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

ISQH, LLC
UNIVERSITY HOUSE AT ISSAQUAH
22975 SE BLACK NUGGET ROAD
ISSAQUAH, WA 98029

RE: UNIVERSITY HOUSE AT ISSAQUAH License # 1565

Dear Administrator:

This letter addresses Compliance Determination(s) 64423 (Completion Date 08/20/2025) and 61133 (Completion Date 06/25/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/20/2025 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-2620-2-a, WAC 388-78A-2620-2-b, WAC 388-78A-2950-6, WAC 388-78A-3010-8-e, WAC 388-78A-2480-1, WAC 388-78A-2485-1, WAC 388-78A-2485-2, WAC 388-78A-2485-3, WAC 388-78A-2485, WAC 388-78A-2600-2-k, WAC 388-78A-2468-1, WAC 388-78A-2090-1-a

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

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

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 #: 1565	Compliance Determination # 61133
Plan of Correction	UNIVERSITY HOUSE AT ISSAQUAH	Completion Date
Page 1 of 14	Licensee: ISQH, LLC	06/25/2025

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 06/16/2025 and 06/18/2025 of:
UNIVERSITY HOUSE AT ISSAQUAH
22975 SE BLACK NUGGET ROAD
ISSAQUAH, WA 98029

The following sample was selected for review during the unannounced on-site visit: 7 of 45 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Yip, ALF Licensor
Kathy Young, 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.

Laurie Anderson
Residential Care Services

06/26/2025
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.

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
Date

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

(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 3 of 4 pets (Pet 1, Pet 2, and Pet 4) living on the facility premises were current with their examinations and certified by a veterinarian to be free of diseases transmittable to humans. This failure placed all 45 residents at risk of contracting illnesses spread by pets.

Findings included...

Review of the facility's undated "Disclosure of Services" showed the facility allowed pets to reside in the facility. The disclosure showed that pets must have regular veterinarian examinations and immunizations, appropriate for the species, and must be certified by a veterinarian to be free of diseases transmittable to humans.

Review of the facility undated document titled, "Pet Addendum" showed no pets were allowed into the facility without first providing a veterinarian's certification the pet was free of diseases transmittable to humans.

Observations on 06/16/2025 at 9:00 AM showed several pets within the facility common spaces.

PET 1 (cat)
Review of the facility's pet records on 06/16/2025 showed no record that Pet 1 was current with all vaccinations appropriate for the species. The records showed no veterinarian certification that Pet 1 was free of diseases transmittable to humans.

PET 2 (dog)
Review of the facility's pet records on 06/16/2025 showed no veterinarian certification that Pet 2 was free of diseases transmittable to humans.

PET 4 (dog)
Review of the facility's pet records on 06/16/2025 showed no veterinarian certification that Pet 4 was free of diseases transmittable to humans. The record showed Pet 4 was due for a health examination on 10/14/2024. The records showed Pet 4 was due for the Leptospirosis vaccine on 01/22/2024, the Bordetella vaccine on 09/11/2024, and the Distemper, Hepatitis, Parainfluenza, Parvo vaccines on 10/04/2023. The were no records that showed Pet 4 received a health examination and vaccinations.

During an interview on 06/17/2025 at 11:28 AM, Staff H, Administrative Services Director, stated that they failed to ensure Pet 1, Pet 2, and Pet 4 vaccinations and veterinarian certifications were up to date. Staff H stated that they were unaware of the requirement to obtain a veterinarian certification when the pet was new to the facility. Staff H stated that they typically collected the certification upon "renewal" of each pet's veterinarian visit. Staff H stated that the facility only required the rabies vaccine. Staff H stated that they were unaware of the requirement for pets to receive all vaccines that were due for the species.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures

used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 4 pets (Pet 1, Pet 2, and Pet 4) living on the facility premises were current with their examinations and certified by a veterinarian to be free of diseases transmittable to humans. This failure placed all 45 residents at risk of contracting illnesses spread by pets.

