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

Parkside Operations LLC
Parkside Retirement Community
2902 I St NE
Auburn, WA 98002

RE: Parkside Retirement Community License # 2638

Dear Administrator:

This letter addresses Compliance Determination(s) 65863 (Completion Date 09/19/2025) and 63062 (Completion Date 07/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/19/2025 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-2305-1, WAC 246-215-02305-2-a, WAC 246-215-02305-2-c, WAC 246-215-02305-2-c-i, WAC 246-215-02305-2-c-ii, WAC 246-215-02305-2-d, WAC 246-215-02305-2-e, WAC 388-78A-2474-4, WAC 388-112A-0105-1, WAC 388-78A-2474-2-e, WAC 388-112A-0611-1-a-iii, WAC 388-112A-0611-2, WAC 388-78A-2620-1-a, WAC 388-78A-2620-1-b, WAC 388-78A-2620-1, WAC 388-78A-2620-2-a, WAC 388-78A-2620-2-b

The Department staff who did the on-site verification:
Kathy Young, Licensor

If you have any questions, please contact me at (206)305-3489.

Sincerely,

James Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

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 follow-up on 07/24/2025 of:

Parkside Retirement Community
2902 I St NE
Auburn, WA 98002

This document references the following SOD dated: 07/24/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 70 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, Licensor
Michelle Yip, ALF Licensor

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.

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

08/06/2025
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)

8/12/25
Date

WAC 246-215-02305 Hands and arms Cleaning procedure (FDA Food Code 2-301.12).

(2) foodemployees shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms.

(a) Rinse under clean, running warm water;

(c) Rub together vigorously for at least ten to fifteen seconds while,

(i) Paying particular attention to removing soil from underneath the fingernails during the cleaning procedure, and

(ii) Creating friction on the surfaces of the hands and arms or surrogate prosthetic devices for hands and arms, finger tips, and areas between the fingers.

(d) Thoroughly rinse under clean, running warm water, and

(e) Immediately follow the cleaning procedure with thorough drying using a method as specified under WAC 246-215-06310

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 ensure 1 of 3 dietary aides (Staff J) who provide resident food services in the dining room, followed proper hand sanitation guidelines. This failure placed all 70 residents at risk of contracting foodborne illnesses.

Findings included:

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

Residential Care Services | Date

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Administrator (or Representative) | Date

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Findings included…

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

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 05/29/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 07/07/2025.

Review of the Washington State Department of Health’s undated Food Worker Manual showed food workers needed to wash their hands frequently in a handwash sink to prevent foodborne illnesses.

Review of the facility’s undated food service policy showed that staff were instructed to follow the proper procedure required for handwashing before handling food.

Review of the facility’s document titled, “Sign Up Sheet”, dated 06/24/2025, listed the staff who signed up to take the dietary staff handwashing training. The list did not include Staff J, Dietary Aide.

Observation on 07/24/2025 at 11:58 AM showed Staff J served residents food and beverages in the dining room. Observation showed Staff J wore a single pair of disposable gloves. Observation showed Staff J took a pen from their apron pocket and wrote down residents’ orders. Staff J gathered the food and beverages and served residents. Observation showed that Staff J touched residents’ beverage cups on the rim before serving the beverage. Observation showed that Staff J never washed their hands in a handwashing sink when switching between tasks, as required. At 12:25 PM, observation showed Staff J washed their hands for the first time during the meal service.

During an interview on 07/24/2025 at 3:19 PM, Staff I, Food Services Manager, stated that Staff J did not attend the handwashing training. Staff I stated that Staff J was aware of the requirement to wash their hands.

This is an uncorrected deficiency previously cited on 05/29/2025 for Washington Administrative Code (WAC) 388-78A-2305, subsection 1 and WAC 246-215-02305 subsections 2a, 2c, 2ci, 2cii, 2d, and 2e.

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

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, Parkside Retirement Community is or will be in compliance with this law and / or regulation on (Date) 9/8/25 9/7/25

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

Administrator (or Representative) — Date: 8/12/25

WAC 388-112A-0105 Who is required to obtain home care aide certification and by when? Unless exempt under WAC 246-980-025 , the following individuals must be certified by the department of health as a home care aide within the required time frames:

(1) All long-term care workers, within two hundred days of the date of hire;

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 twelve hours of continuing education by their birthday each year:

(iii) A certified nursing assistant.

(3) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 3 care staff (Staff A and Staff C) completed all professional certification, as required. This failure placed all

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Plan/Attestation Statement

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Administrator (or Representative) Date

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Based on interview and record review, the facility failed to ensure 2 of 3 care staff (Staff A and Staff C) completed all professional certification, as required. This failure placed all

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70 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 05/29/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 07/07/2025.

Review of the facility's undated caregiver job description showed Nursing Assistants provided direct personal care and supervision to the residents consistent with Washington State regulations.

STAFF A
Review of the facility's employee roster showed the facility hired Staff A, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents. Staff A was required to obtain professional certification from the Washington State Department of Health by 01/27/2025.

Review of Staff A's employee file showed no documentation that Staff A completed the required professional certification.

Review of the facility's care staff schedule showed Staff A worked 10 shifts from 07/07/2025 through 07/21/2025 without the required professional certification.

