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

MG at Tukwila, LLC
Merrill Gardens at Tukwila
112 Andover Park East
Tukwila, WA 98188

RE: Merrill Gardens at Tukwila License # 2727

Dear Administrator:

This letter addresses Compliance Determination(s) 72059 (Completion Date 01/30/2026) and 68710 (Completion Date 12/04/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/30/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2474-2-e, WAC 388-78A-2100-2-b-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-2-a, WAC 388-78A-2610-2-d, WAC 388-78A-2600-1-b

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

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 #: 2727	Compliance Determination # 68710
Plan of Correction	Merrill Gardens at Tukwila	Completion Date
Page 1 of 11	Licensee: MG at Tukwila, LLC	12/04/2025

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 11/18/2025 and 11/21/2025 of:
Merrill Gardens at Tukwila
112 Andover Park East
Tukwila, WA 98188

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:

Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor
Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor
Jane Hermano, NCI

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.

Jim Sherman
Residential Care Services

12-04-2025
Date

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

Administrator (or Representative)

12/6/25
Date

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

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

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 6 staff (Staff A, Staff D, Staff E, and Staff F) completed all required training to perform their job duties and responsibilities. This failure placed 9 residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff F, Senior Care Staff, on 07/28/2021, and Staff G, Care Staff, on 10/03/2022.

CONTINUING EDUCATION
Review of Staff F's undated personnel records showed Staff F provided direct care to residents from 07/28/2021 through 11/21/2025. There was no documentation in Staff F's records that showed Staff F completed the required 12 hours of continuing education between their 04/19/2024 birthday and their 04/19/2025 birthday.

Review of Staff G's undated personnel records showed Staff G provided direct care to residents from 10/05/2022 through 11/21/2025. Review of Staff G's undated personnel

records showed no documentation that Staff G completed the required 12 hours of continuing education between their 10/10/2024 birthday and their 10/10/2025 birthday.

During an interview on 11/21/2025 at 2:25 PM, Staff A, Executive Director, stated that they were unaware Staff F and Staff G had not completed the required 12 hours of continuing education requirements.

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, Merrill Gardens at Tukwila is or will be in compliance with this law and / or regulation on (Date) 1/16/2026 .

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

Administrator (or Representative) Date 12/6/25

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess the need and safety risks of a medical device for 2 of 7 residents (Resident 4 and Resident 8). This failure placed Resident 4 and Resident 8 at risk of potential entrapment and injury when using the medical device.

Findings included...

Review of the facility's policy titled, "Assistive Devices", dated 10/19/2023, showed the facility allowed residents to utilize bedside mobility devices, such as bed canes and bed side rails. Review of the policy showed when assistive devices are implemented for residents, they will be noted in the residents Service Plan. A physical or occupational therapist, or hospice provider must complete an assessment of the resident to

determine the possible benefit to the resident and the risk of entrapment. The policy showed that residents and/or the resident's responsible party should be informed of the risks prior to use.

RESIDENT 4
Observation of Resident 4's apartment on 11/20/2025 at 2:05 PM, showed a half side rail attached at the head of the resident's bed, along the right side of the bed. The bed rail was in the raised position and measured 30 inches wide with a nine-inch gap between vertical rail bars.

During an interview at the same time, Resident 4's spouse stated that Resident 4 used the side rail for bed mobility and transfers while in bed. Resident 4's spouse was unable to recall if staff completed any assessment for Resident 4 to use the half side rail.

Review of Resident 4's records showed the facility admitted Resident 4 on [redacted]/2025. Review of Resident 4's assessments and service plans showed no documentation that Resident 4 used a half side rail on Resident 4's bed for assistance with transferring. The records showed no documentation that Resident 4 was assessed to safely use a bed half side rail.

RESIDENT 8
Observation of Resident 8's apartment on 11/19/2025 at 10:40 AM, showed a U-shaped bed cane (a type of medical device designed to assist persons with repositioning and movement) with a pocket storage, attached near the head of the bed, along the right side.

