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

Ruthaven ALF LLC

Ruthaven ALF LLC
15843 SE 256TH ST
COVINGTON, WA 98042

RE: Ruthaven ALF LLC License # 2659

Dear Administrator:

This letter addresses Compliance Determination(s) 79133 (Completion Date 06/23/2026) and 74690 (Completion Date 04/02/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/23/2026 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-2060, WAC 388-78A-2060-1, WAC 388-78A-2060-2, WAC 388-78A-2060-3, WAC 388-78A-2060-4, WAC 388-78A-2060-5, WAC 388-78A-2060-6, WAC 388-78A-2060-7, WAC 388-78A-2060-8, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2730-2-b-i, WAC 388-78A-2730-2-b-iii, WAC 388-78A-3000-1-a, WAC 388-78A-2480-1, WAC 388-78A-2140-1-d, WAC 388-78A-2140-2-a, WAC 388-78A-2210-1-b, WAC 388-78A-2305-1, WAC 246-215-02115-9, WAC 246-215-04600, WAC 246-215-04600-1, WAC 246-215-04600-2, WAC 246-215-04600-3, WAC 246-215-04565-4, WAC 388-78A-2466-1, WAC 388-78A-2466-1-a, WAC 388-78A-2466-1-b, WAC 388-78A-2466-2, WAC 388-78A-2466

The Department staff who did the on-site verification:
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

HOME AND COMMUNITY LIVING ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 03/23/2026 and 03/25/2026 of:

Ruthaven ALF LLC
15843 SE 256TH ST
COVINGTON, WA 98042

The following sample was selected for review during the unannounced on-site visit: 5 of 11 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jane Hermano, NCI

From:
DSHS, Home and Community Living 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

04-13-2026
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.

Patrick Simon
Administrator (or Representative)

04/21/26
Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(2) Necessary and contraindicated medications;

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

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(5) Mental illness diagnosis, except where protected by confidentiality laws;

(6) Level of personal care needs;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to complete a pre-admission assessment for 3 of 5 sampled residents (Resident 1, Resident 3, and Resident 4). This failure placed Resident 1, Resident 3, and Resident 4 at risk for admission to a facility that was unable to meet resident needs and to have a decreased quality of life.

Findings included:

Note: WAC 388-78A-2070 Timing of preadmission assessment. (1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility. (2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions.

RESIDENT 1
Review of Resident 1's record showed the ALF admitted Resident 1 on [redacted]/2025. The record showed Resident 1's diagnoses included [redacted], and [redacted].

Observation on 03/24/2026 at 1:30 PM showed Resident 1 propelled their wheelchair as they exited the facility. Observation showed Resident 1 used their wheelchair like a walker outside on the street. During an interview at the same time, Staff D, Caregiver, stated that Resident 1's daily outings included visits to the library and light errands such as grocery shopping.

Review of Resident 1's record showed no documentation that Resident 1 had a pre-admission assessment completed by the facility prior to admission to the facility.

RESIDENT 3
Review of Resident 3's record showed the ALF admitted Resident 3 on [redacted]/2026 from a hospital. The record showed Resident 3's diagnoses included [redacted], and [redacted].

Review of Resident 3's record showed no documentation that Resident 3 had a pre-admission assessment by the facility prior to admission to the facility.

RESIDENT 4
Review of Resident 4's record showed the ALF admitted Resident 4 on [redacted]/2025. The record showed Resident 4's diagnoses included [redacted], and [redacted]. The record showed that Resident 4's source of payment was private.

Review of Resident 4's record showed no documentation that Resident 4 had a pre-admission assessment completed by the facility prior to admission.

During an interview on 03/25/2026 at 9:12 AM, Staff E, Manager, stated that Resident [redacted], Resident [redacted], and Resident [redacted] did not move in under emergency circumstances. Staff E stated that they were aware residents receiving Medicaid funds required a Home and Community Services (HCS) Comprehensive Assessment Reporting Evaluation (CARE). Staff E stated Resident [redacted] and Resident [redacted] received Medicaid. Staff E stated that they thought that as long as Resident [redacted] and Resident [redacted] had an HCS assessment, they did not require the facility's pre-admission assessment. Staff E stated they never completed any pre-admission assessments for Resident [redacted] and Resident [redacted] Staff E stated that Resident [redacted] paid for their home care. Staff E stated that Resident [redacted] had no pre-admission assessment.

