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

PARK VISTA RETIREMENT & ASSISTED LIVING COMMUNITY LLC
PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
3425 BOONE RD SE
SALEM, OR 97317

RE: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY License # 1810

Dear Administrator:

This letter addresses Compliance Determination(s) 79610 (Completion Date 06/26/2026) and 76487 (Completion Date 04/27/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/26/2026 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-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2320-2-b

The Department staff who did the on-site verification:
Susan Carmichael, Nursing Consultant Institutional
Kathy Heinz, Long Term Care Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit D
Residential Care Services

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

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 follow-up on 04/27/2026 of:
PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
2944 SE LUND AVE
PORT ORCHARD, WA 98366

This document references the following SOD dated: 04/27/2026

The following sample was selected for review during the unannounced on-site visit: 4 of 58 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Susan Carmichael, Nursing Consultant Institutional
Kathy Heinz, Long Term Care Surveyor

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.

Rebecca Lane

Residential Care Services

04/30/2026

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.

designee

Administrator (or Representative)

5/13/26

Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 5 of 5 sampled staff, (Staff B, Staff C, Staff D, Staff E, and Staff F) were qualified to administer 4 of 4 sample residents (Resident 1, Resident 2, Resident 3 and Resident 4) medications and procedures that required delegation by a Registered Nurse (RN). This failure placed the residents at risk of medical complications and a decreased quality of life by receiving medications and/or procedures incorrectly from staff not delegated by an RN as required.

Findings included...

RESIDENT 1

Review of Resident 1's April 2026 Medication Administration Record (MAR) showed physician orders for Erythromycin Ophthalmic (eye) ointment (for eye infection),

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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:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 5 of 5 sampled staff, (Staff B, Staff C, Staff D, Staff E, and Staff F) were qualified to administer 4 of 4 sample residents (Resident 1, Resident 2, Resident 3 and Resident 4) medications and procedures that required delegation by a Registered Nurse (RN). This failure placed the residents at risk of medical complications and a decreased quality of life by receiving medications and/or procedures incorrectly from staff not delegated by an RN as required.

Findings included…

RESIDENT 1

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Hypochlorus Acid-Sodium Chloride spray (for eye moisture), and Systane Balance eye drops (for eye moisture).

Review of Resident 1's MAR showed that Staff B (Medication Technician/MT), Staff C (MT), and Staff D (MT) administered Resident 1's eye medications from 04/17/2026 through 04/26/2026.

Review of the facility's Nurse Delegation: Nursing Visit record for Resident 1, dated 03/09/2026, showed that Staff B, Staff C, and Staff D were not delegated by Staff A (RN) to administer Resident 1's eye medications.

RESIDENT 2

Review of Resident 2's April 2026 MAR showed a physician order for Lispro insulin (medication to treat diabetes, an illness of the body's inability to regulate blood sugar), six units by injection four times daily plus more units as needed, based on Resident 2's blood sugar level.

Review of Resident 2's April 2026 MAR showed that Staff B and Staff E (Assistant Executive Director) administered Lispro insulin on 04/22/2026, 04/24/2026, and 04/25/2026 to Resident 2.

Review of the facility's Nurse Delegation: Nursing Visit record dated 03/30/2026 for Resident 2 showed that Staff B and Staff E were not delegated by Staff A to administer Resident 2's Lispro insulin.

RESIDENT 3

Review of Resident 3's April 2026 MAR showed a physician order to check Resident 3's blood sugar (a procedure that requires piercing of the skin to collect a blood sample to measure the level of sugar in the blood) at dinner. The April 2026 MAR showed that Staff B checked Resident 3's blood sugar on 04/22/2026 and 04/24/2026.

Review of the facility's Nurse Delegation: Nursing Visit record dated 03/09/2026, showed that Staff B was not delegated by Staff A to check Resident 3's blood sugar.