Findings included...

Based on observation, interview, and record review, the facility failed to ensure the water temperature for 15 of 17 sink faucets tested (Fourth-Floor Common Bathroom, Apartment 444, Fourth-Floor Resident Laundry Room, Third-Floor Common Bathroom, Apartment 302, Third-Floor Resident Laundry Room, Second-Floor Common Bathroom, Apartment 209, Second-Floor Resident Laundry Room, First-Floor Resident Laundry Room, Wellness Center sink, Ground-Floor Women's Common Bathroom, Ground-Floor Men's Common Bathroom, Cougar Arts Room sink, Auditorium sink, Men's Locker Room, and Women's Locker Room) measured between 105 degrees and 120 degrees Fahrenheit (F). This failure placed all 74 assisted living residents at risk of burns from scalding water and a diminished quality of life.

Findings included...

Review of the facility's undated policy titled, "Domestic Hot Water Temperature Monitoring", Revised 06/05/2019, showed the facility kept water temperatures for common area sinks and fixtures within apartments between 105 degrees F and 120 degrees F. The policy showed that a Temperature Monitoring Log was used to document the water temperatures were within range.

Observation on 06/16/2025 at 12:20 PM, showed the boiler (hot water) system was set at 124 degrees F.

Observations on 06/16/2025 at 10:08 AM showed the hot water temperature in the sinks of the Fourth-Floor Common Bathroom measured at 122.5 degrees F; Apartment 444 measured at 121.4 degrees F; Fourth-Floor Resident Laundry Room measured at 122.2 degrees F; Third-Floor Common Bathroom measured at 123.2 degrees F, Apartment 302 measured at 123.2 degrees F; Third-Floor Resident Laundry Room measured at 122.5 degrees F, Second-Floor Common Bathroom measured at 123.0 degrees F; Apartment 209 measured at 122.1 degrees F; Second-Floor Resident Laundry Room measured at 122.9 degrees F; First-Floor Resident Laundry Room measured at 123.5 degrees F; Wellness Center sink measured at 125.4 degrees F; Ground-Floor Women's Common Bathroom measured at 123.4 degrees F; Ground-Floor Men's Common Bathroom measured at 122.9 degrees F; Cougar Arts Room sink measured at 124.5 degrees F;

Auditorium sink measured at 122.9 degrees F; Men's Locker Room measured at 122.3 degrees F; and Women's Locker Room measured at 123.2 degrees F.

During an interview on 06/16/2025 at 10:15 AM, Staff I, Facilities Director, stated that they were unaware of the required water temperature range. Staff I stated that they did not use the water temperature logs.

During an interview on 06/16/2025 at 12:20 PM, Staff I stated that the boiler system set at 124 degrees F was too high, which caused the water temperatures to be measured at above 120 degrees F.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
Date

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide lockable storage for 5 of 7 assisted living residents (Resident 1, Resident 2, Resident 3, Resident 5, and Resident 6). This failure placed Resident 1, Resident 2, Resident 3, Resident 5, Resident 6 at risk of financial loss, property loss, and a diminished quality of life.

Findings included...

Observation of Resident 1's apartment on 06/18/2025 at 9:39 AM showed Resident 1 had no lockable storage within their apartment. Observation of Resident 2's apartment on 06/18/2025 at 10:13 AM showed Resident 2 had no lockable storage within their apartment. Observation of Resident 3's apartment on 06/18/2025 at 11:10 AM showed

Resident 3 had no lockable storage within their apartment. Observation of Resident 5's apartment on 06/17/2025 at 11:10 AM showed Resident 5 had no lockable storage within their apartment. Observation of Resident 6's apartment on 06/17/2025 at 9:15 AM showed Resident 6 had no lockable storage within their apartment.

During an interview on 06/18/2025 at 9:41 AM, Resident 1 stated that they had no lockable storage in their apartment. Resident 1 stated that they were unaware the facility was required to provide lockable storage within their apartment.