During an interview at the same time, Resident 8 stated that they used the bed cane for bed mobility and transfers (moving in and out of bed or from sitting to standing position) every day. Resident 8 stated that the care staff were aware they used a bed cane. Resident 8 was unable to recall if staff completed any assessment for them to use the bed cane. Resident 8 stated they were unaware of any safety concerns when they used the bed cane.

Review of Resident 8's records showed the facility admitted Resident 8 on [redacted]/2025. Resident 8's assessment and service plan, dated 09/03/2025, showed Resident 8 was independent with transfers. There was no documentation that Resident 8 used a bed cane for assistance with transferring. The records showed no documentation that Resident 8 was assessed to safely use a bed cane.

During an interview on 11/20/2025 at 10:45 AM, Staff H, Resident Care Director, stated that they were unaware Resident 8 used a medical device for transferring. Staff H stated an assessment was not completed to determine Resident 8's need to use a bed cane.

Statement of Deficiencies	License #: 2727	Compliance Determination # 68710
Plan of Correction	Merrill Gardens at Tukwila	Completion Date
Page 5 of 11	Licensee: MG at Tukwila, LLC	12/04/2025

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, Merrill Gardens at Tukwila is or will be in compliance with this law and / or regulation on (Date) 1/16/2026.

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

Administrator (or Representative) _____ Date 12/5/25

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;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in 3 of 7 sampled residents' (Resident 6, Resident 7, and Resident 9) Negotiated Service Agreement the care services and interventions to meet the residents' needs. This failure placed Resident 6, Resident 7, and Resident 9 at risk for unmet need and potential worsening condition.

Findings included...

RESIDENT 6
Review of Resident 6's records showed the facility admitted Resident 6 on [redacted]/2025 with multiple diagnoses, which included [redacted]

Review of Resident 6's on-going assessment showed Resident 6 received dialysis (a medical treatment for kidney failure that filter waste and extra fluid from the blood).

Observation on 11/20/2025 at 1:56 PM, showed Resident 6 had a dialysis shunt, which is a tubular raised area that was surgically implanted on their left arm. During an interview at this time, Resident 6 stated that they did not allow blood pressure to be taken, or blood drawn from their left arm.

Review of Resident 6's service plan, equivalent to a negotiated service agreement, dated 09/03/2025, showed documentation that Resident 6 received dialysis treatment. Review of the service plan showed no documentation that provided the staff with guidance about the possible complications with dialysis treatment. The service plan showed no information about their dialysis access site. There was no documentation of an alternate plan in the event Resident 9 was unable to monitor their own symptoms.

RESIDENT 7
Review of Resident 7's records showed the facility admitted Resident 7 on [redacted]2025 with multiple diagnoses, which included [redacted]

Observation of Resident7's apartment on 11/20/2025 at 10:30 AM showed two transfer poles with curved handle on the left side at the end of the bed and next to the toilet. The poles were installed with its top end fixed to the ceiling and its lower end fixed to the floor. During an interview at the same time, Resident 7 stated that they used the poles to pull themselves up from a sitting position and transfer between the bed or toilet and the wheelchair. Collateral Contact 1 (CC1, resident representative), who was present during Resident 7's interview, stated that the facility staff were aware Resident 7 used the transfer poles. CC 1 stated that the Physical Therapist helped installed the poles in September 2025.

Review of Resident 7's full assessment, dated 07/08/2025, showed they were assessed to safely use the transfer poles.

Review of Resident 7's service plan, dated 07/08/2025, showed no documentation that Resident 7 used a transfer pole at the bedside and toilet. The service plan showed no information for staff how to monitor the poles for safety use.

RESIDENT 9

Review of Resident 9's records showed the facility admitted Resident 9 on [redacted]/2023 with multiple diagnoses, which included [redacted]

Review of Resident 9's full assessment, dated 10/03/2025, showed Resident 9 received dialysis treatment.