RESIDENT 4

Review of Resident 4's April 2026 MAR, showed physician orders for Acetaminophen 500 milligram (mg) tablet three times a day (a medication used to treat pain), Quetiapine 25 mg tablet two times a day (a medication used to treat mental health

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disorders) and Tamsulosin 0.4 mg capsule one time per day (a medication used to treat urinary disfunction). The April 2026 MAR showed that Staff B administered Acetaminophen 10 times, Quetiapine seven times, and Tamsulosin six times between 04/17/2026 and 04/26/2026.

Review of the facility's Nurse Delegation: Nursing Visit record dated 03/06/2026, showed that Staff B was not delegated by Staff A to administer the Acetaminophen, Quetiapine and Tamsulosin.

During an interview on 04/27/2026 at 12:30 PM, Staff A acknowledged that Staff B, Staff C, Staff D Staff E, and Staff F were not delegated to administer medications and/or procedures to Resident 1, Resident 2, Resident 3, and Resident 4.

This is an uncorrected deficiency previously cited on 03/03/2026.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 10.11.2026 .

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

Designee 5.13.2026

Administrator (or Representative) Date

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disorders) and Tamsulosin 0.4 mg capsule one time per day (a medication used to treat urinary disfunction). The April 2026 MAR showed that Staff B administered Acetaminophen 10 times, Quetiapine seven times, and Tamsulosin six times between 04/17/2026 and 04/26/2026.

Review of the facility's Nurse Delegation: Nursing Visit record dated 03/06/2026, showed that Staff B was not delegated by Staff A to administer the Acetaminophen, Quetiapine and Tamsulosin.

During an interview on 04/27/2026 at 12:30 PM, Staff A acknowledged that Staff B, Staff C, Staff D Staff E, and Staff F were not delegated to administer medications and/or procedures to Resident 1, Resident 2, Resident 3, and Resident 4.

This is an uncorrected deficiency previously cited on 03/03/2026.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY 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

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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 the unannounced on-site full inspection on 02/17/2026, 02/18/2026, 02/20/2026 and 02/23/2026 of:
PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
2944 SE LUND AVE
PORT ORCHARD, WA 98366

The following sample was selected for review during the unannounced on-site visit: 10 of 56 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Susan Carmichael, Nursing Consultant Institutional
Kathy Heinz, Long Term Care Surveyor

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

03/04/2026
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)

03/13/2026
Date

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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250:

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to develop and implement a safe medication system to ensure 4 of 7 sampled residents (Resident 4, Resident 5, Resident 6, and Resident 7) received medications as prescribed. These failures placed all residents at risk for harm and a potential decline in their health.

Findings included...

RESIDENT 4
Review of Resident 4's December 2025 MAR showed an order, dated 05/03/2022, for Lantus insulin, 30 units once daily in the morning for diabetes (a medical condition where the body fails to regulate blood sugar). The MAR showed Resident 4 did not

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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:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to develop and implement a safe medication system to ensure 4 of 7 sampled residents (Resident 4, Resident 5, Resident 6, and Resident 7) received medications as prescribed. These failures placed all residents at risk for harm and a potential decline in their health.

Findings included…

RESIDENT 4
Review of Resident 4's December 2025 MAR showed an order, dated 05/03/2022, for Lantus insulin, 30 units once daily in the morning for diabetes (a medical condition where the body fails to regulate blood sugar). The MAR showed Resident 4 did not

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receive their Lantus insulin on 02/03/2026 and 02/04/2026. There was no documented reason why staff did not administer Resident 4's Lantus insulin on these two days.

Review of Resident 4's February 2026 MAR showed an order, dated 05/11/2023, to check Resident 4's blood sugar once daily in the evening. The MAR showed no documentation of any blood sugar check on 02/10/2026 and 02/11/2026. There was no documented reason why staff did not check Resident 4's blood sugar on these two days.

RESIDENT 5
Review of Resident 5's January 2026 MAR showed an order, dated 01/06/2026, for Ear Drops, 6.5% solution, to be administered in both ears two times a day for ten days (total of 20 times), for earwax removal. The MAR showed no documentation the medication was given two times daily from 01/07/2026 through 01/12/2026. The MAR showed staff documented "medication not available." The MAR showed Resident 5 only received the medication eight times of the 20 times ordered.