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, Ruthaven ALF LLC is or will be in compliance with this law and / or regulation on (Date)____Sunday, May 17, 2026____ .

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

Patrick Simon — Administrator (or Representative)

04/21/26 — 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;

(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 Assisted Living Facility (ALF) failed to complete an annual assessment for 2 of 6 sampled residents (Resident 2 and Resident 5) and a change of condition assessment for 1 of 6 sampled residents (Resident 1). This failure placed Resident 1, Resident 2, and Resident 5 at risk of potential harm, not having care needs met, and a diminished quality of life.

Findings included...

MEDICAL DEVICE ASSESSMENT AND CHANGE OF CONDITION ASSESSMENT

RESIDENT 1
Observation on 03/25/2026 at 10:35 AM showed an empty bed with half-length bedrails attached near the head of the bed, along both the right and left sides. Observation showed that both bedrails were in the raised position. The bedrails were firmly attached to the metal bed frame. Observation showed empty boxes on the floor labeled with colostomy supplies.

Review of Resident 1's records showed the ALF admitted Resident 1 on [redacted]/2025. Review of the records showed an outside primary physician visit note, dated 02/24/2026. The note showed multiple new diagnoses, which included [redacted].

During an interview on 03/25/2026 at 4:00 PM, Resident 1 stated that they had the colostomy surgery in October 2025 for twisted colon (large intestine). Resident 1 explained that an opening was made through their abdomen. Resident 1 stated that the bedrail came with the bed, and they used the left bedrail for assistance with transferring. Resident 1 stated they used the left bedrail a while back. Resident 1 stated that staff did not complete any assessment for their safe use of the bedrail. Resident 1 stated that they did not remember that a change of condition assessment was completed for the colostomy and related care. Resident 1 stated that they adjusted their daily routine and care for the stoma (opening) in their abdomen.

Review of Resident 1's records showed no documentation that Resident 1 was assessed to safely use a bedrail. The records showed no documentation that Resident 1 was assessed for change of condition when they returned to the facility with a colostomy.

During an interview on 03/25/2026 at 10:40 AM, Staff E, Manager, stated that there was no documentation in Resident 1's records that showed anyone completed a bedrail and a change of condition assessment for colostomy. Staff E stated that they were unsure why a bedrail device and change of condition assessment was not completed for Resident 1.

FACILITY'S ANNUAL ASSESSMENT

RESIDENT 2
Review of Resident 2's records showed the ALF admitted Resident 2 on [redacted]/2022. Review of the records showed no documentation that Resident 2 had annual assessment completed by the facility.

RESIDENT 5

Review of Resident 5's records showed the ALF admitted Resident 5 on [redacted]/2024. Review of the records showed no documentation that Resident 5 had an annual assessment completed by the facility.

During an interview on 03/25/2026 at 9:20 AM, Staff E, Manager, stated that they thought as long as Resident 2 and Resident 5 had a Home and Community Services (HCS) Comprehensive Assessment Reporting Evaluation (CARE) annual assessment completed by the Department's HCS Case Manager, they did not require the facility's annual assessment. Staff E stated that Resident 2 and Resident 5 had no annual assessment performed by the facility.

Plan/Attestation Statement

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Patrick Simon — Administrator (or Representative)

04/21/26 — Date

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to maintain and post the most recent assisted living facility license. The facility failed to post the September 2024 Department of Social and Health Services full inspection report. These failures placed all residents at risk of being uninformed about the facility services as permitted by the facility's license and the facility deficiencies that may affect care and services provided by the facility.

Findings included...

