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

Bellevue Senior Housing, LLC
The Park at Belle Harbour
2168 116th Ave NE
Bellevue, WA 98004

RE: The Park at Belle Harbour License # 2703

Dear Administrator:

This letter addresses Compliance Determination(s) 62307 (Completion Date 07/10/2025) and 59932 (Completion Date 05/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/10/2025 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-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-c, WAC 388-78A-2474-2-d, WAC 388-78A-2474-3

The Department staff who did the on-site verification:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor
Kathy Young, Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

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

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

The department completed data collection for an unannounced on-site follow-up on 05/22/2025 of:

The Park at Belle Harbour
2168 116th Ave NE
Bellevue, WA 98004

This document references the following SOD dated: 05/23/2025

The following sample was selected for review during the unannounced on-site visit: 0 of 31 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
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.

Residential Care Services | 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) | Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 3 of 21 sampled staff (Staff AA, Staff DD, and Staff NN) one-step skin test for Tuberculosis (TB), within three days of hire, as required. The facility failed to complete 3 of 21 sampled staff (Staff L, Staff P, and Staff II) second step TB test, one to three weeks after the first TB test, as required. These failures placed all 31 residents at risk for potential exposure to tuberculosis, an infectious disease.

Findings included…

Record review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/02/2025 for Tuberculosis testing. The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 05/17/2025.

Review of the facility's Tuberculosis policy, dated 12/01/2024, showed that each newly hired care staff member would be screened for TB exposure or symptoms of TB after an employment offer was made prior to the employee's duty assignments. The policy showed that the employee would be screened within three days of employment. The policy showed that employees who received a Bacillus Calmette-Guerin (BCG)

vaccination would be required to provide a physician verification that they were free from TB. The facility policy showed that the facility followed the state regulations to screen and test staff for TB within three days of employment.

ONE-STEP TB TEST
Review of the facility's undated Employee Roster showed that the facility hired Staff AA, Culinary Aide, on 12/19/2024; Staff DD, Culinary Aide, on 10/01/2024; and Staff NN, Culinary Aide, on 02/18/2025.

Review of the facility personnel records showed no documentation that Staff AA and Staff DD completed a TB test within three days of employment, as required. Review of Staff NN's personnel record showed that a one-step TB test was completed on 05/21/2025, 92 days after date of hire and five days after the facility's back in compliance date of 05/17/2025 for the initial citation.

During an interview on 05/22/2025 at 1:30 PM, Staff O, Business Office Manager stated that Staff AA, Staff DD, and Staff NN were minors, and the facility needed to obtain parental consent for TB tests.

TWO-STEP TB TEST
Review of the facility's undated Employee Roster showed that the facility hired Staff L, Resident Assistant, 02/26/2025; Staff P, Resident Assistant, on 07/23/2024; and Staff II, Resident Assistant, on 02/27/2025.

STAFF L
Review of Staff L's personnel record showed a one-step TB test was completed on 05/09/2025 and the results read on 05/12/2025, 40 days after the initial citation, with a negative result. The record showed that as of 05/17/2025, the facility's plan of correction date, there was no documentation that a second-step TB test was completed.

STAFF P
Review of Staff P's personnel records showed that a one-step TB test was completed on 07/23/2024 and the results were negative. A second-step TB test was completed on 08/20/2024, 28 days after the initial one-step TB test which was not within the one to three weeks after the first test was administered, as required.

STAFF II
Review of Staff II's personnel record showed that a one-step TB test was completed on 05/09/2025 and the results read on 05/12/2025, 40 days after the initial citation, with a negative result. The record showed that as of 05/17/2025, the facility's plan of correct date, there was no documentation that a second-step TB test was completed.

During an interview on 05/22/2025 at 1:30 PM, Staff O and Staff D, Director of Resident

Services, stated that they were aware several staff did not complete the TB testing as required.

This is an uncorrected deficiency previously cited on 04/02/2025, subsections (1) and (2).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 3 sampled staff (Staff T) completed the required training to perform their duties and responsibilities. This failure placed all 31 residents at risk of unmet needs and decreased quality of life from untrained staff.

Findings included…

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 04/02/2025.

The ALF signed an attestation statement that stated the facility would have the deficiency corrected by 05/17/2025.

Review of the facility's undated Characteristic Roster, showed the facility provided care and services to 21 residents with a diagnosis of [redacted], or [redacted].