Review of Resident 5's progress notes, dated 01/06/2026 and 01/07/2026, showed that staff documented the medication was not available for to be administered. The notes showed staff charted that Resident 5 had "no side effects" from the missed doses of medication.

During an interview on 02/20/2026 at 1:30 PM, Staff A, Executive Director, stated that they were unaware staff documented Resident 5 had no side effects from medication that was not given.

RESIDENT 6
Review of Resident 6's February 2026 MAR showed a "Nursing Order", dated 02/09/2026, for wound care of a "superficial sore on the top of Resident 6's right foot". The order showed the wound needed to be cleaned with Hydrogen Peroxide, then an application of Bactroban ointment (prescription medication applied to the skin for infection) and covered with a band-aid for seven days. The MAR showed documentation that staff treated Resident 6's wound daily for eight days, 02/09/2026 through 02/16/2026, with Hydrogen Peroxide and Bactroban ointment.

Review of the February 2026 MAR showed "Informational Orders – Skin Care" that showed staff may cleanse a minor skin issue with wound cleanser or warm soapy water, pat dry, and cover with dry band-aid. The order did not include the use of Hydrogen Peroxide to cleanse the wound, or the application of Bactroban ointment which required a physician order. There was no documentation of any physician's order for wound care in Resident 6's records.

During an interview on 02/20/2026 at 2:20 PM, Staff B, Regional Nurse, stated that they were unaware of the "Nursing Order" for Resident 6's wound. Staff B stated that they investigated and determined that Staff I, Medication Technician, originated the "Nursing Order." Staff B stated that there was no documentation of a physician order for

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Hydrogen Peroxide or Bactroban ointment for Resident 6's foot wound.

RESIDENT 7
Review of Resident 7's progress notes showed that Resident 7 returned to the ALF from a skilled nursing facility (SNF) on [redacted]/2026.

MEDICATION FOR LOW BLOOD PRESSURE
Review of Resident 7's February 2026 MAR showed an order, dated 10/09/2025, for Midodrine, 10 milligrams (mg), one tablet three times a day, for low blood pressure. The MAR showed documentation that Resident 7 received this medication and dosage from [redacted]/2026 through 02/18/2026.

Review of a document titled "Order Summary Report", dated [redacted]/2026, showed that when Resident 7 returned to the facility, there was no order from the SNF physician for Resident 7 to continue with the Midodrine 10 mg dosage.

Review of Resident 7's February 2026 MAR showed an order, dated [redacted]/2026, for Midodrine 2.5 mg, one tablet two times a day on Tuesday, Thursday, and Saturday. The order showed Midodrine 2.5 mg, one tablet three times a day on Monday, Wednesday, and Friday. The MAR showed no documentation that Resident 7 received this medication 02/14/2026 through 02/20/2026. Staff documented that the medication was "not available".

During an interview on 02/17/2026 at 2:00 PM, Staff B stated that the ALF staff did not clarify the orders for Resident 7's Midodrine dosages.

MEDICATION FOR MUSCLE CONDITION
Review of Resident 7's February 2026 MAR showed an order dated 07/21/2025 for Ropinrole HCl (Hydrochloride) 0.5 mg, two tablets three times a day for restless leg syndrome (a sleep disorder characterized by irresistible urge to move the legs). The MAR showed that Resident 7 received Ropinrole HCl 0.5 mg two tablets three times a day [redacted]/2026 through 02/18/2026.

Review of a document "Order Summary Report", dated [redacted]/2026, showed that the medication order for Ropinrole HCl 0.5 mg was changed by the SNF physician. The new order showed the dosage was changed to one tablet daily as needed for restless leg syndrome.