During an interview on 07/24/2025 at 3:29 PM, Staff A stated that they continued to work the past two weeks as a caregiver. Staff A stated that they provided personal care services to the residents in the last two weeks, which included tasks such as changing residents' incontinence garments (absorbent articles worn to manage the decreased control of bladder and bowel) and responding to residents' needs, as requested.

STAFF C
Review of the facility's employee roster showed the facility hired Staff C, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents. Staff C was required to obtain professional certification from the Washington State Department of Health by 01/27/2025.

Review of Staff C's employee file showed no documentation that Staff C completed the required professional certification.

Review of the facility's employee care staff schedule showed Staff C worked 10 shifts

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between 07/07/2025 and 07/23/2025 without the required professional certification.

During an interview on 07/24/2025 at 3:23 PM, Staff G, Registered Nurse, stated that since Staff A and Staff C worked the night shift from 10:00 PM to 6:00 AM, they did not expect Staff A and Staff C to provide care and services for the residents. Staff G stated that they were to "stand guard" in the halls.

This is an uncorrected deficiency previously cited on 05/29/2025 for Washington Administrative Code (WAC) 388-78A-2474 subsection 4 and WAC 388-112A-0105 subsection 1.

Plan/Attestation Statement

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

Tom Gallin — Administrator (or Representative)

8/12/25 — Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(1) Develop, implement and disclose to potential and current residents, policies regarding:

(a) The types of pets that are permitted in the assisted living facility; and

(b) The conditions under which pets may be in the assisted living facility.

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 2 pets (Pet 1 and Pet 2) were current with their examinations and veterinarian certified to be free of diseases transmittable to humans. This failure placed all 70 residents at risk of contracting illnesses spread by pets.

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between 07/07/2025 and 07/23/2025 without the required professional certification.

During an interview on 07/24/2025 at 3:23 PM, Staff G, Registered Nurse, stated that since Staff A and Staff C worked the night shift from 10:00 PM to 6:00 AM, they did not expect Staff A and Staff C to provide care and services for the residents. Staff G stated that they were to “stand guard” in the halls.

This is an uncorrected deficiency previously cited on 05/29/2025 for Washington Administrative Code (WAC) 388-78A-2474 subsection 4 and WAC 388-112A-0105 subsection 1.

Plan/Attestation Statement

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Findings included…

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 05/29/2025. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 07/07/2025.

Review of the facility's undated Disclosure of Services showed the facility allowed residents to have pets, provided the pets received regular veterinary examinations, immunizations, and were free of diseases transmittable to humans.

Review of the facility's document titled, "Pet Policy", updated 01/20/2025, showed the facility required residents with pets provide proof their pet received regular veterinary examinations, immunizations, and a veterinarian's letter certifying the pet was free of diseases transmittable to humans.

PET 1
Review of Pet 1's veterinary records, dated 01/13/2024, showed no record of a veterinarian examination.

PET 2
Review of Pet 2's veterinary records, dated 11/24/2024, showed no record of a veterinarian certification that Pet 2 was free of diseases transmittable to humans.

During an interview on 07/24/2025 at 3:25 PM, Staff G, Registered Nurse, stated that they were unaware Pet 1 and Pet 2's veterinarian records were incomplete.

This is an uncorrected deficiency previously cited on 05/29/2025 for Washington Administrative Code (WAC) 388-78A-2620 subsections 2a and 2b.

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Plan/Attestation Statement

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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 the unannounced on-site full inspection on 05/12/2025 and 05/15/2025 of:

Parkside Retirement Community
2902 I St NE
Auburn, WA 98002

The following sample was selected for review during the unannounced on-site visit: 9 of 66 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor
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From:
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Laurie Anderson
Residential Care Services

06/02/2025
Date

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Tom Gallen
Administrator (or Representative)

6-5-2025
Date

WAC 246-215-02305 Hands and arms Cleaning procedure (FDA Food Code 2-301.12).

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 3 dietary aides (Staff J, Staff K, and Staff L) who provide resident food services in the dining room, followed proper hand sanitation guidelines. This failure placed all 66 residents at risk of contracting foodborne illnesses.

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

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Findings included...

Review of the facility's undated food service policies showed that staff were instructed to follow the proper procedure required for handwashing before handling food.

On 05/28/2025, review of the Department of Health's undated Food Worker Manual showed that food workers needed to wash their hands frequently to prevent foodborne illnesses. The manual showed that hands needed to be washed in a handwash sink. The manual showed that hand sanitizer should not be used instead of handwashing. The manual showed that hand sanitizer was acceptable after completion of handwashing.

Observation on 05/13/2025 at 12:37 PM, showed Staff J, Dietary Aide, handled dirty dishes, removed their single-use gloves, and used hand sanitizer. Observation showed that after Staff J used the sanitizer, Staff J put on a fresh pair of gloves and then served food to residents. Observation showed Staff J never washed their hands in a handwashing sink, as required.

Observation on 05/15/2025 at 12:14 PM and 12:19 PM, showed Staff K and Staff L, Dietary Aides, provided resident food service in the dining room. Observation showed Staff K and Staff L removed single-use gloves, used hand sanitizer, and put on fresh gloves to serve food to the residents. Observation showed Staff K and Staff L never washed their hands in a handwashing sink, as required.