During an interview on 06/18/2025 at 10:15 AM, Resident 2 stated that they had no lockable storage in their apartment. Resident 2 stated that their patio door to the resident-accessible courtyard remained unlocked due to an air conditioner hose and attachment that vented through the sliding glass door which prevented the door from closing and locking. Resident 2 stated that they were unaware the facility was required to provide lockable storage within their apartment.

During an interview on 06/18/2025 at 10:13 AM, Resident 3 stated that they had no lockable storage in their apartment. Resident 3 stated that they were unaware the facility was required to provide lockable storage within their apartment.

During an interview on 06/17/2025 at 11:10 AM, Resident 5 stated that they had no lockable storage in their apartment.

During an interview on 06/18/2025 at 11:17 AM, Staff I, Maintenance Director, stated that all assisted living residents did not have lockable storage in their apartments. Staff I stated that they were unaware of the requirement that all assisted living residents must have lockable storage in their apartments.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
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 failed to screen 1 of 15 sampled staff (Staff B) for Tuberculosis (TB), within three days of hire, as required. This failure placed all 45 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

Review of the facility's undated employee roster showed the facility hired Staff B, Community Health Nurse, on 10/01/2024. Review of Staff B's employee records showed that on 10/04/2024, four days after the date of hire, Staff B completed the Quantiferon-TB Gold Plus test (a blood test used to screen for TB) with a negative result.

During an interview on 06/17/2025 at 2:40 PM, Staff G, Executive Director, stated that they were familiar with the TB testing requirement. Staff G stated that Staff B completed the TB blood test late. Staff G stated that when they hired Staff B, Staff B refused to receive a TB skin test. Staff G stated that they requested Staff B complete the TB blood test.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the resident or staff person's health care provider.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 1 of 1 sampled staff (Staff C) completed a chest X-ray within seven days, was evaluated for signs and symptoms of TB, and followed the health care provider's recommendation, following a positive result to a Tuberculosis (TB) skin test. This failure placed all 45 residents at risk of exposure to tuberculosis, an infectious disease.

Findings included...

Review of the facility's undated employee roster showed the facility hired Staff C, Resident Assistant, on 03/08/2024. The records showed that on 03/08/2024, Staff C completed a one-step TB skin test, with a positive result. There was no documentation that showed Staff C completed a chest x-ray, following the positive TB skin test result. There was no documentation that showed Staff C was evaluated for any signs and symptoms of TB. There was no documentation that showed Staff C followed up with their health care provider.

During an interview on 06/17/2025 at 2:40 PM, Staff G, Executive Director, stated that they were unable find any additional TB documents for Staff C. Staff G stated that they were unaware Staff C's TB testing did not meet the regulation guidelines.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure safe disposure of contaminated sharps in 1 of 1 residents' (Resident 5) apartments. This failure placed Resident 5 at risk for potential exposure to infectious diseases and injury.

Findings included...

Review of the facility's document titled "Standard Precautions", dated 04/02/2013, showed that the facility informed all residents on admission the safe injection practice. The document showed the facility required all residents not to throw used syringes into the general trash and not to use unofficial sharps containers (containers used for discarded used needles, syringes, and other sharp medical equipment). The document showed the facility was responsible to provide sharps containers for residents' use.

During an interview on 06/17/2025 at 11:10 AM, Resident 5 stated that they independently used lancets (small, sharp needles used to prick the skin and draw blood) to test their blood sugar levels. Resident 5 stated that they used needles to self-inject insulin (a medication that regulates blood sugar levels) every day. Resident 5 stated that the facility did not provide them with a sharps container. Resident 5 stated that they discarded the used lancets and needles into the uncovered, general trash bins.

Observation of Resident 5's apartment on 06/17/2025 at 11:10 AM showed no sharps container present anywhere in the apartment.