MEDICATION FOR DIABETES
Review of Resident 7's February MAR showed an order, dated 07/31/2025, for Tresiba insulin, 32 units, once daily in the morning for diabetes. The MAR showed documentation that Resident 7 received the medication 02/10/2026, 02/14/2026, 02/17/2026, 02/18/2026, and 02/19/2026 at 5:00 AM. The MAR showed Resident 7 did not receive their Tresiba insulin on 02/11/2026 and 02/12/2026. There was no

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documented reason why staff did not administer Resident 7's insulin on these two days.

Review of a document titled "Order Summary Report", dated [redacted]/2026, showed that the medication order for Tresiba insulin was changed by the SNF physician on [redacted]/2026. The new order showed administration of 32 units once daily at bedtime.

During an interview on 02/17/2026 at 2:00 PM, Staff B stated that the ALF Lead Medication Technician was responsible to make sure Resident 7 received medications as ordered by the physician.

This is a recurring deficiency previously cited on 03/24/2025 under subsection (1)(b).

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 4/17/2026 .

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

Administrator (or Representative) 03/13/2026 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 ;

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

(c) Ensure the staff person performing the ongoing assessments is qualified to perform them.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an assessment was completed for 1 of 1 sampled resident (Resident 7) after discharge from a skilled nursing facility (SNF). This failure placed Resident 7 at risk of harm and potential medical decline from unmet needs.

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documented reason why staff did not administer Resident 7's insulin on these two days.

Review of a document titled "Order Summary Report", dated [redacted]/2026, showed that the medication order for Tresiba insulin was changed by the SNF physician on [redacted]/2026. The new order showed administration of 32 units once daily at bedtime.

During an interview on 02/17/2026 at 2:00 PM, Staff B stated that the ALF Lead Medication Technician was responsible to make sure Resident 7 received medications as ordered by the physician.

This is a recurring deficiency previously cited on 03/24/2025 under subsection (1)(b).

Plan/Attestation Statement

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Administrator (or Representative) Date

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Findings included...

Review of the ALF incident report dated 12/19/2025 that Resident 7 sustained an injury to their leg in the ALF elevator. The hospital admitted Resident 7 on [redacted]/2025 for surgery. After surgery, Resident 7 transferred to a SNF for on-going care. On [redacted]/2026, Resident 7 returned to the ALF, more than one month after the injury occurred.

Review of Resident 7's facility file showed no documentation that the facility staff completed an assessment for any change of condition and new care needs prior to or when Resident 7 returned to the facility.

Review of a facility document titled "Resident Temporary Care Plan" (TCP), dated [redacted]/2026, showed an ALF Medication Technician completed the TCP. The TCP was incomplete. The TCP showed no RN (Registered Nurse) signature to validate the assessment.

During an interview on 02/26/2026 at 2:00 PM, Staff A, Executive Director, stated that Resident 7 was not assessed by any staff upon their return to the ALF.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 4/17/2026

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

Administrator (or Representative) 03/13/2026 Date

WAC 388-112A-0105 Who is required to obtain home care aide certification and by when?

(2) The following individuals must obtain home care aide certification as follows:

(c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire;

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

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Findings included…

Review of the ALF incident report dated 12/19/2025 that Resident 7 sustained an injury to their leg in the ALF elevator. The hospital admitted Resident 7 on [redacted]/2025 for surgery. After surgery, Resident 7 transferred to a SNF for on-going care. On [redacted]/2026, Resident 7 returned to the ALF, more than one month after the injury occurred.

Review of Resident 7's facility file showed no documentation that the facility staff completed an assessment for any change of condition and new care needs prior to or when Resident 7 returned to the facility.

Review of a facility document titled "Resident Temporary Care Plan" (TCP), dated [redacted]/2026, showed an ALF Medication Technician completed the TCP. The TCP was incomplete. The TCP showed no RN (Registered Nurse) signature to validate the assessment.

During an interview on 02/20/2026 at 2:00 PM, Staff A, Executive Director, stated that Resident 7 was not assessed by any staff upon their return to the ALF.

