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

EASTSIDE RETIREMENT ASSOCIATION
EMERALD HEIGHTS
10901 176TH CIRCLE NE
REDMOND, WA 98052

RE: EMERALD HEIGHTS License # 994

Dear Administrator:

This letter addresses Compliance Determination(s) 67437 (Completion Date 10/20/2025) and 63713 (Completion Date 08/25/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/20/2025 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-2305-1, WAC 246-215-02310-5, WAC 388-78A-2474-2-e, WAC 388-78A-2483-2, WAC 388-78A-2350-1, WAC 388-78A-2350-7-b, WAC 388-78A-2851-5

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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: EMERALD HEIGHTS
Provider Type: Assisted Living Facility
License/Cert.#: 994
Compliance Determination #: 63713
Intake ID: 189961
Investigator: Michelle Yip
Region/Unit #: RCS Region 2 / Unit D
Investigation Date(s): 08/06/2025 through 08/25/2025
Complainant Contact Date(s):

Allegation(s):

1. Physical Environment
2. Quality of Care/Treatment
3. Financial Exploitation
4. Resident/Patient/Client Rights

Investigation Methods:

Sample:	Total residents: 50 Resident sample size: 7 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Apartment entry doors Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Maintenance staff
Record Reviews:	Medical records Incident investigation Resident Council meeting notes Disclosure of Services Facility policies and procedures Resident Move-in Agreement

Investigation Summary:

1. and 2. Several named residents (NRs) reported the entry doors of their new apartments were unsafe. The NRs reported the entry doors being heavy, tight and closed too quickly. The NRs reported injuries that were a result of them opening their apartment door when they entered and exited their units. Facility interview showed that they implemented several interventions that addressed the issues, and

the residents' concerns with the door were not yet resolved. Facility interview showed that they were unaware several residents were injured from operating their apartment doors. Facility failed to ensure the apartment entry doors were safely operated. See citation.
Reporter reported the facility failed to install a barrier in the shower stall that prevented the water from coming out of the shower. Facility stated they had intervention in place that included the use of a long shower curtain. Facility stated that they addressed and resolved the affected resident's concern. There was insufficient evidence to substantiate a violation.
3. Reporter reported that the facility posted charges on durable medical equipment (such as a shower chair and a shower bench). Named Resident 1 (NR 1) interview showed that the facility charged them on durable medical equipment. Review of the facility's Disclosure of Services showed the facility did not provide bathing equipment or devices. Review of the facility's Move-in Agreement showed the price list of durable medical equipment. There was insufficient evidence to substantiate a violation.
4. Residents were unable to enter and exit their apartments freely and safely. (Refer to Allegation 1. See citation.)
NR 1 reported their mailbox was installed at a height that was not accessible to them. NR 1 stated that their mails were partially inserted in the mailbox that violated their privacy. Observation showed the resident mailboxes were installed 45 inches above the floor outside each resident's apartment. Observation showed residents' mails were placed in the mailboxes. Facility stated they had intervention in place that addressed the issue. Facility stated their staff collected residents' mails and delivered the mails to each resident every day. There was insufficient evidence to substantiate a violation.

Conclusion / Action:

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

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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 and complaint investigation on 08/06/2025 and 08/12/2025 of:
EMERALD HEIGHTS
10901 176TH CIRCLE NE
REDMOND, WA 98052

This document references the following complaint numbers: 189961.

The following sample was selected for review during the unannounced on-site visit: 7 of 50 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Laurie Anderson
Residential Care Services

08/25/2025
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)

9/2/2025
Date

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14). foodemployees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:

(5) After handling soiled equipment or utensils;

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 facility failed to follow proper sanitation procedures for 1 of 1 kitchen (Assisted Living Kitchen). This failure placed all 50 residents at risk of consuming contaminated food and contracting food borne illnesses.

Findings included...

Review of the facility's undated policy titled, "Personal Hygiene/Cleanliness & Uniform Expectations", showed that staff were to wash their hands after switching tasks, and before beginning a new task. The policy showed that staff were to wash their hands after handling soiled equipment or utensils.

