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

Kent Senior Living Operations, LLC
Hillside Assisted Living
112 KENNEBECK AVE N
KENT, WA 98030

RE: Hillside Assisted Living License # 2714

Dear Administrator:

This letter addresses Compliance Determination(s) 69672 (Completion Date 12/05/2025) and 65595 (Completion Date 09/22/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/05/2025 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-2665, WAC 388-78A-2665-1, WAC 388-78A-2665-2, WAC 388-78A-2665-3, WAC 388-78A-2665-4, WAC 388-78A-2665-5, WAC 388-78A-2665-6, WAC 388-78A-2484-1, WAC 388-78A-2320-1-a, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2100-2-a

The Department staff who did the on-site verification:
Jane Hermano, NCI
Steven Garrett, LTC Licensor

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

Sincerely,

Jim Sherman

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

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

Statement of Deficiencies	License #: 2714	Compliance Determination # 65595
Plan of Correction	Hillside Assisted Living	Completion Date
Page 1 of 13	Licensee: Kent Senior Living Operations, LLC	09/22/2025

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 09/15/2025 and 09/18/2025 of:
Hillside Assisted Living
112 KENNEBECK AVE N
KENT, WA 98030

The following sample was selected for review during the unannounced on-site visit: 9 of 44 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jane Hermano, NCI
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

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.

James Sherman
Residential Care Services

09-29-2025
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)

10/01/2025
Date

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

(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 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 record review and interview, the facility failed to ensure that 7 of 7 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) were verbally informed and given 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 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7 at risk of being discharged and unable to reside in the facility on Medicaid.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that the Assisted Living Facility (ALF) held Medicaid contracts, effective between 10/10/2024 and 09/30/2028.

Review of the facility's records showed that the facility did not have a separate Medicaid policy, as required, that explained their policy on accepting Medicaid as a payment source. There was no documentation that showed the facility verbally informed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7, and provided them with the facility's Medicaid policy in writing. There was no documentation that showed the facility kept a signed and dated corresponding acknowledge receipt of any Medicaid policy in the seven residents' records.

During an interview on 09/16/2025 at 9:29 AM, Staff A, Executive Director, stated that the facility held Medicaid contracts that allowed the facility to accept residents who used Medicaid as a payment source. Staff A stated that when they became the new licensee in August 2024, they were unaware the facility was required to notify residents of their new Medicaid policy, and they did not complete a document of the required Medicaid policy for each resident.

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, Hillside Assisted Living is or will be in compliance with this law and / or regulation on (Date) 11/06/2025

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

Administrator (or Representative) 10/01/2025 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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 sampled staff (Staff D) completed an initial skin test for Tuberculosis (TB), within three days of hire, as required. This failure placed all 44 Assisted Living residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings included...

Review of the facility's undated Assisted Living Facility Resident Characteristic Roster showed that 44 residents received assisted living services.

Review of the facility's Employee Roster, updated 09/11/2025, showed that the facility hired Staff D, Resident Assistant/Medication Technician, on 01/28/2025. Review of Staff D's employee records showed on 02/20/2025, 23 days after hire, the facility administered Staff D the first of the two-steps TB test with a negative result.

During an interview on 08/28/2025 at 3:15 PM, Staff A, Executive Director, stated that they were familiar with the State's requirements for TB testing. Staff A stated that they were unaware Staff D completed their TB test late, beyond three days of employment.

Plan/Attestation Statement

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Administrator (or Representative) 10/01/2025 Date

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

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 sampled residents (Resident 3 and Resident 5) who used oxygen, received oxygen as ordered. This failure placed Resident 3 and Resident 5 at risk for medical errors and potential decline in their health.

Findings included...

RESIDENT 3
Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted] 2025 with medical diagnosis of [redacted]. The records showed that on 03/13/2025, the facility completed Resident 3's assessment. The assessment showed Resident 3 independently managed their use of oxygen.

Observation of Resident 3's apartment on 09/17/2025 at 10:15 AM, showed that an unused oxygen concentrator (a device that generates oxygen) sat in the room. During an interview at the same time, Resident 3 stated that they needed an oxygen supplement when in bed at night. Resident 3 stated that they received oxygen at three liters.

Review of Resident 3's July 2025, August 2025, and September 2025 Medication Administration Records (MARs) showed no documentation of a physician's order for oxygen use.

During an interview on 09/17/2025 at 2:15 PM, Staff G, Licensed Practical Nurse (LPN)/Interim Director of Nursing, was aware Resident 3 used supplemental oxygen at bedtime. Staff G stated that they were unaware that the physician order was not documented in the MAR.