Plan/Attestation Statement

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

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Administrator (or Representative) Date

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care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 6 of 8 sampled staff (Staff A, Staff D, Staff E, Staff F, Staff G, and Staff H), obtained Home Care Aide (HCA) certification within 200 days of hire. This failure placed all 56 residents at risk of receiving care from unqualified staff.

Findings included...

Review of the facility personnel records showed the facility hired Staff A, Executive Director, on 07/21/2022. The records showed Staff A completed 75 hours of long-term care basic training on 10/23/2025. There was no documentation that showed Staff A obtained their HCA certification.

Review of the facility personnel records showed the facility hired Staff D, Assisted Living Director, on 05/21/2021. The records showed Staff D completed 75 hours of long-term care basic training on 08/01/2025. There was no documentation that showed Staff D obtained their HCA certification.

Review of the facility personnel records showed the facility hired Staff E, Medication Technician, on 09/20/2024. The records showed Staff E completed 75 hours of long-term care basic training on 08/01/2025. There was no documentation that showed Staff E obtained their HCA certification.

Review of the facility personnel records showed the facility hired Staff F, Memory Care Director, on 08/19/2024. The records showed Staff F completed 75 hours of long-term care basic training on 08/01/2025. There was no documentation that showed Staff F obtained their HCA certification.

Review of the facility personnel records showed the facility hired Staff G, Medication Technician on 01/01/2024. The records showed Staff G completed 75 hours of long-term care basic training on 07/25/2025. There was no documentation that showed Staff G obtained their HCA certification.

Review of the facility personnel records showed the facility hired Staff H, Medication Technician, on 10/10/2022. The records showed Staff H completed 75 hours of long-term care basic training on 10/22/2025. There was no documentation that showed Staff H obtained their HCA certification.

During an interview on 02/17/2026 at 4:00 PM, Staff A, said that none of the staff

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identified (Staff A, Staff D, Staff E, Staff F, Staff G, and Staff H) became certified as HCAs.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 4/17/26 .

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

Administrator (or Representative) 03/13/2026 Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 14 of 14 sampled staff, (Staff G, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, Staff R, Staff S, Staff T, and Staff U) were qualified to administer 4 of 4 sample residents (Resident 4, Resident 6, Resident 7 and Resident 8) medications and procedures that require delegation by a Registered Nurse (RN). This failure placed the residents at risk of medical complications and a decreased quality of life by receiving medications and/or procedures incorrectly from staff not delegated by an RN as required.

Findings included...

RESIDENT 4
Review of Resident 4's January 2026 and February 2026 Medication Administration Records (MARs) showed an order for Lantus insulin, to inject 30 units once daily, in the morning, for diabetes (a medical condition where the body fails to regulate blood

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identified (Staff A, Staff D, Staff E, Staff F, Staff G, and Staff H) became certified as HCAs.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY 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-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 14 of 14 sampled staff, (Staff G, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, Staff R, Staff S, Staff T, and Staff U) were qualified to administer 4 of 4 sample residents (Resident 4, Resident 6, Resident 7 and Resident 9) medications and procedures that require delegation by a Registered Nurse (RN). This failure placed the residents at risk of medical complications and a decreased quality of life by receiving medications and/or procedures incorrectly from staff not delegated by an RN as required.

Findings included…

RESIDENT 4
Review of Resident 4's January 2026 and February 2026 Medication Administration Records (MARs) showed an order for Lantus insulin, to inject 30 units once daily, in the morning, for diabetes (a medical condition where the body fails to regulate blood

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sugar). The MARs showed an order to check Resident 4's blood sugar one time per day in the evening.

Review of the January 2026 MAR showed that Staff O (Medication Technician/MT) checked Resident 4's blood sugar (a procedure that requires piercing of the skin to collect a blood sample to measure the level of sugar in the blood) on 01/23/2026. Staff I (MT) checked Resident 4's blood sugar on 01/28/2026.

