bedrails attached to the head of the bed, one bedrail attached to each side of the bed and covered with a fabric cover.

Review of Resident 1's records found no medical device assessments for the bedrails.

During an interview on 02/04/2026 at 4:00 PM, Staff W , Resident Care Director-Memory Care, stated that they were aware Resident 1 used bedrails. Staff W stated that they were unable to locate Resident 1's medical device assessment for the bedrails . Staff W,

stated that the Licensed Nurse was responsible for the medical device assessments.

RESIDENT 4
Review of the facility's "Resident Characteristic Roster" dated 01/20/2026 showed that the facility admitted Resident 4 in [redacted] of 2024 with the diagnoses of [redacted], and [redacted].

Observation on 02/04/2026 at 1:24 PM showed Resident 4 seated in a power wheelchair. Observation showed two half-length bedrails attached to the head of a hospital bed, one bedrail attached to each side of the bed and covered with a fabric cover. One bedrail was in the lowered position. Observation showed a trapeze bar located at the head of the hospital bed.

During an interview on 02/04/2026 at 1:24 PM, Resident 4 stated that they used the bedrails and trapeze bar for bed mobility and to get out of bed. Resident 4 stated that they used the trapeze bar to pull themselves up in bed.

Review of Resident 4's records showed that on 12/17/2025, the facility completed an assessment for Resident 4. The assessment showed Resident 4 used a hospital bed with "bilateral enabler (bedrails) and a trapeze bar for independence with bed mobility and skin integrity". The assessment did not show if the bedrails and trapeze bar were secured, with no entrapment-like qualities. There was no documentation that showed the facility assessed Resident 4 to determine Resident 4's ability for safe use of the bedrails and trapeze bar.

During an interview on 02/04/2026 at 2:25 PM, Staff X, Resident Care Coordinator, stated that they were unable to locate the medical device assessment for Resident 1 and Resident 4's bedrail and Resident 4's trapeze in the resident records.

RESIDENT 5
Observation inside Resident 5's apartment on 02/03/2026 at 4:23 PM showed two half-length bedrails attached to the head of the bed, one bedrail attached to each side of the bed and covered with a fabric cover. The bedrails were in the lower position. During an interview at this time, Staff W stated that their staff put the bedrails down in the daytime and put the bedrails up when Resident was in bed at night. Staff W stated that Resident 5 used the bedrails for bed mobility.

Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2024. The records showed that 11/15/2024, Resident 5 received a physician order for the bedrails for mobility of getting in and out of bed. The records showed that on 11/20/2025, the facility completed an assessment for Resident 5. There was no documentation that showed the facility assessed Resident 5 for the safety of the bedrails use.

During an interview on 02/04/2026 at 3:52 PM, Staff W stated that they were aware Resident 5 was using the bedrails. Staff W stated that they were unable to locate the medical device assessment for Resident 5's bedrails.

RESIDENT 6
Observation inside Resident 6's bedroom showed a quarter-length bedrail, covered with a fabric cover, was attached to the right side of the head of the bed. There was a three-inches gap between the bedrail and the mattress. Observation showed the bedrail was up. Observation showed Resident 6 was not in bed. During an interview at this time, Collateral Contact 3 (CC3), Resident 6's family member, stated that the bedrail was installed on the right side of the head of the bed. CC3 stated that Resident 6 used the bedrail to get in and out of the bed from the right side of the bed.

Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2024 with a medical diagnosis of [redacted]. The records showed that on 06/05/2025, Resident 6 received a physician order for the bedrail. The physician order showed the recommendation of placing the bedrail on the resident's left side of the bed. The records showed that on 01/28/2026, the facility completed an assessment for Resident 6. There was no documentation that showed the facility assessed Resident 6 for the safety of the bedrail use.

During an interview on 02/04/2026 at 1:49 PM, Staff X stated that the facility's system showed an order of bedrail which was dated 06/05/2025. Staff X stated that they were unable to locate the medical device assessment for the Resident's bedrail in the resident records.

RESIDENT 7
Observation inside Resident 7's apartment showed a quarter-length bedrail, covered with a fabric cover, was attached to the right side of the head of the bed. There was a three-inches gap between the bedrail and the mattress. The bottom end of the bedrail was inserted between the mattress and the bed frame.

Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2025 with a medical diagnosis of [redacted]. The records showed that on 10/10/2025, the facility completed an assessment for Resident 7. There was no physician order of bedrail. There was no documentation that Resident 7 required to use a bedrail. There was no documentation that showed the facility assessed Resident 7 for the safety of the bedrail use.