RESIDENT 5
Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2025 with a medical diagnosis of [redacted] The records showed a physician's order of oxygen at two liters per minute, by nasal cannula (a narrow flexible tube that delivers oxygen through a person's nose) as needed. The records showed that on 04/28/2025, the facility completed Resident 5's assessment. The assessment showed Resident 5 required assistance with oxygen use.

Review of Resident 5's Service Plan, dated 04/16/2025, showed that Resident 5 received oxygen of two liters per minute via nasal cannula as needed. The Service Plan showed the care staff was responsible for assistance with oxygen therapy and symptoms monitoring.

Review of Resident 5's July 2025, August 2025, and September 2025 MARs showed the medication order of check oxygen twice a day, oxygen at two liters per minute by nasal canula as needed. The MARs showed that the oxygen checks were scheduled at 9:00 AM and 9:00 PM every day.

Observation of Resident 5's apartment on 09/17/2025 at 10:35 AM showed, Resident 5 sat on the side of their bed. Observation showed an oxygen concentrator, which sat on the floor next to the bed. Observation showed a nasal cannula was connected to the

oxygen concentrator. Observation showed Resident 5 placed the nasal cannula under their nose and used the nasal cannula to receive oxygen. Observation showed the oxygen concentrator was set to deliver oxygen at three liters per minute. During an interview at this time, Resident 5 stated that they did not know the oxygen flow rate they used. Resident 5 stated that they did not know how to operate the oxygen concentrator, and they did not know how to adjust the oxygen flow rate on the oxygen concentrator. Resident 5 stated that they always left the oxygen concentrator on.

Observation of Resident 5's apartment on 09/17/2025 at 12:50 PM showed the oxygen concentrator was off and the nasal cannula was left on the floor. Observation showed Resident 5 in their wheelchair returned to their apartment at this time. Observation showed Resident 5 stated they needed their oxygen when they transferred from the wheelchair to the bed. Observation showed Staff G, turned on the oxygen concentrator. Observation showed the oxygen concentrator was set to deliver oxygen at three liters per minute. During an interview, Resident 5 stated that they did not turn off the oxygen concentrator and they did not adjust the flow rate on the oxygen concentrator. Further observation showed Resident used oxygen at three liters per minute via nasal cannula.

During an interview on 09/17/2025 at 1:00 PM, Staff G stated that the oxygen concentrator was set at three liters per minute. Staff G stated that Resident 5's physician order was oxygen two liters per minute via nasal cannula. Staff G stated that their care staff was responsible to ensure Resident 5 use oxygen according to the physician's order. Staff G stated that they did not know why the oxygen was not set at two liters per minute as ordered.

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) 10/01/2025 Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to develop and document on the Service Plan the use of blood thinners or insulin for 4 of 4 sampled residents (Resident 2, Resident 5, Resident 6, and Resident 7) and the discontinuation of catheter care for 1 of 1 sampled resident (Resident 5). This failure placed Resident 2, Resident 5, Resident 6, and Resident 7 at risk for unmet care needs and potential for worsening of medically diagnosed conditions.

Findings included...

RESIDENT 2
Review of Resident 2's Move in Record, showed that the facility admitted Resident 2 on [redacted] 2024.
Review of Resident 2's record showed medical diagnoses that include [redacted].

Review of July 2025, August 2025, and September 2025 Medication Administration Records (MARs) showed that Resident 2 self-administered 2.5 milligrams (mg) of Eliquis (a medication that prevents blood clots), twice a day, by mouth for atrial fibrillation.

Review of Resident 2's annual assessment, dated September 2024, showed Resident 2 independently managed and administered their own medications. Review of the assessment showed Resident 2 was prescribed a medication that placed them at risk of bleeding or bruising easily.

Review of Resident 2's Service Plan, dated 03/20/2025, showed no documentation that explained the potential risks from the use of Eliquis. The plan showed no staff guidance about what actions were needed if Resident 2 showed any side effects associated with Eliquis.

During an interview on 09/17/2025 at 11:18 AM, Staff G, Licensed Practical Nurse, Interim Director of Nursing, stated that they did not develop and document the blood thinner use on Resident 2's service plan.

RESIDENT 5
Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2025.

Observation on 09/17/2025 at 10:35 AM showed Resident 5 did not use a urinary

catheter (a flexible tube inserted to drain urine from the bladder) and a drainage bag.

Review of Resident 5's July 2025, August 2025, and September 2025 MARs showed that Resident 5 received Aspirin (a blood thinner) 81 mg every morning for stroke (a brain injury resulted from the brain's blood supply when interrupted) prevention.