ASSISTED LIVING FACILITY LICENSE
Observation on 03/23/2026 at 9:54 AM, showed the assisted living license posted in the facility expired in February 2026. During an interview at this same time, Staff E, Manager, stated that because the current license was received on the weekend from the Department's License unit, their posting was delayed.

On 03/27/2026, review of an email by the Department's Business Operations and Analysis (BOA) Unit stated that the facility's annual bed fee was due on 01/15/2026. The Department's BOA unit stated that the facility's payment was received and processed on 02/26/2026. The BOA unit stated that the facility contacted them on 03/19/2026 and requested a copy of the facility's new license.

FULL INSPECTION REPORT
Review of the Department's "Secure Tracking and Reporting System (STARS)" showed the Department completed the facility's last full licensing inspection in September 2024.

During an interview on 03/23/2026 at 9:57 AM, Staff E showed the facility's plan of correction of the most recent full inspection. Staff E stated that they were unaware where the copy of the full report was kept. Staff E found the cover letter and the copy of the full inspection report in the Administrator's office.

Plan/Attestation Statement

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Patrick Simon — 04/21/26

Administrator (or Representative) — Date

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(1) Ventilate rooms to:

(a) Prevent excessive odors or moisture; and

This requirement was not met as evidenced by:

Based on observation and interview, the assisted living facility failed to ensure the mechanical ventilation system in 4 of 4 bathrooms (common bathroom, Room 101, Room 106, and Room 107) functioned to exchange air between the inside and outside of the facility. This failure placed all 11 residents at risk of respiratory distress and a diminished quality of life.

Findings included...

Observations on 03/24/2026 between 1:54 PM and 2:30 PM, showed non-functioning ventilation systems in the one common bathroom and the three residents' bedroom bathrooms. Observation showed Staff E, Manager reached out with a tissue up to the vent grille in each identified room. The tissue fell after multiple tests from different locations. Staff E was unsure if there was an airflow exchange in any of these rooms.

During an interview on 03/25/2026 at 3:21 PM, Staff A, Administrator, stated that an outside heating, ventilation, and air conditioning (HVAC) company checked the ventilation system in 2024. Staff A stated that the air vents were functional at that time. Staff A stated that they expected an airflow to the outside of the facility. Staff A stated that they did not check the vents since the HVAC company's visit. Staff A stated that they were unaware the four air exchange vents did not work.

Plan/Attestation Statement

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Patrick Simon — Administrator (or Representative)

04/21/26 — 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 Assisted Living Facility (ALF) failed to ensure 1 of 6 sampled staff (Staff C) was tested for tuberculosis within three days of hire date.

This failure placed 11 residents at risk for potential exposure to tuberculosis, an infectious disease.

Findings included:

Review of the facility's employee list showed that Staff C, Caregiver was hired on 03/03/2025. Review of the record showed Staff C completed a Chest Xray on 11/23/2024, 100 calendar days before date of hire, with negative result of TB. Review showed from 03/03/2025 through 03/23/2026, Staff C worked and provided care and services for residents.

During an interview on 03/24/2026 at 12:48 PM, Staff E, Manager, stated that they were aware of the TB screening requirements. Staff E stated that Staff C had no additional TB screenings on file other than the Chest Xray record. Staff E stated that they were unaware that Staff C was not screened for TB within three days of employment.

Plan/Attestation Statement

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Patrick Simon — Administrator (or Representative)

04/21/26 — 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:

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

(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 Assisted Living Facility failed to document 2 of 5 sampled residents' (Resident 1 and Resident 4) care needs and interventions in their Negotiated Service Agreement (NSA). These failures place Resident 1 and Resident 4 at risk for unmet needs and the potential worsening medical conditions.

Findings included...

RESIDENT 1
Review of Resident 1's records showed that the facility admitted Resident 1 in [redacted] 2025. Review of the records showed an outside primary care visit summary from 02/24/2026, included three new diagnoses of [redacted], and [redacted]. The summary note included instructions on how to manage potential constipation with a colostomy. Review of the service plan, also known as NSA, showed no documentation related to Resident 1's epilepsy, colostomy and care. There was no documentation that explained the colostomy-related complications, including constipation. Review of the service plan showed no documentation of an alternative plan in the event Resident 1 was unable to perform their ostomy care. The service plan showed no instructions to the staff about the symptom monitoring and management of epilepsy.

