STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Caring Places Management, LLC
Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

RE: Westhaven Villa License # 2152

Dear Administrator:

This letter addresses Compliance Determination(s) 78488 (Completion Date 06/04/2026) and 76394 (Completion Date 05/01/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/04/2026 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-2950-6

The Department staff who did the on-site verification:
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Clinton Fridley, Community Nurse Field Manager

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

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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 04/24/2026 of:
Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

This document references the following SOD dated: 05/01/2026

The following sample was selected for review during the unannounced on-site visit: 3 of 26 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

Statement of Deficiencies	License #: 2152	Compliance Determination # 76394
Plan of Correction	Westhaven Villa	Completion Date
Page 2 of 4	Licensee: Caring Places Management, LLC	05/01/2026

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.

Clinton Fridley, RN
Residential Care Services

05/01/2026
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)

5/5/26
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure water temperature did not go above 120 degrees Fahrenheit (F) in 6 of 6 areas (second floor activity room, Resident 1 and 2 rooms, first floor activity room, two first floor public bathrooms). This failure placed all residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

Record review of the facility's plan of correction, dated 02/27/2026, documented the facility would have the hot water temperatures corrected by 04/16/2026. The facility had maintenance adjust the hot water temperatures within safe range of 105-120 degrees F, temporary signage was posted at all sinks to use caution and maintenance would routinely inspect and adjust water heaters to maintain compliance.

An observation on 04/24/2026 at 9:33 AM, the sink in the activity room, on the second floor, had a measured water temperature of 132.2 degrees F. The stream of water was hot to touch with steam rising from it.

An observation on 04/24/2026 at 9:34 AM, in the public resident bathroom across from the administrator's office, the hot water temperature was 131.5 degrees F.

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.

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 _____

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure water temperature did not go above 120 degrees Fahrenheit (F) in 6 of 6 areas (second floor activity room, Resident 1 and 2 rooms, first floor activity room, two first floor public bathrooms). This failure placed all residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included…

Record review of the facility's plan of correction, dated 02/27/2026, documented the facility would have the hot water temperatures corrected by 04/16/2026. The facility had maintenance adjust the hot water temperatures within safe range of 105-120 degrees F, temporary signage was posted at all sinks to use caution and maintenance would routinely inspect and adjust water heaters to maintain compliance.

An observation on 04/24/2026 at 9:33 AM, the sink in the activity room, on the second floor, had a measured water temperature of 132.2 degrees F. The stream of water was hot to touch with steam rising from it.

An observation on 04/24/2026 at 9:34 AM, in the public resident bathroom across from the administrator's office, the hot water temperature was 131.5 degrees F.

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

An observation on 04/24/2026 at 9:36 AM, Resident 1's kitchenette sink had a measured water temperature of 128.1 degrees F.

An observation on 04/24/2026 at 9:36 AM, on the first-floor public activity sink, the hot water temperature was 127.7 degrees F.

An observation on 04/24/2026 at 9:38 AM, resident public bathroom across from Resident 2's (R2) room hot water temperature was 123.8 degrees F.

An observation on 04/24/2026 at 9:41 AM, R2's bathroom sink's hot water temperature was 131.1 degrees F. There was steam rising from the running water.

In an interview on 04/24/2026 at 9:41 AM, R2 stated they had to use cold water to keep the hot water temperature down.

In an interview on 04/24/2026 at 9:46 AM, Staff A, Administrator, stated they were not aware or notified of any concerns with the hot water temperatures.

In an observation on 04/24/2026 at 9:50 AM, in the resident public bathroom across from Staff A's office, the facility's thermometer Staff A used showed the hot water temperature was 128.8 degrees F. Staff A acknowledged the hot water temperature were over the regulation maximum.

Record review of the facility Safety Plan, dated 04/24/2026, documented maintenance was notified to adjust the hot water tanks temperatures, residents and staff were notified and to use caution, signs were posted at all sinks to use caution, hot water temperatures in resident rooms and common areas were to be checked every other day, staff to report any resident complaints about hot water immediately, and all temperature checks would be documented and maintained for review.

In an interview on 04/27/2026 at 10:58 AM, Staff B, Office Manager, stated they checked the hot water temperatures today in public areas and resident rooms with the lowest temperature of 123 degrees F and highest was 129 degrees F.

Record review of hot water temperatures sent to the Department on 04/27/2026 at 4:55 PM, showed there was no date or time the hot water temperatures were checked and the temperatures were still above 120 degrees F.