Review of the facility personnel files showed that the facility hired Staff N, Dishwasher, on 01/28/2025. Staff N's personnel file showed a valid Washington state food handlers card obtained through King County. The food worker card showed it was renewed on

02/04/2025 and expired on 02/04/2027.

Observation on 08/07/2025 at 11:00 AM showed the facility's kitchen commercial dishwasher was under repair. Observation showed the kitchen used three-compartment sinks to wash and sanitize the dirty dishes and utensils. Observation showed Staff N completed tasks that included dirty dishes and clean dishes. Observation showed Staff N wore gloves and removed food debris from dirty dishes with a scrub brush and a sprayer. Observation showed Staff N placed the dirty dishes on the dirty side of the three compartment sinks to be washed. Staff N removed a dirty linen container and boxes away from the area. This provided a clear pathway which allowed Staff N to move a cart full of clean dishes out of the dishwashing room and into the cooking area. Observation showed Staff N put the clean dishes and utensils away. Observation showed Staff N did not change gloves or wash their hands in between the handling of the dirty and clean dishes.

Observation on 08/11/2025 at 12:30 PM showed Staff N went from dirty dishes to clean dishes without washing their hands. Observation showed Staff N removed food debris from the dirty dishes, then placed the dirty dishes and utensils in a dishwashing rack. Observation showed that Staff N then removed the clean dishes from the dishwasher and pushed the dirty rack into the dishwasher. Observation showed Staff N removed the clean dishes from the dishwasher rack on the clean side and placed them on a cart full of clean dishes. Observation showed Staff N then removed the clean utensils from the clean dish rack and hung them up on a magnetic strip. At 12:36 PM, observation showed Staff N removed food debris from dirty dishes and then proceeded to put away the clean dishes and sheet pans. Observation showed Staff O, Sous Chef/Assisted Living Kitchen Manager, intervened and explained to Staff N that their gloves needed to be changed when going from dirty dishes to clean dishes.

During an interview on 08/11/2025 at 12:38 PM, Staff O acknowledged that Staff N did not change gloves between dirty dishes and clean dishes.

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, EMERALD HEIGHTS is or will be in compliance with this law and / or regulation on (Date) 10/8/2025 .

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

Administrator (or Representative) — Date: 9/2/2025

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:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 8 of 8 sampled staff (Staff D, Staff E, Staff G, Staff H, Staff I, Staff J, Staff K, and Staff L) completed the continuing education (CE) training as required. This failure placed all 50 residents at risk for decreased quality of care provided by caregivers with incomplete training.

Findings included...

STAFF D
Review of Staff D's employee records showed the facility hired Staff D as a Nursing Assistant Certified (NA-C), on 07/29/2021. The records showed Staff D maintained an active Nursing Assistant Certified credential. The records showed documentation that Staff D completed two of the required 12 hours of continuing education training from their August 2023 birthday to their August 2024 birthday.

STAFF E
Review of Staff E's employee records showed the facility hired Staff E as a NA-C on 05/26/2023. The records showed Staff E maintained an active NA-C credential. The records showed Staff E completed two of the required 12 hours of continuing education training from their October 2023 birthday to their October 2024 birthday.

STAFF G
Review of Staff G's employee records showed the facility hired Staff G as a NA-C on 12/16/2001. The records showed Staff G maintained an active NA-C credential. The records showed Staff G completed eight of the required 12 hours of continuing education training from their May 2024 birthday to their May 2025 birthday.

Review of the facility's Care Staff schedules from 06/18/2025 through 08/06/2025 showed Staff G worked 17 shifts providing care and services to residents.

STAFF H
Review of Staff H's employee records showed the facility hired Staff H as a NA-C on 12/21/2012. The records showed Staff H maintained an active NA-C credential. The records showed Staff H completed eight of the required 12 hours of continuing education training from their May 2024 birthday to their May 2025 birthday.

Review of the facility's Care Staff schedules from 07/17/2025 through 08/06/2025 showed Staff H worked one shift providing care and services to residents.