During an interview on 03/25/2026 at 4:00 PM, Resident 1 stated that they had the colostomy surgery in October 2025 for a twisted colon (large intestine). Resident 1 explained that an opening was made through their abdomen. Resident 1 stated that they empty and clean their ostomy pouch daily. Resident 1 stated that the staff assisted them with the ostomy care only as needed.

RESIDENT 4
Observation on 03/25/2026 at 1:27 PM showed Resident 4 sat in a chair in the common area. Observation showed Resident 4 was hard of hearing. During an interview at this time, Resident 4 was unable to follow interview questions and organize thoughts into words.

Review of Resident 4's records showed that the facility admitted Resident 4 in [redacted] 2025 with multiple diagnoses, including [redacted] and [redacted]. Review of the service plan showed no documentation about Resident 1's diabetes and its potential risks for low blood sugar and high blood sugar levels. The service plan showed no instructions to the staff about monitoring and what actions to take if Resident 4 showed

signs and symptoms of high or low blood sugar levels.

Plan/Attestation Statement

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Patrick Simon — Administrator (or Representative)

04/21/26 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all controlled substances in pharmacy pre-packaged medication cards stored on 1 of 1 (Medication Cart 1) medication cart were accounted for and documented in the facility-controlled medication count record. This failure placed three residents on prescribed narcotic medications at risk of potential exploitation related to missing medications and medication errors for missed medications that were unaccounted for and unavailable.

Findings included...

Observation on 03/24/2026 at 1:51 PM showed the facility used a mobile medication cart to store, manage, and administer resident medications. The cart had the 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 narcotic lock box contained three single-dose blister pack medication cards (cards that package doses of medications within small, clear, resistant plastic bubbles).

During an interview on 03/24/2026 at 2:00 PM, Staff E, Manager stated that the facility had two shifts for each day. Staff E stated that the Medication Aide ensured each narcotic medication count occurred daily. The Department Representative requested a medication services policy, and as of 04/03/2026, no documentation was provided by

the facility.

Review of the facility's controlled medications daily count showed four columns: one column for the date of the month, one column for the shift, one column for the signature for the staff coming on shift, and one column for the staff leaving shift. The controlled medication log audit records showed no shift audits were signed following the count of the controlled substance medications. Review of the facility's controlled medication log audit records from December 2025, January 2026, February 2026, and March 2026 showed that there were 228 shifts without any staff signatures.

During an interview on 03/25/2026 at 1:15 PM, Staff D, Caregiver, and Medication Aide stated that they were unaware they were required to sign in on the shift daily count records after each count of controlled medication was confirmed and completed.

Plan/Attestation Statement

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Patrick Simon — 04/21/26

Administrator (or Representative) — Date

WAC 246-215-02115 Duties Person in charge (FDA Food Code 2-103.11). The person in charge shall ensure that:

(9) employees are properly maintaining the temperatures of time/temperature control for safety food during hot and cold holding through daily oversight of the employees' routine monitoring of food temperatures;

WAC 246-215-04565 Equipment Manual and mechanical warewashing equipment, chemical sanitization Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114). A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under WAC 246-215-04710 must meet the requirements specified under WAC 246-215-07220 , must be used in accordance with the EPA-registered label use instructions, and must be used as follows:

(4) If another solution of a chemical specified under subsections (1) through (3) of this section is used, the permit holder shall demonstrate to the regulatory authority that the solution achieves sanitization and the use of the solution must be approved;

WAC 246-215-04600 Objective Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (FDA Food Code 4-601.11).

(1) equipment, food-contact surfaces, and utensils must be clean to sight and touch.

(2) The food-contact surfaces of cooking equipment and pans must be kept free of encrusted grease deposits and other soil accumulations.

