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) 80038 (Completion Date 07/07/2026) and 75323 (Completion Date 05/08/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/07/2026 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1793
Compliance Determination #: 75323
Investigator: Carol Gijima
Investigation Date(s): 04/02/2026 through 05/08/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 217740
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Resident left the building unaccompanied

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents, including the named resident Staff Resident Representative
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff progress notes Incident log / reports

Investigation Summary:
1. Per record review, interviews with resident's representative and staff, the named resident left the building unaccompanied. The facility failed to investigate the circumstances leading to resident leaving the facility. Citation issued as the ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/08/2026.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ]

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Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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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: 215777
Region/Unit #: RCS Region 3 / Unit D
Compliance Determination #: 75323
Investigator: Carol Gijima
Investigation Date(s): 04/02/2026 through 05/08/2026
Complainant Contact Date(s): 05/14/2026

Allegation(s):
1. Medication error
2. Financial exploitation

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Staff Resident Representative
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff progress notes Incident log / reports Financial ledger After visit summaries

Investigation Summary:
1. Based on record reviews and interviews with resident's representative and staff, the named resident did not receive the ordered pre-surgery solution resulting in cancellation of procedure. The facility failed to investigate the circumstances leading to resident not receiving their medication as ordered. Citation issued as the ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/08/2026.
2. Per record review, interviews with resident's representative and staff, the financial statements and ledger showed charges for agreed upon care and services.

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There was not sufficient information to support this allegation.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1793
Compliance Determination #: 75323
Investigator: Carol Gijima
Investigation Date(s): 04/02/2026 through 05/08/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 220429
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Resident sustained an injury during transport

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Staff Resident Representative
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff progress notes Incident log / reports

Investigation Summary:
1. Per record review, interviews with named resident and staff, the resident hit their head on the glass window of the transport van. The facility failed to investigate the circumstances leading to resident's incident. Citation issued as the ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/08/2026.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ]

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Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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

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 04/02/2026 of:

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

This document references the following complaint number(s): 217740, 217560, 217377, 215777, 220782, 220429

The following sample was selected for review during the unannounced on-site visit: 4 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

This document was prepared by Residential Care Services for the Locator website.

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

05/14/2026
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)

6/10/2026
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event,

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to investigate and determine the circumstances and implement interventions to prevent recurrence of incidents for to 4 of 5 sample residents (Residents 1, Resident 2, Resident 3, and Resident 4). These failures placed Resident 1, Resident 2, Resident 3, and Resident 4 at risk for potential injury and a decline in their health.

Findings included...

RESIDENT 1
Review of the facility incident report, dated 03/23/2026 at 9:30 PM, showed that Resident 1 was seen outside of the facility knocking on the window. Resident 1 was confused and looking for their room.

Review of Resident 1's negotiated service agreement, dated 01/22/2026, showed that Resident 1 had short term memory loss, was unable to understand safety, needed routine cueing, assistance, re-orientation, and redirection from staff due to confusion and dementia (a decline in cognition that interferes with daylily living). The agreement

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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.

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 _____

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This requirement was not met as evidenced by:

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showed no documentation of any interventions used to redirect Resident 1 from leaving the facility unsupervised.

Review of the facility's document titled, "Facility Caregiver Questionnaire," dated 03/19/2026, showed that Resident 1 kept trying to exit the emergency doors.

During an interview on 04/02/2026 at 12:15 PM, Collateral Contact 2 (CC2), Anonymous staff, stated that Resident 1 had exit seeking behaviors. CC2 stated that they were not aware of the circumstances surrounding Resident 1 leaving the building. CC2 stated that Resident 1's family was told to provide one-to-one care.

During an interview on 04/02/2026 at 12:25 PM, Collateral Contact 3 (CC3), Anonymous Staff, stated that Resident 1 left the building and no one checked the door when the alarm went off. CC3 stated that they heard Resident 1 was seen by staff walking down the road. CC3 stated that Resident 1 had a history of checking and watching the door. CC3 stated that they were not aware of any measures in place before to prevent this from happening.

RESIDENT 2
Review of the facility incident report, dated 03/23/2026 at 10:30 AM, showed that staff observed Resident 2 attempting to cross the road.

Review of Resident 2's negotiated service agreement, dated 01/22/2026, showed Resident 2 was alert and oriented to self. The agreement showed no documentation of any interventions used to redirect Resident 2 from leaving the facility unsupervised.

During an interview on 04/02/2026 at 12:15 PM, CC2 stated that they heard the door alarm and saw Resident 2 outside by the road and was trying to go to their room. CC2 stated that Resident 2 had a history of attempting to leave the building. CC2 stated they were not aware of any prevention measures in place before the 03/23/2026 incident.

During an interview on 05/08/2026 at 12:23 PM, Collateral Contact 4 (CC4), Resident 2's representative, stated that they were not aware that Resident 2 had left the building and crossed the street on 03/23/2026 until they went to visit. CC4 stated that facility informed them that this was not the first time Resident 2 had left the building unattended. CC4 stated that Resident 2 had dementia, and the staff stated the building had locked doors to deter residents from leaving the building unsupervised. CC4 stated they were not aware of any other interventions that were in place to redirect Resident 2 from leaving the building unaccompanied.

RESIDENT 3
During an interview on 04/01/2026 at 4:03 PM, Collateral Contact 1 (CC1, Resident 3's

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representative), stated that Resident 3 needed a colonoscopy (a medical procedure done to check for abnormalities like cancer in the colon, a section of the large intestine). CC1 stated that the colonoscopy was not completed because the facility did not follow the doctor's orders. CC1 stated that they handed the orders to Staff C, Assisted Living Director, and were told by Staff C that they would be entered into the Medication Administration Record (MAR). CC1 stated that they received conflicting reports on why Resident 3 was not given the entire liquid preparation.