During an interview on 05/13/2025 at 12:55 PM, Staff I, Food Service Manager, stated that after staff touch dirty dishes or surfaces, staff were expected to use soap and water to wash their hands. Staff I stated that they were unaware Staff J, Staff K, and Staff L neglected to wash hands per the required procedure.

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, Parkside Retirement Community is or will be in compliance with this law and / or regulation on (Date) 7/7/25 .

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

Administrator (or Representative) — Date: 6/5/25

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and

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Findings included…

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Observation on 05/15/2025 at 12:14 PM and 12:19 PM, showed Staff K and Staff L, Dietary Aides, provided resident food service in the dining room. Observation showed Staff K and Staff L removed single-use gloves, used hand sanitizer, and put on fresh gloves to serve food to the residents. Observation showed Staff K and Staff L never washed their hands in a handwashing sink, as required.

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timely manner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 9 sampled residents (Resident 1, Resident 6, Resident 7, and Resident 8) received medications as prescribed. This failure placed Resident 1, Resident 6, Resident 7, and Resident 8 at risk for compromised health and potential medical complications.

Findings included…

Review of the facility's undated document titled, "Medication Policy", showed the facility was responsible for obtaining medication refills in a timely manner to ensure residents have all physician ordered medications available.

Review of the facility's undated Medication Aide/Medication Technician job description, showed Medication Technicians were responsible to ensure all medications were completely stocked as ordered by the physician. The document showed Medication Technicians were responsible to coordinate medication orders and deliveries with pharmacies and to communicate with physicians and other healthcare providers, as needed.

RESIDENT 1
Observation on 05/15/2025 at 9:30 AM, showed Staff M, Nursing Assistant, provided Resident 1 with an as needed (PRN) pain medication.

Review of Resident 1's records showed that the staff administered Resident 1's medications for medical diagnoses that included [redacted] and [redacted]

Review of Resident 1's Medication Administration Records (MARs) from 02/13/2025 through 05/12/2025, showed that staff failed to administer Resident 1's medications due to unavailability. The facility failed to provide Resident 1 with their Spiriva medication (used to treat COPD) on 04/22/2025, 04/23/2025, 05/06/2025, and 05/12/2025. The facility failed to provide Resident 1 with their Panoprazole medication (used to treat GERD) once on 02/13/2025, 02/14/2025, 02/19/2025, 02/20/2025, 02/21/2025, 02/24/2025, 02/25/2025, 03/30/2025, 03/07/2025, 03/12/2025, 03/13/2025, 03/27/2025, 03/29/2025, and 04/02/2025 and two times each day on 02/26/2025, 02/27/2025, 03/26/2025.

RESIDENT 6

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

Observation on 05/14/2025 at 9:03 AM, showed Staff O, Nursing Assistant, dispensed Resident 6's medications.

Review of Resident 6's assessment, dated 12/21/2024, showed that Resident 6 required assistance with medication management. The assessment showed Resident 6's medication orders included Oxycodone (a pain relief medication) five milligrams (mg), two times daily by mouth and Oxycodone 2.5 mg, PRN by mouth.

Review of Resident 6's February 2025 and April 2025 MARs showed that staff failed to administer Resident 6's Oxycodone 11 times in February 2025 and 10 times in April 2025. The MARs documented that the reason for the missed doses of Oxycodone was "medication unavailable". There was no documentation that showed the staff notified the pharmacy and Resident 6's physician that the Oxycodone medication ran out.

During an interview on 05/15/2025 at 2:00 PM, Staff O stated that Resident 6 used the prescribed Oxycodone for pain relief. Staff O stated they were aware Resident 6's Oxycodone ran out. Staff O stated that when Resident 6 did not receive their Oxycodone, Resident 6 was "grumpy and irritable", and Resident 6 asked the staff why their medication ran out.

RESIDENT 7
Review of Resident 7's assessment, dated 04/29/2025, showed that Resident 7 required assistance with medication management. The assessment showed Resident 7's medication orders included Acetaminophen (a pain relieve medication), 650 MG, twice daily by mouth; Adult Multi-Vitamin (a dietary supplement) one tablet every day by mouth; Brimonidine tartrate (a medication to lower pressure inside the eye) 0.2 percent (%) ophthalmic (eye), instill one drop in both eyes two times a day; Latanoprost (a medication to lower pressure inside the eye) ophthalmic solution 0.005 %, instill one drop in both eyes at bedtime; Loratadine 10 mg, take one tablet every morning by mouth; and Vitamin C (a dietary supplement), one tablet every day by mouth.

Review of Resident 7's March 2025, April 2025, and May 2025 MARs showed that staff failed to administer Resident 7's Acetaminophen five times in March 2025. The MARs showed Resident 7 missed their Adult Multi-Vitamin five times in March 2025, six times in April 2025, and one time in May 2025. The MARs showed Resident 7 missed their Brimonidine tartrate three times in February 2025 and one time in May 2025. Resident 7 missed their Latanoprost ophthalmic solution six times in March 2025, four times in April, and six times in May 2025. Resident 7 missed their Loratadine five times in March 2025, seven times in April, and two times in May 2025. Resident 7 missed their Vitamin C three times in March 2025 and two times in April 2025. The MARs documented that the reason for the missed doses of the medications was "medication unavailable".

RESIDENT 8
Observation on 05/15/2025 at 8:00 AM, showed Staff O dispensed Resident 8's medications.