Review of Resident 5's Service Plan, updated 04/16/2025, showed Resident 5 used a urinary catheter. The Service Plan documented care staff instructions for catheter care. There was no documentation that showed the urinary catheter was removed. The Service Plan did not identify that Resident 5 received blood thinning medication. The Service Plan showed no documentation that explained the potential risks from the use of Aspirin. The plan showed no staff guidance about what actions were needed if Resident 5 showed any side effects associated with Aspirin.

During an interview on 09/18/2025 at 9:00 AM, Staff G stated that they did not document the removal of urinary catheter on Resident 5's service plan. Staff G stated that they were unaware when Resident 5's urinary catheter was removed. Staff G stated that they did not develop and document the blood thinner use on Resident 5's service plan.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2025 with the medical diagnosis of [redacted]. The records showed that on 07/01/2025, the facility assessed Resident 6. The assessment showed Resident 6 independently managed and administered their own medications.

Review of Resident 6's July 2025, August 2025, and September 2025 MARs that Resident 6 received Lispro (a medication lowers blood glucose levels) injection, Humalog (a medication lowers blood glucose levels) injection, and Lantus (a medication lowers blood glucose levels) injection. The MARs showed that between 08/01/2025 and 09/12/2025, Resident 6 used Eliquis 2.5 mg two times daily, by mouth for blood thinner.

Review of Resident 6's Service Plan, updated 07/07/2025, showed Resident 6 used insulin. The Service Plan showed no documentation that explained the possible side effects of insulin usage, such as hypoglycemia (low blood sugar levels). There were no instructions for staff about what actions were needed if Resident 6 showed any side effects of insulin usage. The Service Plan did not identify that Resident 6 received the medication with blood thinning properties. The Service Plan showed no documentation that explained the potential risks from the use of Eliquis. The plan showed no staff guidance about what actions were needed if Resident 6 showed any side effects associated with Eliquis.

During an interview on 09/18/2025 at 9:00 AM, Staff G stated that they did not develop and document the use of blood thinner and insulin on Resident 6's service plan.

RESIDENT 7
Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2024 with the medical diagnoses of [redacted].

Observation of Resident 7's apartment on 09/17/2025 at 10:50 AM showed a transfer pole (a floor-to-ceiling grab bar that provides support for transfers) was installed between Resident 7's bed and recliner. Observation showed Resident 7 used the transfer pole to pull themselves up and move to and from the recliner and the bed.

Review of Resident 7's assessment, undated, showed Resident 7 required assistance with medication management. The assessment did not identify Resident 7's prescribed medication placed them at risk for bleeding or bruising easily. The assessment showed Resident 7 was independent with mobility, transfers, and use of assistive device. There was no documentation that showed Resident used a transfer pole.

Review of the facility's document titled "Providence ElderPlace Seattle", dated 05/01/2025 showed the physician's order of the transfer pole and the physical therapist's assessment of use of the transfer pole by Resident 7. The document showed that on 06/11/2025, the facility was notified of the physician's order and installation of the transfer pole in Resident 7's room.

Review of Resident 7's July 2025, August 2025, and September 2025 eMARs showed Resident 7 received Clopidogrel (a medication used to prevent blood clots), 75 mg every evening, for cerebrovascular disease.

Review of Resident 7's Service Plan, updated 11/24/2024, showed Resident 7 did not show Resident 7 used a transfer pole. There was no documentation of Resident 7's ability to pull themselves up with the transfer pole and transfer onto the bed. There were no instructions provided for the staff on how to maintain and check the safety of the transfer pole. The Service Plan did not identify that Resident 7 received the medication with blood thinning properties. The Service Plan showed no documentation that explained the potential risks from the use of Clopidogrel. The plan showed no staff guidance about what actions were needed if Resident 7 showed any side effects associated with Clopidogrel.

During an interview on 09/18/2025 at 9:00 AM, Staff G stated that they did not develop and document the use of transfer pole and medication with blood thinning properties on Resident 7's service plan.

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, Hillside Assisted Living is or will be in compliance with this law and / or regulation on (Date) 11/10/2025

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

Administrator (or Representative) 10/01/2025 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;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to assess safety considerations for a medical device for 1 of 7 residents (Resident 4) and smoking tobacco products for 6 of 7 residents (Resident 1, Resident 3, Resident 5, Resident 7, Resident 8, and Resident 9). This failure placed Resident 1, Resident 3, Resident 4, Resident 5, Resident 7, Resident 8, and Resident 9 at risk of injury or compromised health conditions from unidentified care needs.