Review of the February 2026 MAR showed that Staff M (MT) administered Resident 4's insulin on 02/07/2026. Staff I administered Resident 4's insulin on 02/11/2026.

Review of the facility's Nurse Delegation: Nursing Visit record dated 12/09/2025, showed that Staff O, Staff M, and Staff I were not delegated by Staff B (Regional Nurse) to administer Resident 4's insulin or check Resident 4's blood sugar.

RESIDENT 6
Review of Resident 6's December 2025, January 2026 and February 2026 MARs showed orders for Erythromycin Ophthalmic (eye) ointment (for eye infection), Hypochlorus Acid-Sodium Chloride spray (for eye moisture), and Systane Balance eye drops (for eye moisture).

Review of Resident 6's December 2025 MAR showed that Staff G (MT), Staff M, Staff Q (MT), Staff R (MT) and Staff U (MT) administered Resident 6's medications from 12/01/2025 through 12/31/2025.

Review of Resident 6's January 2026 MAR showed that Staff G, Staff J (MT), Staff M, Staff N (MT), Staff O, Staff P (MT), Staff Q, and Staff R administered Resident 6's medications from 01/01/2026 through 01/31/2026.

Review of Resident 6's February 2026 MAR showed that Staff I, Staff M, Staff N, Staff O, Staff R, and Staff S (MT) administered Resident 6's medications from 02/01/2026 through 02/17/2026.

Review of the facility's Nurse Delegation: Nursing Visit record for Resident 6, dated 12/09/2025, showed that Staff G, Staff I, Staff J, Staff M, Staff N, Staff O, Staff P, Staff Q, Staff R, Staff S and Staff U were not delegated by Staff B to administer Resident 6's medications.

RESIDENT 7
Review of Resident 7's December 2025 and February 2026 MARs showed an order for Fiasp insulin (medication to treat diabetes), 10 units three times daily plus more units as needed, based on Resident 7's blood sugar level. The MARs showed an order for Ozempic insulin, 0.5 milligrams once a week and Tresiba insulin, 32 units, daily. The

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February 2026 MAR included an order for Lispro insulin, the number of units administered was based on Resident 7's blood sugar level.

Review of Resident 7's December 2025 MAR showed that Staff Q, Staff R, and Staff U (MT) administered the insulin medications from 12/01/2025 through 12/19/2025.

Review of Resident 7's February 2026 MAR showed that Staff M, Staff N, Staff R, and Staff S administered the insulin medications from [redacted] 2026 through 02/19/2026.

Review of the facility's Nurse Delegation: Nursing Visit record dated 12/09/2025 for Resident 7 showed that Staff M, Staff N, Staff Q, Staff R, Staff S, and Staff U were not delegated by Staff B to administer Resident 7's insulin medications.

RESIDENT 9
Review of Resident 9's January 2026 and February 2026 MARs showed orders for Acetaminophen (medication used to treat pain), Quetiapine (medication used to treat mental health disorders) and Tamsulosin (medication used to treat frequent urination).

Review of Resident 9's January 2026 MAR showed that Staff I, Staff L (MT), Staff M, and Staff T (MT), administered Resident 9's medications from 01/01/2026 through 01/31/2026.

Review of Resident 9's February 2026 MAR showed that Staff I, Staff J, Staff K (MT), and Staff L administered the medications from 02/01/2026 through 02/20/2026.

Review of the facility's Nurse Delegation: Nursing Visit record for Resident 9, dated 12/09/2025, showed that Staff I, Staff J, Staff K, Staff L, Staff M, and Staff T were not delegated by Staff B to administer or crush Resident 9's medications.

During an interview on 02/17/2026 at 4:00 PM, Staff B showed a facility list of staff they delegated to administer medications to and/or check blood sugars for Resident 4, Resident 6, Resident 7, and Resident 9. Review of the list showed no documentation that Staff G, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q, Staff R, Staff S, Staff T, and Staff U were on the list of nurse delegated staff.

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

Administrator (or Representative) 03/13/2026 Date

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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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY 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

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