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Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2020. The records showed that on 03/04/2025, the facility completed Resident 8's assessment. The records showed that Resident 8 required medication assistance. The records showed Resident 8's medication orders included Cinnamon (dietary supplement) 500 mg, four capsules daily by mouth; Gabapentin (a medication used to treat a condition where the nerve in the spinal column gets pinched) 100 mg, twice a day by mouth; Invokana (a medication used to manage type 2 diabetes [a medical condition in which the body has trouble controlling blood sugar levels]) 100 mg, one tablet daily by mouth; Januvia (a medication used to treat type 2 diabetes) 100 mg, one tablet daily by mouth; Magnesium (dietary supplement) 125 mg, two capsule every day by mouth; Omeprazole (a medication used to reduce the amount of acid produced in the stomach) 20 mg, one tablet daily by mouth; and Tumeric (supplement) 450-50 mg, two capsules daily by mouth.

Review of Resident 8's February 2025, March 2025, and April 2025 MARs showed that Resident 8 did not receive Cinnamon 13 times in February 2025, 29 times in March 2025, and three times in April. The MARs showed Resident 8 did not receive Gabapentin 10 times in March 2025 and one time in April 2025. The MARs showed Resident 8 did not receive Invokana 16 times in February 2025 and four times in March 2025. The MARs showed Resident 8 did not receive Januvia one time in March and five times in May 2025. The MARs showed Resident 8 did not receive Magnesium 16 times in February 2025 and five times in March 2025. The MARs showed Resident 8 did not receive Omeprazole seven times in February 2025 and four times in March 2025. The MARs showed Resident 8 did not receive Tumeric 16 times in February 2025, 27 times in March 2025, and seven times in April 2025. The MARs documented that the reason for the missed doses of the medications was "medication unavailable".

During an interview on 05/15/2025 at 11:30 AM , Staff G, Registered Nurse, stated that they were required to ensure all residents' medications were available. Staff G stated that when a resident's medication was down to the last seven days of dosages, the Medication Technicians were required to notify the resident's pharmacy. Staff G stated that if the resident required a new refill order, the Medication Technicians were required to obtain the refill order from the resident's physician. Staff G stated that they used the medication ordering form to notify the pharmacy. Staff G stated that they were unable to find any documentation that showed their staff notified the pharmacy when Resident 1, Resident 6, Resident 7, and Resident 8 medications ran out.

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Plan/Attestation Statement

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

Tom Gallen
Administrator (or Representative)

6/5/25
Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure 1 of 3 newly hired care staff (Staff A) completed the national fingerprint background check within 120 days of hire. This failure placed all 66 residents at risk of abuse, neglect, or exploitation from staff with an unknown background.

Findings included...

Review of the facility's employee roster showed the facility hired Staff A, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents. The regulation requirements showed that Staff A's final fingerprint results were due by 11/07/2024.

Review of the facility's undated caregiver job description showed Nursing Assistants provided direct personal care and supervision to the residents consistent with Washington State regulations.

Review of Staff A's employee file showed no documentation that Staff A completed a national fingerprint background check.

During an interview on 5/13/2025 at 8:50 AM, Staff N, Office Manager, stated that they were unaware Staff A did not complete the fingerprint background check. Staff N stated

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Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure 1 of 3 newly hired care staff (Staff A) completed the national fingerprint background check within 120 days of hire. This failure placed all 66 residents at risk of abuse, neglect, or exploitation from staff with an unknown background.

Findings included…

Review of the facility's employee roster showed the facility hired Staff A, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents. The regulation requirements showed that Staff A's final fingerprint results were due by 11/07/2024.

Review of the facility's undated caregiver job description showed Nursing Assistants provided direct personal care and supervision to the residents consistent with Washington State regulations.

Review of Staff A's employee file showed no documentation that Staff A completed a national fingerprint background check.

During an interview on 5/13/2025 at 8:50 AM, Staff N, Office Manager, stated that they were unaware Staff A did not complete the fingerprint background check. Staff N stated

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that Staff A was scheduled twice to complete a fingerprint background check. Staff N stated that Staff A never went to the scheduled fingerprinting appointment. Staff N stated Staff A continued providing resident care without a completed fingerprint background check.

Plan/Attestation Statement

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Tom Gallucci — Administrator (or Representative)

6/5/25 — Date

WAC 388-112A-0105 Who is required to obtain home care aide certification and by when? Unless exempt under WAC 246-980-025 , the following individuals must be certified by the department of health as a home care aide within the required time frames:

(1) All long-term care workers, within two hundred days of the date of hire;

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 twelve hours of continuing education by their birthday each year:

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

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that Staff A was scheduled twice to complete a fingerprint background check. Staff N stated that Staff A never went to the scheduled fingerprinting appointment. Staff N stated Staff A continued providing resident care without a completed fingerprint background check.

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 388-112A-0105 Who is required to obtain home care aide certification and by when? Unless exempt under WAC 246-980-025 , the following individuals must be certified by the department of health as a home care aide within the required time frames:

(1) All long-term care workers, within two hundred days of the date of hire;

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 twelve hours of continuing education by their birthday each year:

(iii) A certified nursing assistant;

(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed.