Review of the facility's employee roster, dated 05/19/2025, showed the facility hired Staff T, Registered Nurse, on 07/28/2024. Review of Staff T's work schedule showed that in May 2025, Staff T worked at the facility providing care and services for residents.

SPECIALTY TRAINING
Review of Staff T's personnel records showed no documentation that Staff T completed the required dementia specialty training.

CARDIOPULMONARY RESUSCITATION (CPR) AND FIRST AID
Review of Staff T's personnel records showed no documentation that Staff T completed the required CPR and first aid training.

During an interview on 05/22/2025 at 1:30 PM, Staff O, Business Office Manager (BOM), stated that they were aware of the staff training requirements. Staff O stated that they checked the personnel records and determined Staff T did not complete the dementia specialty training and the CPR and First Aid training.

This is an uncorrected deficiency previously cited on 04/02/2025, subsections (2)(c) and (2)(d).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) 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

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 03/25/2025 and 03/27/2025 of:
The Park at Belle Harbour
2168 116th Ave NE
Bellevue, WA 98004

The following sample was selected for review during the unannounced on-site visit: 4 of 23 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Kathy Young, 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.

Residential Care Services | 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) | Date

WAC 388-78A-2300 Food and nutrition services.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure a dietary manual was onsite and available to kitchen staff responsible for food preparation in 1 of 1 commercial kitchen (Main Kitchen). This failure placed all 23 residents at risk of unmet dietary needs.

Findings included…

Observations of the main commercial kitchen on 03/26/2025 between 8:42 AM and 12:40 PM, showed Staff B and Staff R, Cooks and Staff N, Director of Culinary Services, prepared food.

During an interview on 03/26/2025 at 8:58 AM, Staff R stated they did not have access to a dietary manual for use during food preparation.

During an interview on 03/26/2025 from 9:14 AM to 9:20 AM, Staff N looked through their office and the kitchen for a dietary manual. Staff N stated that they were unable to

locate a dietary manual. On 03/26/2025 at 11:10 AM, Staff N stated that they determined that they did not have a dietary manual due to an unintentional failed communication from the corporate office.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(c) Safely operate the assisted living facility; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to develop and implement a policy and procedures to ensure resident safety for 2 of 2 open firepits (Firepit 1 and Firepit 2). This placed all 7 assisted living residents at risk of burn injury.

Findings included…

Review of the facility's undated policy titled, "Physical Plant Requirements" showed the facility provided a safe environment for residents. Review of the policy showed there was no procedure to keep the residents safe when near the firepits.

Observation on 03/25/2025 at 9:44 AM, showed a firepit with an open flame in the center of the patio, adjacent to the main dining room. The gas-fueled firepit design was a concrete bowl that was 17 inches high by 42 inches in diameter. The flame extended beyond the height of the firepit bowl. The firepit allowed residents the ability to walk right up to it and completely around it. The patio contained seating and barbeque grills.

Observation on 03/25/2025 at 10:12 AM, showed a second firepit of the same design located on the third floor Garden Terrace patio.

During an interview on 03/25/2025 at 9:45 AM, Staff G, Physical Plant Director, stated that the facility kept the firepit burning between 8:00 AM and 4:30 PM. Staff G stated that the facility used the patio with the firepit to host resident barbeques.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) 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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 pet (Pet 1) received regular veterinary examinations and were current with their vaccinations. This failure placed all 7 assisted living residents at risk of contracting illnesses spread by pets.

Findings included…

Review of the facility's Disclosure of Services showed the facility allowed residents to have pets, provided the pets received regular veterinary examinations and immunizations.

Review of Pet 1's veterinary records showed no record Pet 1 completed a regular veterinary examination. There was no documentation that showed Pet 1 was current with vaccinations.

During an interview on 03/25/2025 at 1:09 PM, Staff O, Business Office Manager, stated that the facility did not have any documentation that showed Pet 1 had a current

veterinarian examination or current vaccinations. Staff O stated that they are aware of the requirement for pets to retain current vaccinations and examinations.

Observation on 03/26/2025 at 10:33 AM, showed Pet 1 in the apartment of two residents.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 4 mechanical and janitor rooms (Second floor Mechanical Room and Forth floor Janitor Room) within assisted living were closed and locked when unattended. This failure placed 7 of 7 residents at risk of becoming trapped in the mechanical and janitor rooms.