(3) Nonfood-contact surfaces of equipment must be kept free of an accumulation of dust, dirt, food residue, and other debris.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement systems and maintain on-site food services in accordance with the Washington Administrative Code (WAC) 246-215. This failure placed 11 residents living at the ALF at risk for foodborne illness and cross-contamination.

Findings included...

Review of the facility's undated policy titled "Housekeeping and Maintenance", showed that the facility ensured a safe, clean, and homelike environment for the residents. The policy showed daily tasks included cleaning the kitchen. The policy showed all hazardous materials were kept and stored in a locked storage area.

Review of the facility's Resident Characteristic Roster showed they provided meal preparation services and care for residents with primary diagnoses of [redacted], and [redacted]. The roster showed that seven residents independently moved about the facility's common areas.

Observation on 03/24/2026 at 11:22 AM, showed the kitchen opened to the resident common dining and living room area, residential style. Observation showed that grime accumulated in corners inside and around some of the kitchen drawers and cabinet knobs. The utensil drawer and two other drawers did not open or close properly. Observations showed that the cabinet shelves for food spices, condiments, and canned foods were stained with a yellowish or brown sticky film and dust. Under the kitchen sink, an unlocked cabinet contained an open bag of pancake mix, along with a purse, a stack of mail, and a used water bottle. Inside another unlocked cabinet to the left contained several chemical cleaning products, including an anti-bacterial all-purpose cleaner and a multi-purpose surface spray. The warning labels on the products stated to avoid drinking and contact with skin and eyes. Observation showed that the stove's burner grates and the area surrounding the burners had built-up grease, hardened food spills, and grimy residues. Observation showed the stove's backsplash was colored in black with visible grease splatters of oil. The metal shelf above the stove held heavily used baking pans with surfaces that were scorched and with rust-colored edges.

Observation on 03/24/2026 at 11:32 AM showed a pot of creamy red soup with the lid off sat on the stovetop. Observation at 11:58 AM, showed the staff served the soup to the residents. Observation showed the staff did not check the temperature of the food before serving. During an interview at the same time, the staff stated that they had no warming table, and once the soup was cooked, they removed the lid and let it cool before serving. Observation showed Staff E, Manager, retrieved a thermometer from the utensil drawer and measured the temperature of the soup. When finished, the staff turned on the faucet at the sink used to wash the pots and pans and ran water over the thermometer for less than 5 seconds.

Observation on 03/24/2026 at 11:56 AM showed another staff member wiped the food preparation counter with single-use wipes. Observation showed that the packet was labeled "disinfecting baby wipes." Staff E showed a bottle of multi-purpose cleaner spray also used to clean and sanitize the rest of the food-contact surfaces.

During an interview, Staff E stated that there was no documentation of any past cooking temperatures and food safety monitoring. Staff E stated that they were aware of the precautions needed to prevent residents from accessing potentially hazardous chemicals. Staff E stated that they were not designated for one particular cleaning task. Staff E stated that the overall cleanliness needed to be monitored and enforced to ensure the kitchen was clean and the sanitizing solution was checked for safe use.

Observation on 03/25/2026 at 11:51 PM, showed the staff served a tuna plate with tomatoes to one resident. The staff stated that they were aware of checking the temperature of the food before serving. The staff stated they did not check the temperature of the food.

Plan/Attestation Statement

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Patrick Simon — 04/21/26

Administrator (or Representative) — Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 sampled staff (Staff E) completed a Washington State Name and Date Background Check every two years. The facility failed to complete a national fingerprint background check for 2 of 6 sampled staff (Staff C and Staff D). These failures placed 11 residents at risk for potential abuse, neglect or exploitation from staff persons with unknown backgrounds.

Findings included...

Note: WAC 388-78A-24681 Background checks—Employment—Provisional hire —Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty days and allow the caregiver or administrator to have unsupervised access to residents when: (1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

STAFF C
Review of the facility's undated Employee's List, showed the facility hired Staff C as a caregiver on 03/03/2025.

