STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

CANTERBURY GARDENS LIMITED PARTNERS
CANTERBURY GARDENS
1457 3rd Ave
Longview, WA 98632

RE: CANTERBURY GARDENS License # 1580

Dear Administrator:

This letter addresses Compliance Determination(s) 70302 (Completion Date 01/08/2026) and 66210 (Completion Date 11/20/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/08/2026 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-2160

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: CANTERBURY GARDENS **Provider Type:** Assisted Living Facility

License/Cert.#: 1580
Intake ID: 193548
Compliance Determination #: 66210
Region/Unit #: RCS Region 3 / Unit E
Investigator: Jacob Ubl
Investigation Date(s): 09/24/2025 through 11/20/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Facility report that a resident had a fall with Injury.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Quality of Care/Treatment: Failed practice Identified. The facility failed to provide a resident with the appropriate transfer needs identified in their Negotiated Service Agreement.

Conclusion / Action:

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

☐ N/A

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Statement of Deficiencies	License #: 1580	Compliance Determination # 66210
Plan of Correction	CANTERBURY GARDENS	Completion Date
Page 1 of 5	Licensee: CANTERBURY GARDENS LIMITED PARTNERS	11/20/2025

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

The department completed data collection for an unannounced on-site complaint investigation on 09/24/2025 and 11/20/2025 of:

CANTERBURY GARDENS
1457 3rd Ave
Longview, WA 98632

This document references the following complaint number(s): 195632, 193548, 192731

The following sample was selected for review during the unannounced on-site visit: 3 of 67 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Clinton Fridley RN
Residential Care Services

11/24/2025
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)

11/25/25
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide care agreed upon in the needs and services plan (the facility's version of the negotiated service agreement [NSA]) for 1 of 3 sampled residents (Resident 1). This failure negatively impacted the residents' quality of life by not having their care needs provided resulting in injury with hospitalization.

Findings included...

Record review of an undated face sheet showed Resident 1 (R1) was admitted to the facility on [redacted]/2022 and documented R1 had a diagnosis of [redacted].

Record review of R1's Incident Report, dated 09/05/2025, showed R1 had a fall while being assisted to the toilet by Staff C, caregiver, and was subsequently sent to the local hospital for evaluation.

Record review of R1's progress note, dated 09/05/2025, showed R1 had suffered compression fractures (bone breakage) of two vertebra bones (a series of small bones forming the backbone).

Record review of R1's NSA, dated 06/11/2025, showed R1 needed one person assistance with transfers.

Record review of a facility policy, dated 12/01/2024, titled, "Assistance with Transfer and Ambulation", showed that a resident would be transferred according to their assessed needs addressed on the NSA and that staff would be trained on safe transfer methods.

In an interview on 09/24/2025 at 2:43 PM, Staff C stated that when they were transferring R1, on 09/05/2025, they assisted R1 near the toilet, R1 held onto grab bars near toilet while standing, then they left R1 there to shut the bathroom door. Staff C stated that R1 fell while they were shutting the bathroom door. Staff C stated that R1 had experienced obvious pain and distress after their fall. Staff C stated that the facility's expectation was that staff assist residents throughout the entire transfer, keeping residents within arm's reach, and they failed to do that. Staff C stated that they didn't know why they deviated from safe transfer training and that in hindsight they could have managed a safe transfer if they had done it differently.

In an interview on 09/24/2025 at 3:17 PM, Staff D, caregiver, stated that, prior to 09/05/2025, R1 was not safe to be left alone, for any length of time, during a transfer. Staff D stated that R1 needed a staff member to be physically assisting and verbally directing R1 throughout the transfer for it to be safe for R1.

In an interview on 09/24/2025 at 3:36 PM, Staff E, caregiver, stated that they relied on other staff to inform them on residents transfer needs and had not referred to any residents NSA's to verify what their transfer needs were.

In an interview on 09/24/2025 at 3:52 PM, Collateral Contact 1 (CC1) stated that, prior to 09/05/2025, R1 was not safe to be left alone, standing, holding onto grab bars, without a staff within arm's reach of R1. CC1 stated that they had noticed that some staff will intermittently transfer residents in an unsafe way and not according to their NSA. CC1 stated that the facility staff needed training on safe transfers.