Findings included…

Record review of the facility's disaster manual, dated March 2023, showed the procedure for locating a missing resident included a search of facility closets and storage rooms.

Review of the facility's undated policy titled, "Physical Plant Requirements" showed the facility provided a safe environment for residents.

Observation on 03/25/2025 at 9:54 AM, showed the Electrical/Mechanical Room on the second floor of assisted living was propped open with a thick sponge. Observation at 10:

04 AM, showed the Janitor Room on the fourth floor of assisted was propped wide open. Observation for both instances showed no staff in the vicinity of the opened rooms.

During interviews on 03/25/2025 at 9:54 AM and 10:04 AM, Staff G, Physical Plant Director, stated that they were aware sometimes the housekeeping staff propped the doors open when they worked in the area. Staff G stated that the doors must be kept closed. Staff G stated that they were unaware staff propped the doors open and left these areas.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 1 of 1 sampled staff (Staff T) received a one-step Tuberculosis (TB) test within three days of hire as required. This failure placed all 23 residents at risk for potential exposure to tuberculosis, and infectious disease.

Findings included…

Review of the facility's Tuberculosis policy, dated 12/01/2024, showed that each newly hired care staff member would be screened for TB exposure or symptoms of TB after an employment offer was made, prior to the employee's duty assignments. The policy showed that new employees would be screened within three days of employment. The policy showed that employees who received a Bacillus Calmette-Guerin (BCG) vaccination would be required to provide a physician verification that they were free from TB. The policy showed that the facility followed the state regulations to screen and test staff for TB within three days of employment.

STAFF T
Review of the facility's Employee Roster showed that the facility hired Staff T, Registered Nurse, on 07/28/2024. Review of Staff T's employee records showed a documented negative blood test for TB on 01/02/2025. Review of Staff T's records showed as of 03/28/2025 there was no evidence of a one-step TB test done within three days of hire, as required. Review of Staff T's records showed no evidence that Staff T obtained a chest X-ray to rule out evidence of TB.

Observation on 03/26/2025 between 9:30 AM and 2:00 PM, showed Staff T interacted with residents. Observation and interview on 03/27/2025 between 10:00 AM and 11:00 AM, showed Staff T worked the day shift.

During an interview on 03/27/2025 between 11:00 and 1:30 PM, Staff D, Director of Resident Services, stated that Staff T showed a history of an adverse reaction to the TB serum. Staff D stated that this was why a one-step TB test was not administered, as required. Staff D stated that Staff T informed them that there was documentation of a chest X-ray, that was done to rule out evidence of TB. Staff D stated that the facility did not have a copy of Staff T's X-ray report to show active TB was ruled out.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 27 of 34 staff (Staff B, Staff D, Staff E, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff R, Staff S, Staff T,

Staff W, Staff Y, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff HH, Staff II, Staff JJ, Staff KK, Staff MM, and Staff NN) one-step skin test for Tuberculosis (TB) test, within three days of hire, as required. The facility failed to perform 3 of 4 staff (Staff V, Staff X, and Staff Z) second step TB test, one to three weeks after the first TB test, as required. These failures placed all 23 residents at risk for potential exposure to tuberculosis, an infectious disease.

Findings included…

Review of the facility's Tuberculosis policy, dated 12/01/2024, showed that each newly hired care staff member would be screened for TB exposure or symptoms of TB after an employment offer was made prior to the employee's duty assignments. The policy showed that the employee would be screened within three days of employment. The policy showed that employees who received a Bacillus Calmette-Guerin (BCG) vaccination would be required to provide a physician verification that they were free from TB. The facility policy showed that the facility followed the state regulations to screen and test staff for TB within three days of employment.