STAFF I
Review of Staff I's employee records showed the facility hired Staff I as a NA-C on 10/05/2023. The records showed Staff I maintained an active NA-C credential. The records showed Staff I completed seven of the required 12 hours of continuing education training from their March 2024 birthday to their March 2025 birthday.

Review of the facility's Care Staff schedules from 07/17/2025 through 08/06/2025, showed Staff I worked six shifts providing care and services to residents.

STAFF J
Review of Staff J's employee records showed the facility hired Staff J as a NA-C on 01/14/2022. The records showed Staff J maintained an active NA-C credential. The records showed Staff J completed 10 of the required 12 hours of continuing education training from their July 2024 birthday to their July 2025 birthday.

Review of the facility's Care Staff schedules from 07/17/2025 through 08/06/2025 showed Staff J worked five shifts per week in the facility, providing care and services to residents.

STAFF K
Review of Staff K's employee records showed the facility hired Staff K as a NA-C on 02/27/2020. The records showed Staff K maintained an active NA-C credential. The records showed Staff K completed six of the required 12 hours of continuing education training from their May 2024 birthday to their May 2025 birthday.

Review of the facility's Care Staff schedules from 06/18/2025 through 08/06/2025 showed Staff K worked 14 shifts in the facility providing care and services to residents.

STAFF L
Review of Staff L's employee records showed the facility hired Staff L as a NA-C on 03/24/2010. The records showed Staff L maintained an active NA-C credential. The records showed Staff L completed eight of the required 12 hours of continuing education training from their February 2024 birthday to their February 2025 birthday.

Review of the facility's Care Staff schedules from 07/17/2025 through 08/06/2025 showed Staff L worked 12 shifts providing care and services to residents.

During an interview on 08/12/2025 at 2:15 PM, Staff M, Human Resource Director, stated that they were unable to locate any additional training documentation for Staff

D. Staff E, Staff G, Staff H, Staff I, Staff J, Staff K, and Staff L.

Review of the facility's email dated 08/14/2025 from Staff A, Health Services Administrator, showed confirmation that the facility was unable to provide additional Department of Social and Health Services approved continuing education documents for Staff D, Staff E, Staff G, Staff H, Staff I, Staff J, Staff K, and Staff L.

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, EMERALD HEIGHTS is or will be in compliance with this law and / or regulation on (Date) 10/9/2025 .

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

Jill Jone — Administrator (or Representative)

9/2/2025 — 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 interview and record review, the facility failed to screen 1 of 4 sampled staff (Staff F) for Tuberculosis (TB). This failure placed all 50 residents at risk of potential exposure to tuberculosis, an infectious disease.

Finding included...

NOTE: WAC 388-78A-2480, Tuberculosis Testing Required, showed (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.

Review of the facility's undated employee list showed the facility hired Staff F, Nursing Assistant Certified (NAC), on 09/11/2024. Review of Staff F's employee records showed that on 07/01/2024, Staff F completed the T-Spot Blood Test (a blood test used to screen for TB) with a negative result. The records showed that on 01/29/2025, 140 days after date of hire, Staff F completed a TB skin test with a negative result.

During an interview on 08/12/2025 at 8:40 AM, Staff P, Assisted Living Manager, stated that they were unaware Staff F's TB testing did not meet the regulation guidelines. Staff P stated that they were unable to locate any additional TB documents for Staff F.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 9/2/2025

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interviews and record review, the facility failed to follow the medical order and notify the outside healthcare provider for 1 of 1 sampled resident (Resident 4). This failure placed Resident 4 at risk of improper care and services and potential medical complications.

Findings included...

Review of the facility's policy titled, "Coordination of Health Care Services", revised November 2017, showed that the facility coordinated services with external healthcare providers to meet the resident's needs, consistent with the resident's service plan agreement. The document showed the facility and service provider maintained ongoing communication regarding timeline for services, progress toward goals, communication with the healthcare provider, and documentation of the services provided and resident outcome.