In an interview on 05/01/2026 at 9:47 AM, Staff A stated they were unsure who or when the hot water temperatures were checked during 04/25/2026 and 04/26/2026. Staff A stated nothing was done after the hot water was checked and remained elevated. The facility staff do not have access to the hot water tanks to turn the hot water down.

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

Statement of Deficiencies	License #: 2152	Compliance Determination # 76394
Plan of Correction	Westhaven Villa	Completion Date
Page 4 of 4	Licensee: Caring Places Management, LLC	05/01/2026

This is an uncorrected and recurring deficiency previously cited on 03/06/2026, 01/22/2026 and 11/21/2025.

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, Westhaven Villa is or will be in compliance with this law and / or regulation on (Date) 5/31/26 .

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

Administrator (or Representative) Date 5/5/26

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

This is an uncorrected and recurring deficiency previously cited on 03/06/2026, 01/22/2026 and 11/21/2025.

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, Westhaven Villa 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

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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 03/04/2026 of:
Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

This document references the following SOD dated: 03/06/2026

The following sample was selected for review during the unannounced on-site visit: 3 of 27 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

Statement of Deficiencies	License #: 2152	Compliance Determination # 73815
Plan of Correction	Westhaven Villa	Completion Date
Page 2 of 4	Licensee: Caring Places Management, LLC	03/06/2026

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.

Clinton Fridley RN
Residential Care Services

03/13/2026
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)

3/25/26
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure water temperature did not go above 120 degrees Fahrenheit (F) in 4 of 4 areas (second floor activity room, Resident 1, 2 and 3 rooms). This failure placed all residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

Record review of the facility's document titled "Plan of Correction," dated 01/22/2026, documented maintenance would adjust the water temperatures, signs were posted to affected sink areas warning of hot water, hot water temperatures would be documented on logs, monitored and audited by the administrator. Maintenance staff was re-educated on the hot water temperature regulations and if facility water temperatures were out of acceptable ranges, maintenance would adjust the water heaters, post signs and implement a safety plan until resolved.

During an observation on 03/04/2026 at 8:59 AM, the sink in the activity room, on the second floor, had a measured water temperature of 127.2 degrees F. The stream of water was hot to touch with stream rising from it. A sign was up on the cabinet door, above the sink, that documented "hot water, caution water temperature being adjusted use with care."

During an observation on 03/04/2026 at 9:10 AM, Resident 1's (R1) bathroom sink had

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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 _____

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure water temperature did not go above 120 degrees Fahrenheit (F) in 4 of 4 areas (second floor activity room, Resident 1, 2 and 3 rooms). This failure placed all residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included…

Record review of the facility's document titled "Plan of Correction," dated 01/22/2026, documented maintenance would adjust the water temperatures, signs were posted to affected sink areas warning of hot water, hot water temperatures would be documented on logs, monitored and audited by the administrator. Maintenance staff was re-educated on the hot water temperature regulations and if facility water temperatures were out of acceptable ranges, maintenance would adjust the water heaters, post signs and implement a safety plan until resolved.

During an observation on 03/04/2026 at 8:59 AM, the sink in the activity room, on the second floor, had a measured water temperature of 127.2 degrees F. The stream of water was hot to touch with stream rising from it. A sign was up on the cabinet door, above the sink, that documented "hot water, caution water temperature being adjusted use with care."

During an observation on 03/04/2026 at 9:10 AM, Resident 1's (R1) bathroom sink had

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water that was steaming and a measured temperature of 126.2 degrees F. R1 stated that the water was hot.

During an observation on 03/04/2026 at 9:15 AM, Resident 2's (R2) bathroom sink had a measured water temperature of 126.1 degrees F.

During an observation on 03/04/2026 at 9:19 AM, Resident 3's (R3) kitchenette sink had a measured water temperature of 122.2 degrees F. R3 stated that at time in the morning the hot water temperature gets really hot the longer it ran and out of nowhere.

During an observation on 03/04/2026 at 9:26 AM, Staff A, Administrator, measured the water temperature in R2's bathroom sink, it was 127.2 degrees F on the facility's probe thermometer.

During an observation on 03/04/2026 at 9:30 AM, Staff A measured the second-floor activity room's resident accessible public sink's water temperature. The first measurement was 98 degrees F, then 118 degrees, and after a minute it increased to 126.2 degrees F and continued to rise when Staff A removed their thermometer from the water. Staff A stated Staff B, Maintenance, had been has been checking the hot water temperatures and that the facility hasn't needed to get the hot water tanks professionally serviced.

