STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Rd SE
SALEM, OR 97317

RE: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY License # 1793

Dear Administrator:

This letter addresses Compliance Determination(s) 83001 (Completion Date 08/28/2026) and 79313 (Completion Date 08/11/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/28/2026 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-2100-2-b, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2100-2-b-iii

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1793
Provider Type: Assisted Living Facility
Intake ID: 227856
Region/Unit #: RCS Region 3 / Unit D
Compliance Determination #: 79313
Investigator: Carol Gijima
Investigation Date(s): 06/22/2026 through 08/11/2026
Complainant Contact Date(s): 08/13/2026

Allegation(s):
1. Facility failed to provide care

Investigation Methods:

Sample:	Total residents: Resident sample size: 2 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Resident representative Collateral contacts Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the discharged records of the named resident Medication administration records (MAR) Staff progress notes Medical records (lab reports, H & P summary) Incident log / reports

Investigation Summary:
1. Per record review and interviews with resident representative, collateral contacts and staff, the facility failed to conduct an assessment and failed to obtain treatment orders when a resident developed a pressure injury. The ALF demonstrated failed provider practice. Citation issued under Statement of Deficiency dated 08/11/2026.

Conclusion / Action:

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- [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 #: 1793	Compliance Determination #79313
Plan of Correction	SILVER CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 4	Licensee: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	08/11/2026

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 06/22/2026 and 07/22/2026 of:

SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
17607 91ST AVENUE E
PUYALLUP, WA 98375

This document references the following complaint number(s): 227856

The following sample was selected for review during the unannounced on-site visit: 2 of 0 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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Statement of Deficiencies	License #: 1793	Compliance Determination #: 79313
Plan of Correction	SILVER CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 2 of 4	Licensee: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	08/11/2026

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

08/13/2026
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.

Theresa Ronto
Administrator (or Representative)

8/16/2026
~~9/27/20~~ RR
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(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;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete an assessment for 1 of 3 sample residents (Resident 1) with a change in condition when they developed a pressure wound that required treatment. The facility failed to obtain treatment orders for the wound. These failures resulted in a decline in Resident 1's health and a poor quality of life from a lack of care and treatment.

Findings included...

Review of Resident 1's unsigned service agreements, dated 10/27/2023, 12/03/2023, 01/03/2024, 04/09/2024, 07/08/2024, and 10/25/2024 showed no documentation that Resident 1 had any pressure wounds or injuries.

Review of the facility progress notes showed the following:

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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

08/13/2026
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.

Administrator (or Representative)

Date

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(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete an assessment for 1 of 3 sample residents (Resident 1) with a change in condition when they developed a pressure wound that required treatment. The facility failed to obtain treatment orders for the wound. These failures resulted in a decline in Resident 1's health and a poor quality of life from a lack of care and treatment.

Findings included...

Review of Resident 1's unsigned service agreements, dated 10/27/2023, 12/03/2023, 01/03/2024, 04/08/2024, 07/08/2024, and 10/25/2024 showed no documentation that Resident 1 had any pressure wounds or injuries.

Review of the facility progress notes showed the following:

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On [redacted]/2024 at 1:32 PM, Resident 1 re-admitted to the ALF from another residential setting, "free of wounds".
On 01/24/2025 at 10:23 PM, during care, staff noticed that Resident 1's left leg was swollen and staff advised Resident 1 to elevate the leg. Resident 1 called emergency services to be transported to the hospital. There was no facility documentation that showed when Resident 1 returned to the facility.

Review of hospital records, dated 01/24/2025, showed that Resident 1 was admitted to the hospital on 01/24/2025 with multiple pressure ulcers and various bed sores all over their bottom. The records documented Resident 1 had a Stage 3 pressure injury (a deep wound with full thickness skin loss) on their sacrum (area at the base of the spine) and a Stage 2 pressure injury (partial thickness skin loss) to both sides of their buttocks. The records showed that treatment of Dakin's (a solution used to treat pressure injuries and prevent infection) and a barrier cream for surrounding areas were ordered.

Further review of the facility progress notes showed:
On 02/05/2025 at 2:22 PM: staff documented Resident 1's "pressure wound is not looking so good".
On 02/05/2025 at 10:21 PM: staff documented Resident 1's "wound needs more care and attention".
On 02/06/2025 at 2:20 PM: staff documented Resident 1 "has a pressure wound which does not look so good".
On 02/06/2025 at 8:00 PM: documentation showed Resident 1 notified the Administrator of not feeling well. The progress notes showed that that Resident 1 "has a pressure ulcer on their sacrum...wound has a foul smell...was warm and the resident complained of pain and discomfort". Resident 1 was sent to the hospital.

Review of Resident 1's records showed no documentation that the facility staff notified the primary care provider of the wound. The records showed no treatment orders for any wound care on file. There was no documentation in the records that showed the facility staff provided any treatment for the wound.

During an interview on 06/22/2026 at 3:16 PM, Collateral Contact 1 (CC1), Resident 1's representative, stated that Resident 1 was totally dependent on the ALF staff for care. CC1 stated that staff failed to monitor Resident 1 to prevent the development of a pressure wound. CC1 stated that staff did not get treatment for Resident 1's wound which resulted in an infection which required hospitalization. CC1 stated that they were unaware that Resident 1 had any pressure injuries until their hospitalization on 02/06/2025. CC1 stated that Resident 1's death certificate noted the wound was a contributing factor to their death.

During an interview on 08/03/2026 at 10:59 AM, Collateral Contact 2 (CC2), Home Health staff, stated that Resident 1 received home health services for physical therapy and not for wound care. CC2 stated that on the 10/07/2024 visit, home health staff discovered that Resident 1 had a wound to their coccyx (tailbone) that measured 0.8 x 0.6 x 0.1 centimeters. CC2 stated that home health offered nursing wound care and

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Resident 1 declined subsequent visits.

During an interview on 08/03/2026 at 11:07 AM, Collateral Contact 3 (CC3), Home Health staff, stated that Resident 1 did not receive their services. CC3 stated that Resident 1 wound care services ended on 08/06/2024.

During an interview on 08/03/2026 at 11:44 AM, Staff B, Registered Nurse, stated that staff applied a barrier cream to Resident 1's to buttocks. Staff B stated that there were no assessments completed for Resident 1's change in condition when they developed a pressure wound. Staff B stated that they were not sure when the wound developed, and that home health managed the wound care for residents. Staff B stated that there were no orders or wound care notes from home health related to the current wound. Staff B stated that they did not know if Resident 1's primary care provider was notified of the pressure wound to initiate treatment.

Review of Resident 1's records showed no documentation that any home health agency managed Resident 1's wounds. There was no documentation that showed the facility nurse was notified of wounds prior to 02/06/2025, the day Resident 1 was sent to the hospital.

Review of Resident 1's death certificate, dated 03/07/2025, showed that the pressure wound contributed to Resident 1's death.

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 9/25/2026.

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

Theresa Ponto
Administrator (or Representative)

8/16/2026
Date

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Resident 1 declined subsequent visits.

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

_____ _____

Administrator (or Representative) Date

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