Review of Resident 4's records showed the facility admitted Resident 4 in [redacted] 2024 with medical diagnoses of [redacted] and [redacted]. The records showed that on 03/11/2025, the facility completed Resident 4's assessment. The assessment showed Resident 4 required assistance to check BS levels, monitor for signs and symptoms of hypoglycemia (low BS level) and hyperglycemia (high BS level), and notify the physician of any abnormal findings. The assessment showed Resident 4 required assistance to coordinate diabetic care needs with a named outside healthcare provider.

Review of Resident 4's June 2025, July 2025, and August 2025 Medication Administration Records (MAR) showed the medical orders included instructions to monitor fasting BS (the BS level after a person has not eaten for at least eight hours), twice a day (before breakfast and before dinner). If BS was greater than 350 milligrams per deciliter (mg/dL – a unit of measurement used to determine BS levels) or any BS above of 250 mg/dL with symptoms of hyperglycemia, please contact the named outside healthcare provider.

Review of the June 2025 MAR showed that on 06/18/2025 at 8:21 PM, the recorded BS was 335. The MAR showed no documentation that the facility staff assessed the resident for symptoms of hyperglycemia. The MAR showed that on 06/23/2025 at 8:44 AM, the recorded BS was 308. The MAR showed no documentation that the facility staff assessed the resident for symptoms of hyperglycemia.

Review of the July 2025 MAR showed that on 07/15/2025 at 5:59 PM, the recorded BS was 400. The MAR showed no documentation that the facility staff notified the outside healthcare provider of the high BS level. The MAR showed that on 07/22/2025 at 8:56 AM, the recorded BS was 258. The MAR showed no documentation that the facility staff assessed the resident for symptoms of hyperglycemia. The MAR showed that on 07/29/2025 at 5:36 PM, the recorded BS was 399. The MAR showed no documentation that the facility staff notified the outside healthcare provider of the high BS level. The MAR showed that on 07/30/2025 at 9:02 AM, the recorded BS was 278. The MAR showed no documentation that the facility staff assessed Resident 4 for symptoms of hyperglycemia.

During an interview on 08/12/2025 at 1:00 PM, Staff P, Licensed Practical Nurse, Assisted Living Director, stated that the licensed nurses were responsible for monitoring Resident 4's blood sugar levels and documenting their actions in the resident's records. Staff P stated that the licensed nurses were responsible for assessing the resident's symptoms and notifying the outside healthcare provider in accordance with the medical orders. Staff P stated that the licensed nurses were responsible to notify the outside healthcare provider by fax of the resident's high blood sugar results, then document the task in the resident's records. Staff P stated they were unable to locate any documentation that showed the licensed nurses assessed Resident 4 and notified the provider on several occasions. Staff P stated that they were unsure if the nurses notified the provider.

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, EMERALD HEIGHTS is or will be in compliance with this law and / or regulation on (Date) 10/8/2025

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

Administrator (or Representative) — Date: 9/2/2025

WAC 388-78A-2851 Applicability requirements for physical plant.

(5) The department may require a facility to meet requirements if building components or systems are deemed by the department to jeopardize the health or safety of residents.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 6 of 6 sampled Residents' (Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13) entry doors were safely operated. This failure placed Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13 at risk for injuries and a diminished quality of life.

Findings included...

During the resident group meeting on 08/07/2025 at 2:00 PM, several anonymous residents stated that the entry doors of the new apartments were a "universal concern". The residents stated that the doors were so heavy that many residents experienced difficulty opening the doors. The residents stated that the doors did not stay open long enough to give the residents enough time to pass through before the doors closed. The residents stated that they felt the doors were unsafe to operate. The residents stated that many of them reported injuries that were a result of them opening their apartment door.

RESIDENT 8
Review of Resident 8's records showed that the facility admitted Resident 8 in [redacted] 2024. The records showed that on 06/17/2025, Resident 8 moved into their current apartment. The records showed Resident 8 independently used a motorized chair. The records showed that on 06/24/2025, Resident 8 reported pain in their right hip and back. The records showed since 06/24/2025, Resident 8 used prescribed medication for pain relief.

Review of the facility's untitled, undated document showed that Resident 8 resided in an American with Disabilities Act (ADA) unit.