Observation on 11/20/2025 at 11:10 AM, showed Resident 9 had a dialysis catheter, a tube used to access a person's blood for dialysis that was surgically implanted in the neck area. During an interview at this time, Resident 9 stated that the access site was painful after their dialysis treatment. Resident 9 stated that they had a private caregiver (PCG) seven days a week from 8:00 AM until 8:00 PM. Resident 9 stated that the PCG helped them to toilet, shower, and tidy the apartment. Resident 9 stated that they were unsure of any assistance from the staff when the PCG left at 8:00 PM.

Review of Resident 9's service plan, dated 10/03/2025, showed documentation that Resident 9 received dialysis treatment. Review of the service plan showed no documentation that provided the staff with guidance about the possible complications with dialysis treatment. The service plan showed no information about their dialysis access site. There was no documentation of an alternate plan in the event Resident 9 was unable to monitor their own symptoms. Review of the service plan showed no documentation that clearly define the roles and responsibilities of the PCG and the care staff. The service plan showed no alternate plan how Resident 9 would receive care and services when PCG was unavailable.

Review of electronic mail (email) from Staff H, Resident Care Director, on 11/27/2025 at 8:17 AM, showed that Resident 7 and Resident 9's service plan did not document any safety plan related to their dialysis treatment.

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, Merrill Gardens at Tukwila is or will be in compliance with this law and / or regulation on (Date) 1/16/2026.

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

Administrator (or Representative) — Date: 12/6/2025

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 3 staff (Staff I, Staff J, and Staff K) followed infection control practices while providing laundry services and personal care to residents. This failure placed all residents at risk for cross contamination and contracting or spreading illness from possible infection.

Findings included...

Review of the facility's policy titled, "Infection Control", revised 06/26/2023, showed that in addition to their policies and procedures, the facility followed regulatory guidelines developed by the Center for Disease Control and all appropriate state and federal regulations. The policy showed the importance of hand washing. The policy showed a soap and water guidelines for staff after removal of gloves and after providing "hands on" care to a resident. The policy showed that the facility followed a standard of practice for laundry to ensure proper infection control. The policy showed that all soiled laundry are transported in bags and washed immediately.

Observation on 11/19/2025 at 8:46 AM, showed Staff I, Housekeeper, knocked and announced laundry service for a resident. Observation showed Staff I did not wash their hands before putting on the gloves. Staff I used a hand sanitizer on their gloves. Staff I then folded the dirty blanket and fitted sheet off the bed. Observation showed Staff I, with the same gloves, removed the clean linens from a plastic bag and gathered the dirty linens and placed them in the same plastic bag. Staff I loaded the bagged linen on top of the housekeeping cart. With the same gloved hands, Staff I put on the clean fitted bed sheets and pillowcases. After the bed was made, Staff I removed their gloves and discarded them in the housekeeping cart garbage. Staff I pushed the housekeeping cart to the main laundry area on the first floor. Staff I added the plastic bag on top of the to-be-washed laundry pile. Observation showed Staff I did not wash their hands and change gloves after they handled the dirty laundry.

During an interview on 11/19/2025 at 9:00 AM, Staff I stated that they forgot to take off the gloves and wash their hands after they handled the dirty laundry.

Observation on 11/19/2025 at 10:17 AM, showed Staff J, Housekeeper, entered a resident's apartment with gloved hands. Staff J stripped the bed, rolled the dirty bed sheets and pillowcases off the bed. Staff J carried the dirty linens close to their body against their garments outside the resident's apartment. Staff J placed them in a plastic bag on top of the housekeeping cart. With the same gloves, Staff J made the bed with clean fitted sheets and pillowcases. Staff J removed their gloves and transported the bagged dirty linen to the main laundry room. Observation showed Staff J did not wash their hands and change gloves after they handled the dirty laundry.