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.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 5 sampled care staff (Staff A, Staff C, Staff D, and Staff E) completed all professional certification and trainings, as required. This failure placed all 66 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included…

Review of the facility's undated caregiver job description showed Nursing Assistants provided direct personal care and supervision to the residents consistent with Washington State regulations.

PROFESSIONAL CERTIFICATION
STAFF A
Review of the facility's employee roster showed the facility hired Staff A, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents. Review of the facility's employee schedule showed Staff A worked in April 2025 and May 2025. Staff A was required to obtain professional certification from the Washington State Department of Health by 01/27/2025.

Review of Staff A's employee file showed no documentation that Staff A completed the required certification.

STAFF C
Review of the facility's employee roster showed the facility hired Staff C, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents. Review of the facility's employee schedule showed Staff C worked in April 2025 and May 2025. Staff C was required to obtain professional certification from the Washington State Department of Health by 01/27/2025.

Review of Staff C's employee file showed no documentation that Staff C completed the required certification.

During an interview on 5/13/2025 at 9:45 AM, Staff H, Administrator, stated that they were unaware Staff A and Staff C did not complete the required certification.

CONTINUING EDUCATION (CE)
STAFF D
Review of the facility's undated employee roster showed that the facility hired Staff D, Nursing Assistant, on 09/01/2020. Review of the facility's employee schedule showed Staff D worked in April 2025 and May 2025. Review of Staff D's employee records showed that Staff D's Nursing Assistant Certification was first issued on 03/01/2017 and was in active status. The records showed that Staff D completed eight hours of the CE

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training between their February 2024 and February 2025 birthdays, four hours short of the required 12 hours of CE training.

STAFF E
Review of the facility's undated Employee Roster showed that the facility hired Staff E, Nursing Assistant, on 04/01/2020. Review of the facility's employee schedule showed Staff E worked in April 2025 and May 2025. Review of Staff E's employee records showed that Staff E's Nursing Assistant Certification was first issued on 07/05/2018 and was in active status. There was no documentation that showed Staff E completed any CE training between their January 2024 and January 2025 birthdays, as required.

During an interview on 05/14/2025 at 2:00 PM, Staff N, Office Manager, stated that they were unsure if Staff D and Staff E completed any CE between their 2024 and 2025 birthdays, as required. Staff N stated that they were unable to find any documentation that showed Staff D and Staff E completed the Department of Social and Health Services (DSHS) approved CE certification their 2024 birthday to their 2025 birthday.

Plan/Attestation Statement

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Tom Gallen — Administrator (or Representative)

6/5/25 — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility to ensure that 3 of 3 care staff (Staff A, staff B, and Staff C), were screened for Tuberculosis (TB) within three days of hire. This failure placed all 66 residents at risk of contracting TB, an infectious respiratory illness.

Findings included...

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training between their February 2024 and February 2025 birthdays, four hours short of the required 12 hours of CE training.

STAFF E
Review of the facility's undated Employee Roster showed that the facility hired Staff E, Nursing Assistant, on 04/01/2020. Review of the facility's employee schedule showed Staff E worked in April 2025 and May 2025. Review of Staff E's employee records showed that Staff E's Nursing Assistant Certification was first issued on 07/05/2018 and was in active status. There was no documentation that showed Staff E completed any CE training between their January 2024 and January 2025 birthdays, as required.

During an interview on 05/14/2025 at 2:00 PM, Staff N, Office Manager, stated that they were unsure if Staff D and Staff E completed any CE between their 2024 and 2025 birthdays, as required. Staff N stated that they were unable to find any documentation that showed Staff D and Staff E completed the Department of Social and Health Services (DSHS) approved CE certification their 2024 birthday to their 2025 birthday.

Plan/Attestation Statement

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_____ _____
Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility to ensure that 3 of 3 care staff (Staff A, staff B, and Staff C), were screened for Tuberculosis (TB) within three days of hire. This failure placed all 66 residents at risk of contracting TB, an infectious respiratory illness.

Findings included…

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Review of the facility's undated caregiver job description showed Nursing Assistants provided direct personal care and supervision to the residents consistent with Washington State regulations.

STAFF A
Review of the facility's employee roster showed the facility hired Staff A, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents.

Review of Staff A's employee records showed no documentation Staff A completed any TB testing.

STAFF B
Review of the facility's employee roster showed the facility hired Staff B, Nursing Assistant, on 07/03/2024 to provide direct care and services to the residents.

Review of Staff B's employee records showed Staff B completed a one-step TB test on 07/08/2024 with negative results, eight days after their date of hire.

STAFF C
Review of the facility's employee roster showed the facility hired Staff C, Nursing Assistant, on 07/11/2024 to provide direct care and services to the residents.

Review of Staff C's employee records showed no documentation Staff C completed any TB testing.

During an interview on 05/13/2025 at 9:58 AM, Staff G, Registered Nurse, stated that they were unaware of the regulations and did not correctly complete the TB testing for Staff A, Staff B, and Staff C.

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

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

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type

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font that is at least fourteen point; and

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 7 of 9 sampled residents (Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9) received a copy of the facility's policy regarding Medicaid as a payment source, with a signed and dated acknowledgement by the resident. This failure placed Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9 at risk of being discharged and unable to reside in the facility on [redacted].