During an interview on 08/11/2025 at 11:06 AM, Resident 8 stated that they used a motorized chair to enter and exit the apartment through the entry door. Resident 8 stated the door was heavy. Resident 8 stated that it required a lot of effort to open the door, operate the motorized chair, and get through the door at the same time. Resident 8 stated that in June 2025, one week after they moved into the apartment, they developed back pain that required them to use pain relieve prescription. Resident 8 stated that they believed the pain was a result of the difficulty they had to open the door. Resident 8 stated that they were concerned about their safety because they were unable to open the door to evacuate during emergencies.

RESIDENT 9
Review of Resident 9's records showed that the facility admitted Resident 9 in [redacted] 2023. The records showed that on 06/18/2025, Resident 9 moved into their current apartment. The records showed Resident 9 independently used an electric scooter outside the apartment. The records showed that on 07/04/2025 at 1:00 PM, Resident 9 reported an injury to their lower legs and feet when their electric sooter became trapped between the door and the door frame as they exited their room. The records showed Resident 9 found a blue bruise on their left and right ankles because of the incident.

Observation on 08/12/2025 at 1:00 PM showed Resident 9 independently operated the electric scooter. Observation showed that when Resident 9 entered the apartment, Resident 9 used the left hand to rotate the doorknob and used the right hand to control the scooter at the same time.

During an interview on 08/12/2025 at 12:45 PM, Resident 9 stated that the door was heavy to open and stay open. Resident 9 stated that pushing the door open from outside was easier than pulling the door open from inside the apartment. Resident 9 stated that pulling the door open required more effort and coordination. Resident 9 stated that it was particularly difficult for the wheelchair users like themselves, who were required to manage the wheelchair and the door at the same time. Resident 9 stated that two weeks after they moved in, they were injured by the door as they exited their apartment. Resident 9 stated that they used one hand to turn the door handle and the other hand to control the electric scooter. Resident 9 stated that when they exited the room, their left hand slipped on the door handle and the scooter continued moving. Resident 9 stated the door slammed back onto them which injured their left and right ankles. Resident 9 stated that their ankles were bruised and swollen, and they were in pain.

RESIDENT 10
Review of Resident 10's records showed that the facility admitted Resident 10 in [redacted] 2025. The records showed that on 07/30/2025, Resident 10 moved into their current apartment. The records showed Resident 10 used a four-wheel walker outside the

apartment. The records showed that on 07/30/2025, Resident 10 reported a fall.

Observation of Resident 10's apartment on 08/12/2025 at 12:27 PM showed the entry door was partially opened. Observation showed a rubber door wedge was attached to the door edge which left a gap between the door and the door frame.

During an interview on 08/12/2025 at 12:27 PM, Resident 10 stated that the entry door was too heavy, and they were unable to open the door on their own. Resident 10 stated that when they moved in, they were injured by the door as they entered their apartment. Resident 10 stated that it was difficult to push their walker, hold the door open, and walk through the entry all at the same time. Resident 10 stated that the door slammed back too quickly, and it did not give them enough time to pass through it. Resident 10 stated that on 07/30/2025, as they passed through the doorway, the door slammed back and knocked them and the walker over. Resident 10 stated that they fell on the floor which resulted in bruises on their right arm. Resident 10 stated that after they fell, they got up on their own. Resident 10 stated that they did not report the incident or the injury to the facility.

RESIDENT 11
Review of Resident 11's records showed that the facility admitted Resident 11 in [redacted] 2025. The records showed that on 06/12/2025, Resident 11 moved into their current apartment. The records showed Resident 11 used a four-wheel walker, a wheelchair, and an electric scooter.

Observation of Resident 11's apartment on 08/11/2025 at 1:37 PM showed the door was partially opened with a two feet gap between the door and frame. Observation showed a door stopper was placed at the bottom of the door that prevented the door from fully closing. Observation showed a rubber wedge was attached to the side of the door edge. Observation inside the apartment showed Resident 11 seated in the armchair. Observation showed a walker next to the resident.