During an interview on 06/18/2025 at 1:00 PM, Staff J, Registered Nurse, Community Health Director, stated that the facility used sharps containers to safely discard and store the used lancets and needles. Staff J stated that they were unaware a sharps container was not provided to Resident 5. Staff J stated that they were unaware Resident 5's lancets and needles were discarded into the general trash.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp — Administrator (or Representative)

7/3/2025 — Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit 8 of 8 sampled contracted staff (Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, and Staff R)'s Washington state name and date of birth background authorization form, within one business day after their start date. This failure placed all 45 residents at risk of abuse and neglect from caregivers and staff with an unknown background.

Findings included...

Note: WAC 388-78A-2464 Background checks—Process—Background authorization form. Before the assisted living facility employs, directly or by contract, an administrator, staff person or caregiver, or accepts any volunteer, or student, the home must: (1) Require the person to complete a DSHS background authorization form; and (2) Submit to the department's background check central unit (BCCU), including any additional documentation and information requested by the department.

STAFF K
Review of the facility's personnel records showed that the facility hired Staff K, Contracted Agency Resident Assistant, on 03/01/2025. Review of Staff K's employee records showed on 05/30/2024, a background check was completed through a third-party company. There was no documentation that showed the facility submitted a Washington state name and date of birth background check authorization form to the department at the time of Staff K's hire.

STAFF L
Review of the facility's personnel records showed that the facility hired Staff L, Contracted Agency Resident Assistant, on 05/01/2025. Review of Staff L's employee records showed on 01/22/2025, a background check was completed through a third-party company. There was no documentation that showed the facility submitted a Washington state name and date of birth background check authorization form to the department at the time of Staff L's hire.

STAFF M
Review of the facility's personnel records showed that the facility hired Staff M, Contracted Agency Resident Assistant, on 03/04/2025. Review of Staff M's employee records showed on 09/24/2024, a background check was completed through a third-party company. There was no documentation that showed the facility submitted a Washington state name and date of birth background check authorization form to the department at the time of Staff M's hire.

STAFF N
Review of the facility's personnel records showed that the facility hired Staff N, Contracted Agency Resident Assistant, on 03/04/2025. Review of Staff N's employee records showed on 06/16/2025, a background check was completed through a third-party company. There was no documentation that showed the facility submitted a Washington state name and date of birth background check authorization form to the department at the time of Staff N's hire.

STAFF O
Review of the facility's personnel records showed that the facility hired Staff O, Contracted Agency Resident Assistant, on 04/19/2025. Review of Staff O's employee records showed a Washington state name and date of birth background check authorization form, dated 04/04/2025, signed by Staff O. There was no documentation that showed the facility submitted the background check authorization form to the department. There was no documentation that showed the facility completed any Washington State name and date of birth background check for Staff O.

STAFF P
Review of the facility's personnel records showed that the facility hired Staff P, Contracted Agency Resident Assistant, on 04/18/2025. Review of Staff P's employee records showed on 02/03/2025, a background check was completed through a third-party company. There was no documentation that showed the facility submitted a Washington state name and date of birth background check authorization form to the department at the time of Staff P's hire.

STAFF Q
Review of the facility's personnel records showed that the facility hired Staff Q, Contracted Agency Resident Assistant, on 05/23/2025. Review of Staff Q's employee records showed on 01/27/2025, a background check was completed through a third-party company. There was no documentation that showed the facility submitted a Washington state name and date of birth background check authorization form to the department at the time of Staff Q's hire.

STAFF R
Review of the facility's personnel records showed that the facility hired Staff R, Contracted Agency Resident Assistant, on 06/05/2025. Review of Staff R's employee records showed on 01/16/2025, a background check was completed through a third-party company. There was no documentation that showed the facility submitted a Washington state name and date of birth background check authorization form to the department at the time of Staff R's hire.