Record review of the facility's water temperature check log, dated 02/16/2026, documented the upstairs activity room sink's water temperature was 121.4 degrees F a vacant resident room, number 226, water temperature was 122.2 degrees F and another vacant room's water temperature was 126.4 degrees F. The temperature log identified that the readings were all out of the safe range and water temperature adjustments were made, no further documentation regarding what the adjustments were, or if they were validated to have corrected the issue.

Record review of the facility's water temperature check log documented, dated 02/27/2026, documented a vacant resident room, number 219, water temperature was 125.2 degrees F, that it was not in the safe range and that the temperature was lowered. There was no documentation to elaborate what included in the lowered temperature.

On 03/04/2026 at 9:46 PM, Staff A stated there were no other water temperature logs completed after 02/27/2026. Staff A acknowledged that water was over the regulation and the concern with the risk of injury to the residents.

On 03/05/2026 at 4:40 PM, Staff B stated they were unaware that the hot water temperatures were above the regulation and acknowledged that the second-floor activity room resident accessible public sink and the east side of the facility's hot water temperatures tend to run higher. Staff B stated the hot water needed to run for at least

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a few minutes before they checked the hot water as it took a moment for the water to get up to the temperature.

This is a recurring deficiency previously cited on 11/21/2025 and an uncorrected deficiency previously cited on 01/22/2026.

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, Westhaven Villa is or will be in compliance with this law and / or regulation on (Date) 4.15.26 .

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

Administrator (or Representative) Date 3/25/26

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a few minutes before they checked the hot water as it took a moment for the water to get up to the temperature.

This is a recurring deficiency previously cited on 11/21/2025 and an uncorrected deficiency previously cited on 01/22/2026.

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, Westhaven Villa 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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 01/22/2026 of:
Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

This document references the following SOD dated: 01/22/2026

The following sample was selected for review during the unannounced on-site visit: 6 of 28 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

Statement of Deficiencies	License #: 2152	Compliance Determination # 71753
Plan of Correction	Westhaven Villa	Completion Date
Page 2 of 4	Licensee: Caring Places Management, LLC	01/22/2026

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.

Clinton Fridley RN
Residential Care Services

01/28/2026
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)

2/5/26
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure the facility's hot water temperature did not go above 120 degrees Fahrenheit (F) in 9 of 9 areas (second floor activity room, first floor activity room, two public restrooms, dining room sink, Resident 1, 2 and 3 rooms). This failure placed all residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

Record review of the facility's document titled, "Plan of Correction," dated 11/25/2025, documented maintenance would adjust the water temperatures, signs were posted to affected sink areas warning of hot water, hot water temperatures would be documented on the logs and monitored and audited by the administrator. Maintenance staff were re-educated on the hot water temperature regulations.

Record review of the facility document titled, "Assisted Living Water Temperature," dated 12/17/2025, documented Staff B, Maintenance, signed the documented to show they were educated on the facility's hot water temperature regulation, they would use a digital or approved thermometer, document all corrective actions taken, and that they understood to notify the administrator immediately if the water temperature was above 120 degrees F or under 105 degrees F.

On 01/22/2026 at 11:39 AM, in the activity room on the second floor, at the public

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.

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 _____

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure the facility's hot water temperature did not go above 120 degrees Fahrenheit (F) in 9 of 9 areas (second floor activity room, first floor activity room, two public restrooms, dining room sink, Resident 1, 2 and 3 rooms). This failure placed all residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included…

Record review of the facility's document titled, "Plan of Correction," dated 11/25/2025, documented maintenance would adjust the water temperatures, signs were posted to affected sink areas warning of hot water, hot water temperatures would be documented on the logs and monitored and audited by the administrator. Maintenance staff were re-educated on the hot water temperature regulations.

Record review of the facility document titled, "Assisted Living Water Temperature," dated 12/17/2025, documented Staff B, Maintenance, signed the documented to show they were educated on the facility's hot water temperature regulation, they would use a digital or approved thermometer, document all corrective actions taken, and that they understood to notify the administrator immediately if the water temperature was above 120 degrees F or under 105 degrees F.

On 01/22/2026 at 11:39 AM, in the activity room on the second floor, at the public

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resident accessible sink, the water temperature was 135.0 degrees F. There was steam observed rising from the running hot water and it was hot to touch.