ONE-STEP TB TEST

Review of the facility's Employee Roster showed that the facility hired Staff B, Cook, on 02/24/2025; Staff D, Director of Resident services, on 02/26/2024; Staff E, Resident Assistant, on 11/27/2024; Staff H, Resident Assistant, on 02/25/2025; Staff I, Resident Assistant, on 02/01/2025; Staff J, Housekeeper, on 03/19/2025; Staff K, Culinary Aide, on 02/28/2025; Staff L, Resident Assistant, on 02/26/2025; Staff M, Culinary Aide, on 02/24/2025; Staff R, Cook, on 02/04/2025; Staff S, Licensed Practical Nurse, on 03/21/2025; Staff W, Culinary Aide, on 07/15/2024; Staff Y, Cook, on 08/05/2024; Staff AA, Culinary Aide, on 12/19/2024; Staff BB, LPN, on 01/23/2025; Staff CC, LPN, on 06/18/2024; Staff DD, Culinary Aide, on 10/01/2024; Staff EE, Resident Assistant, on 01/09/2025; Staff FF, LPN, on 08/01/2024; Staff GG, Resident Assistant, on 01/09/2025; Staff HH, Culinary Aide, on 09/10/2024; Staff II, Resident Assistant, on 02/27/2025; Staff JJ, LPN, on 08/20/2024; Staff KK, Maintenance Assistant, on 05/23/2024; Staff MM, Director of Community Relations, on 08/26/2024; and Staff NN, Culinary Aide, on 02/18/2025.

Review of the facility personnel records showed no documentation that Staff B, Staff E, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff R, Staff S, Staff AA, Staff BB, Staff CC, Staff DD, Staff EE, Staff FF, Staff GG, Staff HH, Staff II, Staff JJ, Staff KK, Staff MM, and Staff NN completed any TB testing withing three days of employment, as required.

Review of Staff D's personnel records showed that on 03/29/2024, Staff D completed a two-step TB test, with negative results, four days after date of employment.

Review of Staff W's personnel records showed that Staff W completed a one-step TB test on 08/23/2024. The records showed that on 09/11/2024, Staff W completed the

second TB test. The one-step was completed 38 days after date of employment.

Review of Staff Y's personnel records showed that on 08/27/2024, Staff Y completed a one-step TB test with negative results. On 09/12/2024, Staff Y completed the second TB test, with negative results. The one-step was completed 22 days after date of employment.

During an interview on 03/27/2025 at 10:16 AM, Staff O, Business Office Manager stated that they were aware that TB testing was required for all facility staff within three days of employment.

During an interview on 03/26/2025 at 11:51 AM, Staff O, stated that the facility was informed that their contracted institutional pharmacy would no longer provide TB solution without a physician's order. Staff O stated that was the reason why the newly hired staff did not have a TB test done.

During an interview on 03/26/2025 at 2:30 PM, Staff A, Executive Director, stated that they were unaware of the pharmacy's new policy until that morning.

TWO-STEP TB TEST

Review of the facility's Employee Roster showed that the facility hired Staff V, Move in Coordinator, on 12/30/2024; Staff X, Active Living Coordinator, on 12/31/2024; and Staff Z, Active Living Coordinator, on 12/31/2024.

Review of Staff V's personnel records showed that on 12/30/2024, Staff V completed a one-step TB test, with a negative result. There was no documentation that showed Staff V completed a two-step TB test within the one to three weeks after the first test was administered, as required.

Review of Staff X's personnel records showed that on 01/02/2024, Staff X completed a one-step TB test, with a negative result. There was no documentation that showed Staff X completed a two-step TB test within the one to three weeks after the first test was administered, as required.

Review of Staff Z's personnel records showed that on 01/02/2024, Staff Z completed a one-step TB test, with a negative result. There was no documentation that showed Staff Z completed a two-step TB test within the one to three weeks after the first test was administered, as required.

During an interview on 03/27/2025 at 12:30 PM, Staff D stated that that they administered the TB test to several of the staff. Staff D stated they were unsure what

happened to the staff TB records. Staff D stated they were aware that Staff V, Staff X, and Staff Z did not have a second-step TB completed within one to three weeks after the first test was administered as required. Staff D stated they realized all three staff would need to repeat the two-step TB 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, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) 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 2 of 12 sampled staff (Staff A and Staff M) Washington state name and date of birth background inquiry (BGI) within one business day after their start date. This failure placed all 23 residents as risk for abuse and neglect from caregivers and staff persons with 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

STAFF A
Review of the facility's employee roster showed that the facility hired Staff A, Executive Director, on 02/16/2024. Review of Staff A's employee records showed the facility

completed a Washington state name and date of birth BGI on 02/20/2024, four business days after date of hire.

During an interview on 03/27/2025 at 1:30 PM, Staff A stated that they received orientation at an affiliated facility that completed the BGI. Staff A stated that they were not aware the BGI was done late.