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 12/15/2023, the Assisted Living Facility (ALF) received a citation under this regulation for all residents in the facility. The system showed that the ALF signed an attestation statement that stated the facility would have the deficiency corrected by 01/29/2024. Review of STARS showed that on 02/07/2024, the facility was put back in compliance.

Review of the facility's undated document titled, "Medicaid Payment Policy", showed the facility accepted and provided services to clients whose payment source was through the [redacted] program.

Review of the facility's undated Characteristic Roster showed the facility admitted Resident 1 in [redacted] 2015, Resident 3 in [redacted] 2016, Resident 5 in [redacted] 2023, Resident 6 in [redacted] 2016, Resident 7 in [redacted] 2019, Resident 8 in [redacted] 2019, and Resident 9 in [redacted] 2020.

Review of Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9's resident records showed no documentation that the facility informed the residents of the facility's policy on accepting [redacted] payments. The records showed no documentation that Resident 1, Resident 3, Resident 6, Resident 7, Resident 8, and Resident 9 ever signed the facility's Medicaid policy.

During an interview on 05/19/2025 at 10:00 AM, Staff H, Administrator, stated that in February 2024, the facility established a system that included the facility's Medicaid policy notice in the residents' admission process. Staff H stated that they implemented the [redacted] notice to those residents who were admitted to the facility after February 2024.

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During an interview on 05/19/2025 at 3:00 PM, Staff N, Office Manager, stated that Resident 1, Resident 3, Resident 6, Resident 7, Resident 8, and Resident 9 were admitted to the facility before February 2024. Staff N stated that when they implemented the [redacted] notice in February 2024, they did not inform and complete the [redacted] notice for residents who were admitted before February 2024. Staff N stated that there was no [redacted] notice signed and available in the resident's record for Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9.

This is a recurring deficiency previously cited on 12/15/2023 for subsections (1), (2), (3), (4), (5), and (6).

Plan/Attestation Statement

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

Tom Gallen — Administrator (or Representative)

6/5/25 — Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 3 of 3 sampled staff's (Staff D, Staff E, and Staff F) Washington State name and date of birth background inquiry (BGI) every two years. This failure placed all 66 residents at risk of potential abuse, neglect, or exploitation from staff persons with unknown backgrounds.

Findings included...

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

During an interview on 05/19/2025 at 3:00 PM, Staff N, Office Manager, stated that Resident 1, Resident 3, Resident 6, Resident 7, Resident 8, and Resident 9 were admitted to the facility before February 2024. Staff N stated that when they implemented the [redacted] notice in February 2024, they did not inform and complete the [redacted] notice for residents who were admitted before February 2024. Staff N stated that there was no [redacted] notice signed and available in the resident's record for Resident 1, Resident 3, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9.

This is a recurring deficiency previously cited on 12/15/2023 for subsections (1), (2), (3), (4), (5), and (6).

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Administrator (or Representative) Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 3 of 3 sampled staff's (Staff D, Staff E, and Staff F) Washington State name and date of birth background inquiry (BGI) every two years. This failure placed all 66 residents at risk of potential abuse, neglect, or exploitation from staff persons with unknown backgrounds.

Findings included…

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STAFF D
Review of the facility's undated Employee Roster showed that the facility hired Staff D, Nursing Assistant, on 09/01/2020. Review of Staff D's employee records showed their previous Washington state name and date of birth BGI expired on 09/22/2022. The records showed that the facility submitted and completed a BGI on 02/13/2023, 144 days after the previous BGI expired. The records showed their current BGI expired on 02/13/2025. The record showed no documentation that as of 05/12/2025, 88 after the BGI expired, the facility submitted and completed a new BGI for Staff D.

STAFF E
Review of the facility's undated Employee Roster showed that the facility hired Staff E, Nursing Assistant, on 04/01/2020. Review of Staff E's employee records showed their current Washington state name and date of birth BGI expired on 02/10/2025. The records showed no documentation that as of 05/12/2025, 91 days after the BGI expired, the facility submitted and completed a new BGI for Staff E.

STAFF F
Review of the facility's undated Employee Roster showed that the facility hired Staff F, Food Service Manager, on 02/19/2018. Review of Staff F's employee records showed their previous Washington state name and date of birth BGI expired on 01/07/2022. The records showed that the facility submitted and completed a BGI on 02/13/2023, 402 days after the previous BGI expired. The records showed their current BGI expired on 02/13/2025. The record showed no documentation that as of 05/12/2025, 88 after the BGI expired, the facility submitted and completed a new BGI for Staff F.

During an interview on 05/13/2025 at 9:00 AM, Staff N, Office Manager, stated that they kept staff's background check due dates on a spreadsheet. Staff N stated that when a staff's background check was due, the reminder indicator turned red on the spreadsheet. Staff N stated that their system failed when the reminder indicator did not turn red to show the background checks were past due. Staff N stated that they did not complete the two-year BGI for Staff D, Staff E, and Staff F, as required.

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

Plan/Attestation Statement

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

Tom Gallin — Administrator (or Representative)

6/5/25 — Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(c) Safely operate the assisted living facility; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to ensure safe storage of oxygen cylinders in 1 of 1 storage room (Storage Room 1). This failure placed all 66 at risk for harm and injury.

Findings included...