During an interview on 02/04/2026 at 2:45 PM, Staff V, Resident Care Director-Assisted Living, stated that they were unable to locate the medical device assessment for the Resident's bedrail in the resident records.

During an interview on 02/05/2026 at 2:30 PM, Staff V stated that Resident 7's family

member put in the bedrail for Resident 7 about a week ago. Staff V stated that they were unaware of Resident 7 using a bedrail. Staff V stated that they recommended Resident 7 to take the bedrail down while they would obtain a physician's order of the bedrail.

WOUND ASSESSMENT
RESIDENT 8
Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2025. The records showed that on 10/07/2025, the facility completed an assessment for Resident 8. The assessment showed that Resident 8 had no skin breakdown or wound. The assessment showed Resident 8 required assistance with Care Associates "reporting skin issues or wounds to nurse". Review of Resident 8's Service Plan Report, dated 10/08/2025, showed that the facility's Care Associates were responsible to report any new skin issues or wounds.

Review of Resident 8's wound clinic visit summary, dated 11/03/2025, showed that on 11/03/2025, Resident 8 attended the wound clinic. The visit summary showed that Resident 8 had a right lower limb ulcer (open wound on the skin). The visit summary listed the wound clinic provider's instructions for the facility's nurse. The visit summary showed that Resident 8's follow-up visits were scheduled for 11/10/2025, 11/17/2025, and 11/24/2025.

Review of Resident 8's progress notes, dated between 11/01/2025 and 02/03/2026, showed that on 11/03/2025, Resident 8 attended the wound clinic and received wound care instructions. The progress notes showed that on 11/06/2025, the facility's nurse changed the right lower leg dressing. The progress notes showed that on 11/13/2025, Resident 8 had "open sores"; and that the facility's nurse cleansed the wound, applied topical, and applied dressing. The progress notes showed no documentation of Resident 8's skin condition of the right lower limb ulcer after 11/13/2025.

Further review of Resident 8's records showed no documentation that showed the facility assessed Resident 8's right lower limb ulcer. There was no documentation that Resident 8 received wound management service from the wound clinic. There was no documentation that showed the wound clinic provider's instructions for the facility's nurse.

During an interview on 02/04/2026 at 3:00 PM, Staff V stated that the facility's system showed Resident 8's most recent assessment was completed on 10/07/2025 and their service plan was completed on 10/08/2025. Staff V stated that their licensed nurse was responsible to assess the resident. Staff V stated that they did not find any documentation that showed the nurse assessed Resident 8, when Resident 8 developed a wound on the right lower leg in November 2025. Staff V stated that they were unable to locate additional documentation about the resident's wound condition after 11/13/2025.

During an interview on 02/05/2026 at 1:00 PM, Staff P, Licensed Practical Nurse (LPN),

stated that they were aware Resident 8 had a right lower limb ulcer and required wound management in November 2025. Staff P stated that they were aware Resident 8 received wound management from the wound clinic. Staff P stated that they did not complete an assessment and they did not update Resident 8's service plan when Resident 8 developed a wound in November 2025. Staff P stated that they last observed Resident 8's wound on the right lower limb sometime in late December 2025 and they did not remember the exact date. Staff P stated that in late December 2025, Resident 8's wound was healed and Resident 8 no longer required dressing to the wound. Staff P stated that they did not document their observations of Resident 8's wound in the resident records. Staff P stated that they were unable to locate any documentation about Resident 8's wounds after 11/13/2025 in the facility's system.

MEDICAL DIAGNOSIS
RESIDENT 9
Review of Resident 9's records showed that the facility admitted Resident 9 in [redacted] 2025 with a medical diagnosis of [redacted].

Review of Resident 9's November 2025, December 2025, January 2026, and February 2026 Electronic Medication Administration Records (EMARs) showed that Resident 9's medication orders included phenytoin (a medication that controls and prevent seizures) 100 milligram (MG), one capsule by mouth three times daily for epilepsy and Primidone (a medication that controls seizures) 250 MG, one tablet by mouth two times daily for epilepsy.

Review of Resident 9's records showed that on 01/29/2026, the facility completed an assessment for Resident 9. There was no documentation in the assessment of Resident 9's [redacted] diagnosis and type of seizures. There was no documentation in the assessment of the signs and symptoms of epilepsy for staff to monitor. There was no documentation of the interventions required by staff if Resident 9 experienced a seizure.

During an interview on 02/05/2026, Staff P stated that they were unaware Resident 9 had an [redacted] diagnosis and received medication for epilepsy. Staff P stated that they were unaware of the signs and symptoms of Resident 9 when the resident experienced seizure. Staff P stated that they did not document the residents' epilepsy, the signs and symptoms, and the interventions to guide staff when a resident experienced a seizure.