Review of Resident 3's March 2026 MAR showed no orders for the March colonoscopy procedure. The records showed Resident 3 was re-scheduled for a less invasive procedure April 9, 2026. Review of the March 2026 MAR showed no orders were input into the computer.

RESIDENT 4
Review of Resident 4's negotiated service agreement, dated 01/15/2026, showed that Resident 4 needed staff physical assistance for care services.

Review of Resident 4's progress notes, dated 04/09/2026, showed that the facility bus driver reported that Resident 4's wheelchair tipped backward while the bus went up a hill on the way to an appointment. The progress noted stated that Resident 4 bumped their head on the glass.

During an interview on 04/24/2026 at 1:00 PM, Staff B, Assistant Executive Director, stated that Resident 4 was driven to an appointment by the facility bus driver. During the trip, Resident 4's wheelchair rolled back which resulted in Resident 4 hitting their head against the bus window. Staff B stated that Staff A conducted the investigation.

During an interview on 04/02/2026 at 12:40 PM, Staff B stated that they were notified that Resident 1 had eloped and was outside the building. Staff B stated that Resident 1 walked out the front door. Staff B stated they didn't know who last saw Resident 1. Staff B stated that Staff A notified them that Resident 2 had eloped. Staff B stated that Staff A conducted both investigations. Staff B stated that staff informed them that they didn't have the complete pre-surgery preparation material for Resident 3 and were not able to complete as instructed. Staff B stated that the 2nd liquid administration was not completed. Staff B stated that the orders should have been on the MAR.

During an interview on 04/02/2026 at 11:55 AM, Staff C, Assisted Living Director, stated that they were not aware of how Resident 1 got out of the building without staff noticing. Staff C stated that Resident 1 was found in the parking lot. Staff C stated that they did not know if the alarm went off or not. Staff C stated that Resident 2 wandered around instead of going to their room and went outside. Staff C stated that the alarm went off when Resident 2 left the building and a med tech went after them. Staff C stated that both Resident 1 and Resident 2 attempted to leave the building in the past, and they were found right outside the door. Staff C stated that they did not know what the circumstances were that led to both Resident 1 and Resident 2 leaving the building

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unattended. Staff C stated, "they really should not have been admitted here." Staff C stated that they were not aware of any medication errors for Resident 3. Staff C stated that the pre-surgery liquid solution for Resident 3 was on the MAR for staff to administer. Staff C stated that Resident 3 refused to take the pre-surgery liquid solution.

During an interview on 04/08/2026 at 3:42 PM, Staff A, Administrator, stated that they believe Resident 1 went out the front door. Staff A stated that the alarm went off and staff did not see anything and turned it off. Staff A stated that Resident 1 pounded on the front window for maybe 30 minutes or so. Staff A stated that care staff reported that this was not the first time Resident 1 had left the building and staff would just redirect Resident 1 back into the building. Staff A stated that Resident 1's family was under the assumption the facility had memory care. Staff A stated that there was no documentation for the findings from their investigation. Staff A stated that Resident 2 had a history of eloping and this was not new behavior. Staff A stated that Resident 2 walked towards the street, going home when staff found them. Staff A stated that Resident 3's pre-surgery preparation was not documented in the MAR. Staff A stated, "I have nothing for an investigation, nothing there, no reports as it was before my time."

Review of the facility records showed no documentation that staff completed any investigation related to Resident 1 and Resident 2 leaving the facility unattended. There was no documentation of any investigation related to Resident 3's missed colonoscopy appointment due to pre-surgery orders not followed. There was no documentation of any investigation related to Resident 4's bus incident where Resident 4 rolled back in an unsecured wheelchair and hit their head on the facility bus's window.

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) 6/22/26.

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

Administrator (or Representative) — Date 6/10/26

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unattended. Staff C stated, "they really should not have been admitted here." Staff C stated that they were not aware of any medication errors for Resident 3. Staff C stated that the pre-surgery liquid solution for Resident 3 was on the MAR for staff to administer. Staff C stated that Resident 3 refused to take the pre-surgery liquid solution.

During an interview on 04/08/2026 at 3:42 PM, Staff A, Administrator, stated that they believe Resident 1 went out the front door. Staff A stated that the alarm went off and staff did not see anything and turned it off. Staff A stated that Resident 1 pounded on the front window for maybe 30 minutes or so. Staff A stated that care staff reported that this was not the first time Resident 1 had left the building and staff would just redirect Resident 1 back into the building. Staff A stated that Resident 1's family was under the assumption the facility had memory care. Staff A stated that there was no documentation for the findings from their investigation. Staff A stated that Resident 2 had a history of eloping and this was not new behavior. Staff A stated that Resident 2 walked towards the street, going home when staff found them. Staff A stated that Resident 3's pre-surgery preparation was not documented in the MAR. Staff A stated, "I have nothing for an investigation, nothing there, no reports as it was before my time."

Review of the facility records showed no documentation that staff completed any investigation related to Resident 1 and Resident 2 leaving the facility unattended. There was no documentation of any investigation related to Resident 3's missed colonoscopy appointment due to pre-surgery orders not followed. There was no documentation of any investigation related to Resident 4's bus incident where Resident 4 rolled back in an unsecured wheelchair and hit their head on the facility bus's window.

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

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