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

Sunrise Senior Living Management Inc
SUNRISE OF BELLEVUE
15928 NE 8TH ST
BELLEVUE, WA 98008

RE: SUNRISE OF BELLEVUE License # 2163

Dear Administrator:

This letter addresses Compliance Determination(s) 61258 (Completion Date 06/20/2025) and 58267 (Completion Date 04/30/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/20/2025 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-2474-4, WAC 388-112A-0060-1, WAC 388-112A-0060-1-a, WAC 388-112A-0060-1-a-iii, WAC 388-78A-2260-1, WAC 388-78A-2660-2

The Department staff who did the on-site verification:

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

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 #: 2163	Compliance Determination #58267
Plan of Correction	SUNRISE OF BELLEVUE	Completion Date
Page 1 of 7	Licensee: Sunrise Senior Living Management Inc	04/30/2025

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 04/22/2025 and 04/25/2025 of:
SUNRISE OF BELLEVUE
15928 NE 8TH ST
BELLEVUE, WA 98008

The following sample was selected for review during the unannounced on-site visit: 9 of 62 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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.

Laurie Anderson
Residential Care Services

05/06/2025
Date

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

Administrator (or Representative)

5/6/25
Date

WAC 388-112A-0060 What are the training and certification requirements for volunteers and long-term care workers in assisted living facilities and assisted living facility administrators?

(1) The following chart provides a summary of the training and certification requirements for a volunteer, an administrator or designee, and a long-term care worker in an assisted living facility: Who Status Facility orientation Safety/ orientation training Seventy-hour long-term care worker basic training Specialty training Continuing education (CE) Required credential

(a) Long-term care worker in assisted living facility.

(iii) Employed in an assisted living facility and does not meet the criteria in subsection (1)(a) or (b) of this section. Meets the definition of long-term care worker in WAC 388-112A-0010 . Not required. Required. Five hours per WAC 388-112A-0200 (2) and 388-112A-0220 . Required. Seventy-hours per WAC 388-112A-0300 and 388-112A-0340 . Required per WAC 388-112A-0400 . Required. Twelve hours per WAC 388-112A-0611 . Home care aide certification required per WAC 388-112A-0105 within two hundred days of the date of hire as provided in WAC 246-980-050 (unless the department of health issues a provisional certification under WAC 246-980-065).

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 6 staff (Staff D) completed all the training required to perform their job duties and responsibilities. This failure placed all 62 residents at risk of unmet care needs from staff with incomplete training.

Findings included:

Review of the facility's personnel records showed the facility hired Staff D, Care Manager, on 09/24/2024. The records showed that on 01/31/2024, Staff D completed the basic training requirements for long-term care workers. Review of the personnel records showed documentation that Staff D's current credential as a Nursing Assistant Registered expired on 10/04/2025. The records showed no documentation that Staff D completed the Home Care Aide certification (HCA).

During an interview on 04/25/2025 at 1:10 PM, Staff A, Executive Director, stated that they were unaware that Staff D worked at the facility for 214 days without completing the HCA certification.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 6/14/25.

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

Administrator (or Representative) — Date: 5/16/25

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure that narcotic medications stored in 4 of 4 medication carts (Cart 1, Cart 2, Cart 3, and Cart 4) were accounted for and documented on the controlled medication count record. This failure placed the residents on prescribed narcotic medications at risk of potential exploitation and potential medication errors for missed medications that were unavailable.

Findings included:

Observation on 04/22/2025 at 1:15 PM showed each floor used a medication cart to manage and administer resident medications. Each cart used its own controlled drug

count log, kept in the lock box of the cart with the narcotic or controlled medications (medications used to treat moderate to severe pain). Observation showed the first-floor medication cart (Cart 1) narcotic lock box contained seven single dose/blister pack medication card (a card that packages doses of medications within small, clear, or light-resistant colored plastic bubbles). Observation showed the second-floor medication cart (Cart 2) narcotic lock box contained eight single dose/blister pack medication cards. Observation showed the third-floor medication cart (Cart 3) narcotic lock box contained one single dose/blister pack medication card. Observation showed the fourth-floor medication cart (Cart 4) narcotic lock box contained two single dose/blister pack medication cards and five narcotic solutions in bottles. The narcotic medications found inside the locked boxes were hydrocodone (for severe chronic pain), oxycodone (for moderate to severe pain), morphine sulfate oral solution (for moderate to severe acute pain and chronic pain or shortness of breath), tramadol (for moderate to moderately severe pain), zolpidem (for sleeping), and lorazepam (for anxiety).

Review of the facility's policy titled, "Controlled Drug Security and Reconciliation", revised 05/20/2023, showed the facility stored and inventoried controlled drugs in a secure manner as defined under the Federal Drug Enforcement Agency. Review of the policy showed two authorized team members (a nurse or a nurse delegated staff) counted and verified each controlled medications at the beginning and end of each shift. Review of the policy showed the Resident Care Director was responsible to ensure that a controlled medication count occurred, as required. Review of the policy showed that the two team members were expected to sign the controlled drugs daily count log after they verified the actual number of controlled medications.

Review of the facility's February 2025, March 2025, and April 2025 controlled medications daily count logs showed there were three shifts for each day of the month. Review of the logs showed there were 85 missing team members signatures over 44 different shifts.

During an interview on 04/22/2025 at 1:34 PM, Staff J, Wellness Nurse, stated that two authorized team members were required to sign on the daily count log after each count of the controlled medication was confirmed and completed.