Findings included...

Note: 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 document titled, "Resident Assessment Policy", revised August 2024, showed that residents were assessed prior to move-in and a re-assessment were completed annually or as resident's needs and conditions changed.

MEDICAL DEVICE

RESIDENT 4
Observation of Resident 4's apartment on 09/16/2025 at 9:28 AM, showed a regular bed with an M-shaped half-length bedrail attached near the head of the bed, along the left side. During an interview at the same time, Resident 4 stated that they had previously used the bedrail to get in and out of the bed. Resident 4 stated that they no longer used the bedrail as they slept in the recliner, which was more comfortable. Resident 4 stated they were unable to recall if any nurse assessed and explained the potential risks of using the bedrail.

Review of Resident 4's records showed the facility admitted Resident 4 on [redacted] 2019. Review of Resident 4's assessment, dated 03/17/2025 showed no documentation Resident used a bedrail.

During an interview on 09/18/2025 at 10:15 AM, Staff A, Executive Director, stated they were aware Resident 4 used a bedside mobility aid. Staff A stated that Resident 4 was assessed to safely use the mobility aid. Staff A provided Resident 4's side rail use assessment, dated 09/16/2019. Staff A provided no additional information.

SMOKING
RESIDENT 1
Observation on 09/16/2025 at 10:53 AM, showed Resident 1 smoking near the corner of the west side of the facility building. Observation showed Resident 1 smoked with another resident.

During an interview at the same time, Resident 1 stated that they smoke at least eight cigarettes daily. Resident 1 stated their smoking materials included a lighter which remained in their pocket. Resident 1 stated that two or more residents had smoked simultaneously in the designated smoking area.

Review of Resident 1's records showed that the facility admitted Resident 1 in [redacted] 2025. Review of the assessment, dated 07/15/2025, showed Resident 1's tobacco use. Resident 1's records showed no documentation Resident 1 was assessed for safe smoking, unsupervised.

RESIDENT 3
Observation of Resident 3's apartment on 09/17/2025 at 10:15 AM, showed that an unused oxygen concentrator sat in the room. Observation showed Resident 3 kept their smoking materials in the seat of their walker.

During an interview on 09/17/2025 at 10:25 AM, Resident 3 stated that they previously attempted to quit smoking and failed. Resident 3 stated they did not require oxygen supplement throughout the day but require one at bedtime.

Review of Resident 3's records showed that the facility admitted Resident 3 in [redacted]

2025. Review of the service plan, dated 03/13/2025, showed Resident 3's tobacco use. Resident 3's records showed no document Resident 3 was assessed for safe smoking, unsupervised and access to oxygen equipment.

RESIDENT 5
Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2025. The records showed that on 04/28/2025, the facility completed Resident 5's assessment. The assessment showed Resident 5 used tobacco. There was no documentation that showed the facility assessed the resident's ability and safety of tobacco use.

RESIDENT 7
Review of Resident 7's records showed that the facility admitted Resident 7 in [redacted] 2024. The records showed that on 01/03/2025, the facility completed Resident 7's assessment. The assessment showed Resident 7 used tobacco. There was no documentation that showed the facility assessed the resident's ability and safety of tobacco use.

RESIDENT 8
Observation on 09/16/2025 at 10:53 AM, showed Resident 8 smoking near the corner of the west side of the facility building. Observation showed Resident 8 smoked with another resident.

Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2022. Review of the service plan, dated 03/11/2025, showed Resident 8's tobacco use. Review of Resident 8's records showed no document Resident 8 was assessed for safe smoking, unsupervised.

RESIDENT 9
Review of Resident 9's records showed that the facility admitted Resident 9 in [redacted] 2024. Review of the assessment, dated 03/17/2025, showed Resident 8 was not identified for tobacco use. Review of the service plan, dated 03/17/2025, showed Resident 8 smoked cigarette and cannabis (also known as marijuana). Resident 9's records showed no document Resident 9 was assessed for safe smoking, unsupervised.

During an interview on 09/18/2025 at 10:18 AM, Staff A, Executive Director, stated that they allow smoking in designated outside areas of the facility. Staff A stated that they did not complete an assessment to determine Resident 1, Resident 3, Resident 5, Resident 7, Resident 8, and Resident 9 were safe of tobacco use.

Statement of Deficiencies	License #: 2714	Compliance Determination # 65595
Plan of Correction	Hillside Assisted Living	Completion Date
Page 13 of 13	Licensee: Kent Senior Living Operations, LLC	09/22/2025

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Administrator (or Representative) 10/01/2025 Date