Review of the facility's undated document titled, "Oxygen Policy", showed that the facility was responsible to ensure the safe use, handling, and storage of oxygen within the facility. The document showed that the oxygen cylinders must be stored upright in a cart, rack, or stand and secured to prevent tipping over.

Observation on 05/12/2025 at 11:55 AM showed that Storage Room 1 contained several extra oxygen cylinders. The storage room observation showed a rack full of oxygen cylinders sat on the floor. Observation showed another six oxygen cylinders were stacked on top and in between the oxygen cylinders in the rack. Observation showed the six oxygen cylinders were tipping over and were not placed upright in a separate cart, rack, or stand for safe storage. The storage room observation showed there were five more oxygen cylinders, free standing, on a shelf that sat one foot above the floor.

During an interview on 05/12/2025 at 11:55 AM, Staff H, Administrator, stated that they were unaware that the oxygen cylinders were not safely stored.

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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-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(c) Safely operate the assisted living facility; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility failed to ensure safe storage of oxygen cylinders in 1 of 1 storage room (Storage Room 1). This failure placed all 66 at risk for harm and injury.

Findings included…

Review of the facility's undated document titled, "Oxygen Policy", showed that the facility was responsible to ensure the safe use, handling, and storage of oxygen within the facility. The document showed that the oxygen cylinders must be stored upright in a cart, rack, or stand and secured to prevent tipping over.

Observation on 05/12/2025 at 11:55 AM showed that Storage Room 1 contained several extra oxygen cylinders. The storage room observation showed a rack full of oxygen cylinders sat on the floor. Observation showed another six oxygen cylinders were stacked on top and in between the oxygen cylinders in the rack. Observation showed the six oxygen cylinders were tipping over and were not placed upright in a separate cart, rack, or stand for safe storage. The storage room observation showed there were five more oxygen cylinders, free standing, on a shelf that sat one foot above the floor.

During an interview on 05/12/2025 at 11:55 AM, Staff H, Administrator, stated that they were unaware that the oxygen cylinders were not safely stored.

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

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, Parkside Retirement Community is or will be in compliance with this law and / or regulation on (Date) 7/7/25 .

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

Jim Gallin — Administrator (or Representative)

6/5/25 — Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(1) Develop, implement and disclose to potential and current residents, policies regarding:

(a) The types of pets that are permitted in the assisted living facility; and

(b) The conditions under which pets may be in the assisted living facility.

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 3 pets (Pet 3, cat) was current with their examination and veterinarian certified to be free of diseases transmittable to humans. This failure placed all 66 residents at risk of contracting illnesses spread by pets.

Findings included...

Observations on 05/12/2025 at 9:00 AM and 05/15/2025 at 3:30 PM showed pets lived at the facility. Observation showed resident walked their pet throughout the facility.

Observation on 05/15/2025 at 8:05 AM showed Pet 3 resided in Resident 8's apartment. During an interview at this time, Resident 8 stated that Pet 3 lived with them in the apartment.

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Parkside Retirement Community 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

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Review of the facility's undated Disclosure of Services showed the facility allowed residents to have pets, provided the pets received regular veterinary examinations, immunizations, and were free of diseases transmittable to humans.

Review of the facility's document titled, "Pet Policy", updated 01/20/2025, showed the facility required residents with pets provide proof their pet received regular veterinary examinations, immunizations, and a veterinarian's letter certifying the pet was free of diseases transmittable to humans.

Review of Pet 3's veterinary records, dated 01/13/2024, showed no record of a veterinary examination or veterinarian certification that Pet 3 was free of diseases transmittable to humans.

During an interview on 05/15/2025 at 12:30 PM, Staff H, Administrator, stated that they were unaware Pet 3's veterinarian records were incomplete.

Plan/Attestation Statement

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

Tom Gallin — Administrator (or Representative)

6/5/25 — Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect 66 of 66 Residents (Resident 1 through Resident 66) from verbal abuse from another

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Administrator (or Representative) Date

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(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect 66 of 66 Residents (Resident 1 through Resident 66) from verbal abuse from another

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resident. The facility failed to protect all 66 residents' dignity and right to be respected. This failure placed all 66 Residents at risk for diminished quality of life from a lack of dignity and respect and increased emotional and psychological harm.

Findings included…

During the Resident Group Meeting on 05/14/2025 at 2:00 PM, nine residents attended the meeting. During the meeting, all nine residents stated that the facility rules forbid any type of racism, hostile talk, and harassment. The residents stated that the administration did not enforce the rule. During the group meeting, Resident 10 stated that Resident 2 called them a "black" name and "I am not even black". Resident 10 stated that Resident 2 told them to "shut up, you're a white piece of [blank]". Resident 10 stated that they moved apartments and now lived next door to Resident 2. Resident 10 stated that Resident 2 called multiple residents derogatory names when they were out in the hallway or in the common areas. During the group meeting other residents confirmed Resident 10's statements. Several unidentified residents and Resident 11, Resident Council President, stated that whenever they encountered Resident 2, they were often subjected to unprovoked verbal vitriol (cruel and bitter criticism). The residents all stated that they believed Resident 2 verbally abused them and violated their rights. The residents all stated that they informed the administration of these issues and nothing changed.

RESIDENT 2
Review of the facility's Characteristic Roster, dated 05/09/2025, showed the facility admitted Resident 2 in [redacted] 2024 with the diagnosis of [redacted].