Observation on 11/20/2025 at 7:52 AM, showed Staff K, Caregiver, went inside an apartment and announced the resident's morning care. With gloved hands, Staff K pulled the resident's walker and assisted the resident to stand. In the bathroom, Staff K removed the resident's dirty socks and pants, followed by a heavily soiled disposable brief. Observation showed with the same gloved hands, Staff K dressed the resident with clean socks, pants, and a new disposable brief. Observation showed that after Staff K completed the tasks, Staff K removed the soiled bed sheets and dumped them on the floor inside the resident's closet. During an interview at this time, Staff K stated that the resident's bed and sheets were wet with urine. Observation showed Staff K removed their gloves and washed their hands without soap after they provided care. Observation showed Staff K did not bag the bedding contaminated with urine.

During an interview on 11/20/2025 at 8:20 AM, Staff K stated that they were aware of the requirements to wash dirty hands with soap and water. Staff K stated that they were aware of changing gloves between tasks. Staff K stated that they were unaware of placing soiled linens in a designated container.

During an interview on 11/20/2025 at 9:00 AM, Staff L, Maintenance Director, stated they supervised the housekeeping staff. Staff L stated that the facility provided infection control training to all staff. Staff L stated that the training included proper hand hygiene and timing between dirty to clean tasks. Staff L stated that they expected the staff to follow proper hand hygiene practices, as required.

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, Merrill Gardens at Tukwila is or will be in compliance with this law and / or regulation on (Date) 1/16/2026.

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

Administrator (or Representative) Date 12/6/2025

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:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement their policy related to safe use of a bed rail medical device for 1 of 1 resident (Resident 4). This failure placed Resident 4 at risk of potential entrapment and injury.

Findings included...

Review of the facility's policy titled, "Assistive Devices", dated 10/19/2023, showed the facility allowed the use of bedside rails to assist residents with repositioning and movement while in bed. The policy showed that upon a resident's move into the community or the implementation of a new assistive device, the device will be noted in their service plan as applicable. The policy showed that risks with the use of bed rails may include entrapment, strangulation, suffocation, more serious fall-related injuries if a resident climbs over the device, or increased agitation and anxiety if perceived as a restraint. The policy showed that a resident and/or responsible party should be informed of the risks prior to use. The policy showed that if any openings within the device exceeded 4 ¾ inches for one axis (vertical or horizontal), a cover that allows for safe gripping and for the device to be used for its intended purpose must be in place.

Observation of Resident 4's apartment on 11/20/2025 at 2:05 PM, showed a half side rail attached at the head of the resident's bed, along the right side of the bed. The bed rail was in the raised position and measured 30 inches wide with a nine-inch gap between vertical rail bars. Observation showed the bed side rail was uncovered. During an interview at the same time, Resident 4's spouse stated that Resident 4 used the side rail for bed mobility and transfers while in bed. Resident 4's spouse was unable to recall if facility staff completed any assessment or were informed of risks involved in the use of bed rails.

Review of Resident 4's records showed the facility admitted Resident 4 on [redacted] 2025. Review of Resident 4's assessments and service plans (equivalent to the negotiated service agreement) showed no documentation that Resident 4 used a half side rail on Resident 4's bed for assistance with mobility and transferring. The records showed no documentation that Resident 4 was assessed by the facility to safely use a bed half side rail.

During an interview on 11/21/2025 at 1:05 PM, Staff A, General Manager/Administrator, stated that they were unaware of the policy of covering bed side rails. Staff A stated that they were unaware that Resident 4 had an uncovered side bed rail with greater than 4 ¾ inches between the vertical rail bars.

Note: cross-reference WAC 388-78A-2100 Ongoing Assessments. (2)The assisted living facility must: (b) Complete an assessment specifically focused on a resident's identified problems and related issues: (i)Consistent with the resident's change of condition as specified in WAC 388-78A-2120; (ii)When the resident's negotiated service agreement

no longer addresses the resident's current needs and preferences;

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, Merrill Gardens at Tukwila is or will be in compliance with this law and / or regulation on (Date) 1/16/2026 .

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

Administrator (or Representative) — Date: 12/6/2025