During an interview on 04/24/2025 at 11:02 AM, Staff A, Executive Director, stated that the Resident Care Director (RCD) ensured narcotic medications count occurred daily. Staff A stated that the RCD position was vacant since January 2025. Staff A stated that they expected the nurses and delegated nursing assistants to sign the logbooks following the count of narcotic medications. Staff A stated they were unaware authorized team members did not follow the required process.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 6/14/25 .

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

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

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 4 of 4 residents' (Resident 10, Resident 13, Resident 14, and Resident 15) rights of privacy and dignity were maintained and protected. This failure violated Resident 10, Resident 13, Resident 14, and Resident 15 rights of privacy and place them all at risk of a diminished quality of life.

Findings included:

Note: RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

IDENTIFIABLE HEALTH INFORMATION
Observation of the third floor on 04/22/2025 at 10:46 AM, showed an unattended medication cart, outside the activity room, across from the hair salon and the elevator. Observation showed an empty used medication card sat on top of the cart. The medication card was face up and the pharmacy label showed Resident 10's health information. Observation showed several residents and visitors walking through the area and past the cart.

During an interview on 04/22/2025 at 1:16 PM, Staff I, Medication Care Manager (unlicensed staff who dispenses medications), stated that they provided medication administration to the residents on the third floor. Staff I stated that they forgot to dispose of the empty medication card when they left the cart. Staff I stated that they were aware that a pharmacy label was attached to the medication card. Staff I stated

that they were aware Resident 10's health information was accessible to anyone who passed by the cart.

MEDICATION ADMINISTRATION
Review of the facility's document titled, "Medication Oversight Program", dated January 2023, showed the facility followed all applicable state laws and regulations and accepted standards of practice related to medications and medication administration. The document showed that transporting medication carts to the point of care ensured dignity and privacy in the medication administration process. The document showed that the medication cart was transported to a quiet and private area within the Reminiscence neighborhood (the facility's memory care unit). Review of the document showed residents individually received their medications from staff at the cart.

Observation on 04/23/2025 at 1:09 PM showed residents in the memory care unit gathered together to watch a musical program on television. Observation showed Staff H, Wellness Nurse, obtained blood pressure measurement of an unidentified resident who was seated in the room. Observation showed another unidentified resident watched as Staff H took the blood pressure measurement.

Observation on 04/24/2025 at 8:56 AM, showed Resident 13 was seated at a table across from Resident 15. Observation showed Staff G, Wellness Nurse, interrupted Resident 13's breakfast and obtained their blood pressure measurement. Observation showed that Staff G then administered Resident 13's oral medications. Observation showed Staff G returned to the dining room, interrupted Resident 15's breakfast, and loudly announced the names of each of Resident 15's medications. Observation showed Resident 13 stopped eating their breakfast and watched as Resident 15 received their medication. Observation showed Staff G next approached Resident 14 who was seated at another table with four other unidentified residents. Observation showed that as Staff G administered Resident 14's medications, one of the unidentified residents at the table watched.

During an interview on 04/24/2025 at 9:05 AM, Staff G stated that they were trained to administer resident medications at mealtime in the dining area. Staff G stated that they were unaware this practice violated residents' privacy and rights.

During an interview on 04/24/2025 at 9:14 AM, Resident 13 stated that they were not offered a different location other than the dining room to receive their medications and check their blood pressure. Resident 13 stated that they did not know what else they could do if staff were already in the dining area to perform this task. Resident 13 stated that they would prefer their blood pressure monitored, and the results discussed outside of the dining area, in privacy.

Observation on 04/24/2025 at 12:05 PM, showed several unidentified residents were in the dining area for lunch. Observation showed Resident 13 sat at the same table as Resident 15. Observation showed Staff G approached Resident 13 and checked Resident 13's blood pressure as Resident 15 watched. Observation showed that Staff G

did not offer Resident 13 a private area to check their blood pressure.

Review of Resident 13's service plan, dated 11/27/2024; Resident 14's service plan, dated 02/27/2025; and Resident 15's service plan, dated 11/05/2024, showed Resident 13, Resident 14, and Resident 15 required assistance and supervision with medication management from the facility's nursing staff. Review of Resident 13's plan showed no documentation or consent by Resident 13 that they agreed to receive their medications with meals or have their blood pressure checked in the dining area. Review of Resident 14 and Resident 15's service plans showed no documentation or consent by the residents that they agreed to receive their medications with meals in the dining area.

During an interview on 04/25/2025 at 2:15 PM, Staff A, Executive Director, stated they were unaware why staff provided residents' medication administration and blood pressure checks during mealtimes, in the dining room.

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, SUNRISE OF BELLEVUE is or will be in compliance with this law and / or regulation on (Date) 6/14/25.

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

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

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

05/06/2025

Sunrise Senior Living Management Inc
SUNRISE OF BELLEVUE
15928 NE 8TH ST
BELLEVUE, WA 98008

RE: SUNRISE OF BELLEVUE # 2163

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/30/2025 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-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

The facility failed to obtain signatures and dates by the resident, resident's representative, resident's family member responsible for implementing the family

medication and treatment plan, and a representative of the assisted living facility for Resident 9 and Resident 11 medication assistance plans. Resident 9 and Resident 11's assessments showed their family members provided medication management assistance. Resident 9 confirmed that they received assistance from family members with oversight by facility staff as needed. During the licensing inspection, the facility obtained all required signatures on the medication management plans to meet the regulatory requirements.

WAC 388-78A-2220 Prescribed medication authorizations.

(2) The documentation required above in subsection (1) of this section must include the following information:

(a) The name of the resident;

Resident prescribed dietary supplements in bottles stored on the facility's four medication carts were not labeled with any residents' names. During the full inspection, the staff labeled all medication bottles with the resident name.

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