Review of Resident 2' s Behavior Support Plan (BSP), dated 09/27/2025, showed that Resident 2 had a history of assault on staff and peers. The BSP showed the triggers that prompted Resident 2's aggressive behaviors. The BSP provided staff with instructions on how to manage Resident 2's behaviors.

Review of Resident 2's Service Plan, dated 10/29/2024, documented a long history of "mental illness". The plan documented Resident 2's behaviors which included scratching themself/others, verbal abuse, hitting/kicking, and withdrawal related to physical discomfort, boredom, mental confusion, fatigue, hunger, and disease associated changes. The plan documented Resident 2 had a history of "yelling at people around" them.

During an interview on 05/14/2025 at 1:29 PM, Resident 2 responded to the resident

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interview questionnaire with the Department of Social and Health Services (DSHS) Representative. During the interview Resident 2 stated that they were not a resident of the facility and would not be staying. Resident 2 stated that they were to leave that afternoon to return to the “USA, Seattle”. During the interview, Resident 2 stated that “others”, “everyone”, called them “black bitch”. Resident 2 stated that the facility would not allow their family to visit. During the interview, Resident 2 stated they did not want to answer any further questions and terminated the interview. Resident 2 then called the DSHS Representative multiple derogatory names and walked out of the room.

Observation on 05/14/2025 at 1:40 PM showed Resident 2 in the hallway with their walker piled high with various personal belongings. Observation showed various unidentified residents in the hallway in the near proximity of Resident 2. During the observation, Resident 2 was overheard making derogatory comments and name calling in a loud voice. It was unclear if Resident 2’s comments were directed at the other residents or if Resident 2 was responding to internal stimuli.

During an interview on 05/14/2025 at 1:45 PM, Staff G, Registered Nurse, Director of Nursing, stated that the facility focused on admitting higher acuity mental health residents with behavioral challenges. Staff G stated that they and Staff H, Administrator, assessed Resident 2 at a psychiatric hospital prior to Resident 2’s admission. Staff G stated that they met with the physicians/psychiatrist at the hospital to discuss Resident 2’s physical and mental health needs. Staff G stated that upon discharge from the hospital to the facility, Resident 2 was supposed to be placed on Hospice Services (end of life care) due to Resident 2’s poor health. Staff G stated that it was not expected for Resident 2 to be physically functioning as well as they were due to their health problems.

Staff G stated that they were well informed of Resident 2’s verbal and physical aggressions towards others. Staff G stated that when they and Staff H attempted to interview Resident 2 at the hospital, they were unable to interview or assess Resident 2 due to the verbal vitriol from Resident 2. Staff G stated that Resident 2 refused all medications and therefore, did not have any prescribed medications ordered. Staff G stated that the staff were all trained to intervene when they heard Resident 2 being verbally aggressive towards others.

Staff G stated that they have observed several of the other residents intentionally provoke Resident 2 to get a reaction. Staff G stated that they have observed Resident 10 intentionally make statements to provoke Resident 2. Staff G stated that other residents also intentionally stared at Resident 2 in the dining room or laughed at Resident 2 to get a reaction. Staff G stated that many of the residents in the facility were diagnosed with [redacted] and it was not possible to determine if the staring or laughing was related to their mental disorder, effects of psychotropic medications, or external/internal stimuli.

Staff G stated that they were aware of Resident 2’s behaviors and multiple resident complaints of verbal aggression. Staff G stated that since none of the residents used the

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term verbal abuse, the facility did not take any further action to address Resident 2's aggression and validate the concerns of the other residents.

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, Parkside Retirement Community is or will be in compliance with this law and / or regulation on (Date) 7/7/25 .

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

Tom Gallucci — Administrator (or Representative)

6/5/25 — Date

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

AMENDED
06/02/2025

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

Parkside Operations LLC
Parkside Retirement Community
2902 I St NE
Auburn, WA 98002

RE: Parkside Retirement Community # 2638

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/29/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:
• Wrote the enclosed report; and
• May take licensing enforcement action based on many deficiency listed on the enclosed report; and
• May inspect your program to determine if you have corrected all deficiencies; and
• Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately;
• Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

• Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  o Sign and date the enclosed report;
  o For each deficiency, indicate the date you have or will correct each deficiency;
  o Return the Plan/Attestation Statement and report with signatures to:

Laurie Anderson, Community Field Manager
Residential Care Services
Region 2, Unit D
Preferred methods:

eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

The facility failed to keep the halls and exterior paths free of trip hazards. During the full inspection, staff cleared the hall floor, the exterior patio, and the exterior path of all potential trip hazards.

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the assisted living facility must:

(1) Notify construction review services:

(a) In writing;

(b) Thirty days or more before the intended change in use;

(c) Describe the current and proposed use of the room; and

(d) Provide all additional documentation as requested by construction review services;

(2) Obtain the written approval of construction review services for the new use of the room; and

The facility changed five resident apartments into offices or storage without notifying Construction Review Services (CRS) 30 days in advance and receiving permission to make the changes. During the full inspection, the facility notified CRS.

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

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

• Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 2, Unit D
Residential Care Services

Enclosure

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

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

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If You Have Any Questions:

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Sincerely,

Laurie Anderson, Community Field Manager
Region 2, Unit D
Residential Care Services

Enclosure

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