Review of Staff C's personnel records showed Staff C completed and renewed their Washington State Name and Date of Background Inquiry (BGI) on 04/28/2025. The BGI showed no disqualifying result. Review of the records showed Staff B completed a national fingerprint on 03/26/2026, 388 calendar days since the hire date.

STAFF D
Review of the facility's undated Employee's List, showed the facility hired Staff D as a caregiver on 04/24/2025.

Review of Staff D's personnel records showed Staff D completed their preliminary BGI result on 04/24/2025. There was no documentation that showed Staff D completed a national fingerprint background check, 333 calendar days since hire date.

Observation on 03/24/2026 and 03/25/2026 between 9:00 AM and 3:00 PM showed Staff D provided medication assistance and administration services to residents.

STAFF E
Review of the facility's undated employee list, showed the facility hired Staff E, Manager on 10/31/2022.

Review of Staff E's facility personnel records showed that their previous Washington State BGI was completed on 08/01/2023. This background check inquiry expired on 08/01/2025. The records showed that on 03/23/2026, the facility completed Staff E's BGI during the Department's Licensing visit, 214 calendar days after the previous background check expired.

Observation showed on 03/24/2026 and 03/25/2026 between 9:00 AM and 1:00 PM, Staff E had direct access to residents.

During an interview on 03/24/2026 at 1:15 PM, Staff E stated that their two-year background check was submitted late.

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, Ruthaven ALF LLC is or will be in compliance with this law and / or regulation on (Date) Sunday, May 17, 2026 .

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

Patrick Simon — 04/21/26

Administrator (or Representative) — Date

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

Ruthaven ALF LLC
Ruthaven ALF LLC
15843 SE 256TH ST
COVINGTON, WA 98042

RE: Ruthaven ALF LLC # 2659

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/02/2026 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:

James Sherman, 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 calendar days of Last Date of Data Collection (04/02/2026), no later than 05/17/2026 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-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471 ; and

(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

The Assisted Living Facility failed to maintain records of certification and credential requirements and continuing education training for staff who provided care and services. The facility obtained the staff's current records at the time of visit and filed them alongside each staff member's records.

This deficiency was corrected by the exit conference.

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 You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

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

Enclosure

Ruthaven ALF LLC Plan of correction in response to the SOD dated 4/2/26 and received via email on 4/16/26 are as follows:

Page 2/16: WAC 388-78A-2060 Preadmission Assessment: Ruthaven ALF LLC, Staff and hired Nurse Delegator were unaware of the requirements regarding Preadmission assessments. Moving forward all new admissions will have a preadmission assessment completed prior to admission to the facility.

Page 4/16: WAC 388-78A-2100 Ongoing Assessments: Ruthaven ALF LLC, Staff and hired Nurse Delegator were under impression that the DSHS Annual Assessment acted as the ongoing assessment. Moving forward all residents will have an internal Annual Assessment completed on the anniversary or sooner if needed of their previous assessment.

Page 6/16: WAC 388-78A-2730: Licesnee's responsibility: The updated License has been posted.

Page 7/16 WAC 388-78A-3000: Ventilation: 4 new, more powerful bathroom exhaust fans have been purchased and will be installed within 45 days of 4/2/26.

Page 8/16: WAC 388-78A-2480 Tuberculosis Testing Required: Staff members will have TB testing up to date.

Page 9/16: WAC 388-78A-2140 Negotiated service agreement contents: Care Plans have been updated to reflect current care needs for all residents.

Page 11/16: WAC 388-78A-2210 Medication Services: Medication log is updated every shift and medication count is logged by the Staff member who administered the medication.

Page 12/16: WAC 246-215-02115 Duties of Person in Charge: Temperature logs have been established for food temperatures for each and every meal.

Page 12/16: WAC 246-215-04565 & WAC 246-215-04600: Equipment Manual and mechanical warewashing equipment and proper sanitation solution has been established and implemented.

Page 13/16: WAC 388-78A-2305 Food Sanitation: Unkept areas have been brought up to standard.

Page 14/16: WAC 388-78A-24466: Background checks: All staff have been brought current for background checks.

AuthentiSIGN
Patrick Simon 04/21/26