STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

MCP Sequoia WA OpCo LLC
The Sequoia Senior Living
825 Lilly Rd NE
Olympia, WA 98506

RE: The Sequoia Senior Living License # 2763

Dear Administrator:

This letter addresses Compliance Determination(s) 76404 (Completion Date 04/23/2026) and 72700 (Completion Date 03/02/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/23/2026 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-2630-1-a, WAC 388-78A-2630-1

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: The Sequoia Senior Living
Provider Type: Assisted Living Facility

License/Cert.#: 2763
Intake ID: 211396
Compliance Determination #: 72700
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 02/10/2026 through 03/02/2026
Complainant Contact Date(s):

Allegation(s):
Quality of care/treatment: Report of resident sustaining injury from care staff when care was being provided.

Investigation Methods:

Sample:	Total residents: 87 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	State reporting log Incident investigation Facility policies Staff working schedule Interim Service Plan

Investigation Summary:
Quality of care/treatment: Facility failed to notify the department when resident made allegation of sustaining injury caused by care staff when care was being provided. Failed practice identified.

Conclusion / Action:

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

☐ N/A

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

The department completed data collection for an unannounced on-site complaint investigation on 02/10/2026 of:

The Sequoia Senior Living
825 Lilly Rd NE
Olympia, WA 98506

This document references the following complaint number(s): 209063, 209301, 211396

The following sample was selected for review during the unannounced on-site visit: 3 of 87 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2763	Compliance Determination # 72700
Plan of Correction	The Sequoia Senior Living	Completion Date
Page 2 of 4	Licensee: MCP Sequoia WA OpCo LLC	03/02/2026

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.

Clinton Fridley RN
Residential Care Services

03/04/2026
Date

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

Caroline Driscoll
Administrator (or Representative)

3-13-26
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff immediately reported abuse to the department's Complaint Resolution Unit for 1 of 3 residents (Residents 3 [R3]) reviewed. This failure resulted in Resident 3 not placed all residents at risk for ongoing abuse.

Findings included...

RCW 74.34.035 Reports—Mandated and Permissive—Contents—Confidentiality.
(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

Record review of the facility policy titled, "Abuse (Alleged) Investigations and Reporting," revised 02/13/2017, showed all reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated and reported by community management. Community staff were to be trained to report incidents of suspected abuse to the administrator, or his/her designee and the appropriate state agencies upon hire/beginning of services and as needed. Should an incident or

suspected incident of resident abuse and/or neglect be reported, immediate attention shall be given to treating and protecting the resident which may include interventions to protect the resident during the investigation. Allegations of abuse will be reported to the appropriate regulatory and investigative agencies by the administrator or designee in accordance with state and federal requirements.

Record review of facility records show that R3 admitted on [redacted]/2023.

Record review of R3's incident report, dated 02/02/2026, showed that R3 reported a caregiver had been too rough with them during care and had caused bruising to R3's upper right arm.

In an interview on 02/10/2026 at 11:13 AM, R3 stated they were laying down and a caregiver was helping them up and they were rough with them and caused bruising to their arms.

In an interview on 02/10/2026 at 1:56 PM, Staff C, caregiver, stated on the morning of 01/31/2026 they had gone into R3's room and was informed by R3 that Staff D, night shift caregiver, was rough with them when they were providing care. Staff C stated they observed dark purple bruises on R3's arm. Staff C stated they then informed Staff B, former wellness director, of what R3 told them that morning at 8:00 AM.

In an interview on 02/10/2026 at 12:45 PM, Staff A, Executive Director, stated that they were not made aware of R3 sustaining bruises during care on 01/31/2026 until 02/02/2026 when two care staff informed them of the incident. Staff A stated they confronted Staff B about the incident and Staff B admitted being informed of the allegation of abuse on 01/31/2026 but forgot to follow up and went home for the day. Staff A stated Staff B was terminated for not following the facility policy.

Record review of facility provided actual worked schedule showed Staff D worked the night shift on 01/31/2026 and 02/01/2026.

In an interview on 02/17/2026 at 4:05 PM, Staff A stated Staff B should have called them as soon as they were made aware of the allegation of abuse on 01/31/2026. Staff A stated they would have suspended Staff D while they did their investigation and would have notified the department.

In an interview on 02/26/2026 at 4:00 PM, Staff E, wellness director, stated Staff B was made aware of the incident on 01/31/2026 and should have immediately called Staff A for direction. Staff B stated Staff D should have been immediately suspended to protect the residents and a report to the department should have been done within 24 hours.

Statement of Deficiencies	License #: 2763	Compliance Determination # 72700
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Page 4 of 4	Licensee: MCP Sequoia WA OpCo LLC	03/02/2026

This is a recurring deficiency previously cited on 08/25/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Sequoia Senior Living is or will be in compliance with this law and / or regulation on (Date) 4-15-26 .

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

Carolyn Driscoll — Administrator (or Representative)

3-13-26 — Date