During an interview on 08/11/2025 at 1:37 PM, Resident 11 stated that the entry door was heavy and tight. Resident 11 stated that they experienced difficulty opening the door. Resident 11 stated that they used a door wedge and a door stopper to keep the door open. Resident 11 stated that they kept the door open, which minimized their struggles with opening the door or calling staff for assistance with the door. Resident 11 stated that it required a lot of effort and force to open the door. Resident 11 stated that when they opened the door to exit the room, they lost their balance when the door closed and knocked into them. The door banged into their arms and shoulders and bruised their arms.

RESIDENT 12
Review of Resident 12's records showed that the facility admitted Resident 12 in [redacted] 2025. The records showed that on 07/08/2025, Resident 12 moved into their current apartment. The records showed Resident 12 used a four-wheel walker.

Observation of Resident 12's apartment on 08/07/2025 at 3:18 PM showed the entry door was partially open. A door stopper was placed at the bottom of the door that left about an inch gap between the door and the door frame. Observation showed Resident 12 was inside their apartment, shouting for assistance to open the door. Observation showed when the door was opened, Resident 12 independently walked with a four-wheel walker out of the apartment.

During an interview on 08/12/2025 at 1:26 PM, Resident 12 stated that the door was "impossible" for them. Resident 12 stated that pulling the door open was more difficult than pushing the door open. Resident 12 stated that they almost fell a few times when the door slammed back and knocked them off balance. Resident 12 stated that it was difficult to open the door and walk through the entry as they used their walker, all at the same time.

RESIDENT 13
Review of Resident 13's records showed that the facility admitted Resident 13 in [redacted] 2025. The records showed that on 06/17/2025, Resident 13 moved into their current apartment. The records showed Resident 13 used a four-wheel walker.
Observation of Resident 13's apartment on 08/12/2025 at 1:05 PM showed a four-wheel walker was placed in front of the entry door. Observation showed the door was partially opened. Observation showed a rubber door stopper at the bottom of the door that left a gap between the door and the door frame.

During an interview on 08/12/2025 at 1:05 PM, Resident 13 stated that the entry door into the apartment was an issue. Resident 13 stated that the door was not only heavy, and it also shut on people very fast. Resident 13 stated that there was no device or mechanism on the door that would hold the door open. Resident 13 stated that it was difficult for anyone who used a walker to operate the door and manage a walker at the same time. Resident 13 stated that they left the walker outside in front of the apartment when they entered the apartment to minimize the burdens.

During an interview on 08/11/2025 at 2:45 PM, Staff Q, Executive Director, stated that they were aware of the residents' concerns related to the apartment entry doors being heavy, tight and closed too quickly. Staff Q stated that they were aware many residents experienced difficulties in operating the doors to go into and out of their apartment every day. Staff Q stated they implemented several interventions that addressed the issues. Staff Q stated that they adjusted the door tension that made the door easier to open; they referred individual residents to physical therapist for evaluation and therapy; and they offered residents the option to move to the skilled nursing facility. Staff Q stated that they encouraged the residents to use the call system to summon staff for assistance whenever they needed to enter or exit their apartment. Staff Q stated that the residents requested installation of an assistive door device that enabled them to operate the door independently and safely. Staff Q stated that the residents and the facility were unable to make an agreement about the costs for the installation of the device. Staff Q stated that the residents' concerns with the door were not yet resolved.

During an interview on 08/12/2025 at 1:00 PM, Staff P, Licensed Practical Nurse, Assisted Living Director, stated that they were aware of the residents' concerns of the apartment entry doors being heavy. Staff P stated that the door became an issue when the residents moved into their new Assisted Living building. Staff P stated that the residents brought up the door issues in each resident council meeting. Staff P stated that the facility addressed the issues. Staff P stated that they were unaware several residents were injured from operating their apartment door. Staff P stated that not all the residents notified them about their injuries.

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, EMERALD HEIGHTS is or will be in compliance with this law and / or regulation on (Date) 10/08/2025.

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

Administrator (or Representative)

9/2/2025
Date