During an interview on 06/24/2025 at 4:42 PM, Staff G, Executive Director, stated that the facility hired Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, and Staff R from contracted agencies. Staff G stated that the contracted agencies provided them with the background check reports. Staff G stated that they were unaware the background checks were required to be completed through the department. Staff G stated that they did not complete the Washington state name and date of birth

background checks with the department for the contracted agency care staff at the time of hire.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 1 sampled resident's (Resident 5) assessment included all required elements, as required. This failure placed Resident 5 at risk for unmet care needs and possible medical complications.

Findings included ...

During the interview on 06/17/2025 at 11:10 AM, Resident 5 stated that they had a history of seizures (a medical condition in the brain that causes a variety of changes in behavior, movement, sensation, awareness, or consciousness). Resident 5 stated that since they moved into the facility in [redacted] 2023, they experienced two seizure episodes. Resident 5 stated that after each seizure episode, they were sent to the emergency department.

Review of Resident 5's records showed that the facility admitted Resident 5 to the Assisted Living Facility in [redacted] 2025. The records showed that Resident 5 lived in the facility as an independent living resident between [redacted] 2023 and [redacted]

2025. The records showed that on 02/24/2025 and 03/10/2025, the facility assessed Resident 5 when Resident 5 was admitted to the Assisted Living Facility. The assessments showed no documentation of Resident 5's medical history or medical diagnosis of a [redacted]. The records showed Resident 5's medication list included Oxcarbazepine (a medication used to treat seizures) tablet, 150 milligrams, two tablets by mouth twice daily. The records showed no [redacted] was listed on the resident's medical diagnoses.

During an interview on 06/18/2025 at 1:00 PM, Staff J, Registered Nurse, Community Health Director, stated that they were unaware Resident 5 had a medical history and a medical diagnosis of a [redacted]. Staff J stated that when Resident 5 was admitted to Assisted Living, they completed assessments for Resident 5. Staff J stated that in the assessments, Resident 5 and their doctor did not disclose their [redacted] diagnosis and medical history.

During an interview on 06/23/2025 at 10:28 AM, Collateral Contact 1 (CC1, Resident 5's family), stated that since Resident 5 moved into the facility, Resident 5 experienced two seizure episodes. The first time in December 2023, and another time in April 2024. CC1 stated that both seizure episodes happened at the facility. CC1 stated that Resident 5 was transported to the emergency department for evaluation after each episode.

During an interview on 06/25/2025 at 3:10 PM, Staff G, Executive Director, stated that Resident 5 was admitted to the Assisted Living Facility in [redacted] 2025. Staff G stated that they were unaware Resident 5 experienced any seizure episode prior to Resident 5's admission to the Assisted Living Facility. Staff G stated that they did not document any events for independent living residents.

During an interview on 06/25/2025 at 3:51 PM, Staff S, Registered Nurse, Area Community Health Director, stated that Resident 5's records showed the facility admitted Resident 5 to the Assisted Living Facility in [redacted] 2025. Staff S stated that the facility completed an admission assessment on 02/24/2025 and a 14-days assessment on 03/10/2025 for Resident 5. Staff S stated the assessments did not show Resident 5's [redacted] diagnosis and medical history.

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, UNIVERSITY HOUSE AT ISSAQUAH is or will be in compliance with this law and / or regulation on (Date) 8/7/2025 .

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

Susan Vahlkamp
Administrator (or Representative)

7/3/2025
Date

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

06/26/2025

ISQH, LLC
UNIVERSITY HOUSE AT ISSAQUAH
22975 SE BLACK NUGGET ROAD
ISSAQUAH, WA 98029

RE: UNIVERSITY HOUSE AT ISSAQUAH # 1565

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 06/25/2025 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-3030 Toilet rooms and bathrooms.

(2) The assisted living facility must provide each toilet room and bathroom with:

(e) Provide mechanical ventilation to the outside; and

The facility did not ensure all common area bathroom air exchange vents worked to provide ventilation outside of the building. During the full inspection, the facility repaired the mechanical ventilation.

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