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) 3/5/2026 Date

WAC 388-78A-2090 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:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 sampled resident (Resident 3) with a medical condition was assessed for seizure activity and assessed for a medical device for safe and proper use of the device within 14 days of admission. The facility also failed to ensure the device was safely installed for use and secured to prevent any entrapment. These failures placed Resident 3 at risk of compromised health, entrapment and injury.

Findings included...

BEDSIDE RAIL
Review of the facility's document titled "Risk Management – Residents Bedside Mobility Device" dated 06/01/2023, showed that bedrails were not permitted in the facility "without a physician's order and must be included in the resident's care plan". The policy showed that bedside rails are assessed for safety upon admission. The policy showed that the beside rail order "shall include the medical symptom being treated,

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Administrator (or Representative) Date

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(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 sampled resident (Resident 3) with a medical condition was assessed for seizure activity and assessed for a medical device for safe and proper use of the device within 14 days of admission. The facility also failed to ensure the device was safely installed for use and secured to prevent any entrapment. These failures placed Resident 3 at risk of compromised health, entrapment and injury.

Findings included...

BEDSIDE RAIL
Review of the facility's document titled "Risk Management – Residents Bedside Mobility Device" dated 06/01/2023, showed that bedrails were not permitted in the facility “without a physician’s order and must be included in the resident’s care plan”. The policy showed that bedside rails are assessed for safety upon admission. The policy showed that the beside rail order “shall include the medical symptom being treated,

when the bedside rail should be used, and when the bedside rail should be removed/no in use, and the frequency of checks while in use. The policy showed that the “Community Leader shall verify safety reviews are completed to maintain safe bedside rail use, including evaluation of continued necessity, whether current side rail is appropriate for resident’s medical condition, and if an alternative is now more appropriate”. The policy showed that the bedside rails would be evaluated by the facility maintenance team quarterly for proper installation of the side rail, and evaluation documented for review by the Safety Committee at Safety Committee meetings.

Review of the facility’s Characteristics Roster dated 01/20/2026 showed that the facility admitted Resident 3 in [redacted] 2025 with the diagnosis of [redacted] and [redacted]. The Characteristics Roster showed that Resident 3 received Hospice care services.

Observation on 02/04/2026 at 2:37: PM showed Resident 3 lay in a hospital bed. Observation showed two 1/2 length bedrails attached to either side of the head of the bed in the raised position. Observation showed a private caregiver Collateral Contact 2 (CC2) in the apartment provided care for Resident 3. Observation showed Resident 3 was alert and responsive.

During an interview on 02/04/2025 at 2:37 PM, Resident 3 was pleasant but unable to respond to questions appropriately. Resident 3 could not state why the bedside rails were attached to the bed or for what purpose they were used.

During an interview on 02/04/2026 at 2:40 PM, CC2 stated that Resident 3 used the bedside rails to assist with turning on their side when incontinence care was provided and when repositioned.

Review of Resident 3’s records showed a Hospice certification and plan of care dated 12/13/2025 that showed an order for ½ length bed rails.

Review of Resident 3's medical records found there was no bed siderail assessment within 14 days of admission. Review of Resident 3's “Service Plan Report” dated 01/29/2026, did not show Resident 3 used bedside rails.

SEIZURE MEDICAITON
Review of Resident 3’s electronic medication administration record (eMAR), dated February 2026, showed an order for Levetiracetam (an antiepileptic/seizure medication) 500 milligrams (MG) by mouth twice for “indication for use antiepileptic”.

Review of Resident 3’s medical records found there was no assessment for epilepsy/seizure activity.

During an interview on 02/04/2026 at 2:25 PM, Staff V, Resident Care Director for Assisted Living, stated that there was not a bedside rail assessment for Resident 3. Staff V stated that they were not aware of epileptic/seizure activity as it pertained to Resident 3. Staff V stated that the Licensed Nurse was responsible for residents' medical condition assessments and medical device assessments which included bedside rails.

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

Administrator (or Representative) 3/5/2026. Date

During an interview on 02/04/2026 at 2:25 PM, Staff V, Resident Care Director for Assisted Living, stated that there was not a bedside rail assessment for Resident 3. Staff V stated that they were not aware of epileptic/seizure activity as it pertained to Resident 3. Staff V stated that the Licensed Nurse was responsible for residents' medical condition assessments and medical device assessments which included bedside rails.

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Administrator (or Representative) Date