STAFF M
Review of the facility's employee roster showed that the facility hired Staff M, Culinary Aide, on 02/24/2025. Review of Staff M's employee records showed the facility completed a Washington state name and date of birth BGI, on 02/27/2025, three business days after date 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, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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

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

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure 5 of 6 staff (Staff B, Staff E, Staff F, Staff T, and Staff U) completed the required training to perform their duties and responsibilities. This failure placed all 23 residents at risk of unmet needs

and decreased quality of life from untrained staff.

Findings included…

Review of the facility's undated personnel records showed the facility hired Staff B, Cook, on 02/24/2025; Staff E, Resident Assistant, on 11/27/2024; Staff F, Resident Assistant, on 07/08/2024; Staff T Registered Nurse, on 07/28/2024; and Staff U, Resident Assistant, on 07/22/2024. Review of the personnel records showed that the staff worked at the facility providing care and services for residents.

Review of the facility's Resident Assistant job description showed the Resident Assistant worked with residents to provide direct care, including emotional support. The job description showed the position required state mandated trainings and First Aid and Cardiopulmonary Resuscitation (CPR) certifications.

SPECIALTY TRAINING
Review of Staff E, Staff T, and Staff U's personnel records showed no documentation that Staff E, Staff F, Staff T, and Staff U completed the required dementia and mental health specialty training.

CPR and First AID
Review of Staff E, Staff T, and Staff U's personnel records showed no documentation that Staff E, Staff T, and Staff U completed the required CPR training. The personnel records showed no documentation that Staff E, Staff T, and Staff U completed the required first aid training.

FACILITY ORIENTATION
Review of Staff B, Staff E, Staff F, and Staff U's personnel records showed no documentation that the staff completed the facility orientation prior to routine interaction with residents.

During an interview on 03/27/2025 at 10:30 AM, Staff O, Business Office Manager (BOM) stated that they were aware of the staff training requirements. Staff O stated that they checked the personnel records and determined Staff B, Staff E, Staff F, Staff T, and Staff U did not complete the facility orientation, specialty training, and CPR and First Aid.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Park at Belle Harbour is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) 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

04/04/2025

Bellevue Senior Housing, LLC
The Park at Belle Harbour
2168 116th Ave NE
Bellevue, WA 98004

RE: The Park at Belle Harbour # 2703

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 04/02/2025 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-2680 Electronic monitoring equipment Audio monitoring and video monitoring.

(2) The assisted living facility may video monitor and video record activities in the facility or on the premises, without an audio component, only in the following areas:

(a) Entrances, exits, and elevators as long as the cameras are:

(ii) Not focused on areas where residents gather.

The facility cameras were focused on two common areas where memory care residents gathered. During the full inspection, the facility disconnected the cameras that were focused on resident common areas.

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

(iii) Able to be moved to the location where needed; and

(f) Make sure first-aid supplies are appropriate for:

(i) The size of the assisted living facility;

(ii) The services provided;

(iii) The residents served; and

(iv) The response time of emergency medical services.

The facility first aid kits were not clearly marked, readily available, and appropriate for the size of the facility. During the full inspection, the facility placed clearly marked first aid kits throughout the facility that were readily available.

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

The water temperatures in second-floor assisted living common bathrooms and the Rainier Room measured too low. During the full inspection, the facility adjusted the water temperatures to meet the required temperature range.

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.

Nine shift audit records were not signed by staff after each shift, following the count of controlled substance medications. During the inspection, the facility provided the nurses with in-service training. The in-service training ensure both the on-coming and off-going nurses completed shift counts at the end of each shift and signed the controlled substance count sheets.

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 medications in bottles stored on the facility medication carts were not labeled with any residents' name. During the full inspection, the staff labeled all medication bottles with the resident name. The facility implemented improved guidelines for medication storage.

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

The facility's staff were not tested annually with fitting respirators to use if respiratory hazards were encountered. Facility staff were last tested in January 2024. During the inspection, the facility scheduled the initial fit test for all new staff and the annual test

for all other staff. The Respiratory Protection Program Administrator reviewed the RPP protocol and coordinated implementation with the supervisors to ensure that all staff in their department completed the medical evaluation, received appropriate training and annual fit testing.

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, Community Field Manager
Region 2, Unit D
Residential Care Services

Enclosure