In an interview on 09/24/2025 at 4:17 PM, Staff F, caregiver, stated that prior to 09/05/2025, R1 was not safe to be left alone at any point during a transfer without a staff within arm's reach of R1.

In an interview on 09/24/2025 at 4:33 PM, Collateral Contact 2 (CC2) stated that prior to 09/05/2025, R1 was not safe transferring unless a staff was present and touching R1 throughout the entire transfer. CC2 stated that they had noticed that some staff were performing unsafe transfers with residents recently. CC2 stated that some staff needed a refresh training on safe transfers.

In an interview on 09/25/2025 at 1:53 PM, Staff A, executive director, stated that Staff C should not have walked away from R1 in the middle of the bathroom transfer at the facility and they failed to properly do a one-person transfer for R1 on 09/05/2025 like R1's NSA requires. Staff A stated their expectation was for staff to transfer residents in a safe manner according to their NSA assessed needs and this failure necessitated an all-staff training on transfers at the facility. Staff A stated that it's completely unacceptable for a staff member, Staff C, to walk away from a resident, R1, in the middle of a transfer and they intend to investigate why it happened and why Staff C did not follow R1's NSA.

In an interview on 09/25/2025 at 2:06 PM, Staff B, director of nursing services, stated that it was unacceptable for R1 to be left for any length of time, standing, holding onto grab bars by themselves, without a staff immediately available, within arm's reach, when Staff C was transferring R1 on 09/05/2025 and walked away from R1 in the middle of the transfer. Staff B stated that Staff C failed to transfer R1 according to what R1's NSA instructs. Staff B stated their expectation for a safe, one person transfer, was for the staff member to be in contact with the resident, assisting with a safe transfer, throughout the entire transfer process and Staff C failed to do that for R1 on 09/05/2025 when transferring R1 in the bathroom. Staff B stated that it's unacceptable for Staff C to walk away from R1 in the middle of a transfer in the bathroom on 09/05/2025 when R1 fell without a staff in arms reach and they don't know why Staff C would do that since staff are specifically trained not to leave a residents side, alone, unattended, during a transfer.

In an interview on 09/26/2025 at 1:15 PM, Collateral Contact 3 (CC3) stated that they had witnessed several unsafe transfers at the facility. CC3 stated that an example of what they had witnessed was a staff member attempting to transfer a resident by lifting on the residents right arm only and that staff member had to be stopped in the middle of the transfer to be educated on safe transfer techniques. CC3 reported that this made them feel upset and that they couldn't trust the facility to safely transfer residents.

In an interview on 11/20/2025 at 2:55 PM, Staff B stated that Staff C no longer works at the facility. Staff B stated that during staff transfer trainings the last few months, specific staff were identified as not performing safe transfers consistently and the facility has provided additional one on one training to these staff as an intervention.

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, CANTERBURY GARDENS is or will be in compliance with this law and / or regulation on (Date) 12/2/25.

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

Administrator (or Representative) Date 11/25/25

Please see attached Plan of Correction

Canterbury Gardens
1457 3rd Ave
Longview, WA 98632

Plan Of Correction:

The portion of the negotiated service agreement that was not followed was regarding the residents' transfer status and the amount of assistance she needed with transfers. After speaking with staff, we concluded that some caregivers had not been taught or still had questions regarding safe transfers techniques.

We held two in-services for nursing staff regarding safe transfer techniques on 10/09/2025. During these in-services we showed a short video we had made showing a step-by-step example of how to execute a safe two-person transfer from bed to a wheelchair.

Going forward, we plan to continue to do training every other month for our caregivers to show safe transfer techniques and answer any questions they may have, the next training being on 12/11/2025. We will have staff sign paper stating that they are to review resident care service plans to place in their employee file.

Our Care Staff Coordinator has also been picking up shifts where she trains any staff that have voiced concerns about transfers, or with staff who we receive complaints about regarding transfers or other care problems. We plan to continue to have her assist with on-the-floor training as needed.

Julie Medack
Executive Director

Allison Herrera
Director of Residential Services