On 01/22/2026 at 12:11 PM, the public resident accessible bathroom next to the administrator's office had a water temperature of 132.3 degrees F.

On 01/22/2026 at 12:14 PM, in the public bathroom on the first floor across from Resident 2 (R2)'s room the hot water temperature was 128.3 degrees F.

On 01/22/2026 at 12:16 PM, in the dining room at the resident accessible sink, the hot water temperature was 121.8 degrees F.

On 01/22/2026 at 12:36 PM, Staff A, Administrator, came into the public bathroom on the first floor across from their office. Staff A checked the running hot water temperature with the facility's probe thermometer with just the tip in the water that read 113 degrees F. The Department checked the running hot water the same time with the thermometer reading at 133.4 degrees F. Staff A inserted their probe thermometer further into the water and the hot water temperature was 133.4 degrees and stated, "I guess we will turn them down." Staff A acknowledged they were unaware that the hot water temperatures were out of range and the facility was requested to complete a safety plan to address the hot water temperatures.

Record review of the facility's document titled, "Hot Water Temperature Safety Plan," undated, documented the hot water temperatures were running above safe limits and the facility would have maintenance adjust the main hot water heater thermostat to bring the hot water temperatures down, post temporary warning signs of hot water, maintenance would complete and maintain hot water temperature logs and the administrator would review the logs weekly for the first month and ensure corrective actions were taken if temperatures exceeded safe limits.

On 01/22/2026 at 12:42 PM, R1's kitchenet sink, the hot water temperature was 123.7 degrees F. R1 stated sometimes their water inside of their apartment was hot.

On 01/22/2026 at 12:45 PM, in R2's bathroom sink, the running hot water temperature was 128.9 degrees F. R2 was watching and stated, "that looks like it's hot, it has steam."

On 01/22/2026 at 12:55 PM, in Resident 3's (R3) bathroom, the hot water temperature was 136.3 degrees F with steam and heat rising from the running hot water temperature.

On 01/22/2026 at 1:29 PM Staff B stated yesterday, 01/21/2026, the hot water temperatures in the kitchen were low so they turned up two of the three hot water

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tanks for the facility. Staff B stated they only had the hot water tanks turned up for an hour and a half and then turned them down shortly before 7:00 PM before leaving the facility for the day. Staff B was unaware of the hot water temperatures being above 120 degrees F and had not checked the hot water temperatures that day 01/22/2026.

This is an uncorrected deficiency previously cited on 11/21/2025.

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, Westhaven Villa is or will be in compliance with this law and / or regulation on (Date) 2/13/26 .

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

Administrator (or Representative) Date 2/5/26

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

tanks for the facility. Staff B stated they only had the hot water tanks turned up for an hour and a half and then turned them down shortly before 7:00 PM before leaving the facility for the day. Staff B was unaware of the hot water temperatures being above 120 degrees F and had not checked the hot water temperatures that day 01/22/2026.

This is an uncorrected deficiency previously cited on 11/21/2025.

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, Westhaven Villa 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

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

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

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 11/10/2025 and 11/13/2025 of:
Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

The following sample was selected for review during the unannounced on-site visit: 7 of 36 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Clinton Fridley, Adult Family Home Nurse Field Manager

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

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

Statement of Deficiencies	License #: 2152	Compliance Determination # 68489
Plan of Correction	Westhaven Villa	Completion Date
Page 2 of 27	Licensee: Caring Places Management, LLC	11/21/2025

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

11/25/2025
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)

12/5/25
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure the facility's hot water temperature did not go below 105 and above 120 degrees Fahrenheit (F) in 6 of 6 areas (Resident 1's bathroom, second floor activity room, first floor activity room, public restrooms, Resident 7 (R7) kitchenette). This failure placed 36 of 36 residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

On 11/10/2025 at 10:24 AM, in the activity room on the first floor, at the public resident accessible sink, the hot water temperature was 126.6 degrees F. There was steam observed rising from the running hot water and was hot to touch.

In an observation on 11/10/2025 at 10:43 AM, the public resident accessible bathroom across from the administrator's office hot water temperature was 128.6 degrees F.

On 11/10/2025 at 10:45 AM, in the resident dining room the public resident accessible sink's hot water temperature was 127 degrees F.

In an observation on 11/10/2025 at 10:47 AM, the public resident accessible bathroom next to the elevator had a hot water temperature of 129.4 degrees F.

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.

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

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure the facility's hot water temperature did not go below 105 and above 120 degrees Fahrenheit (F) in 6 of 6 areas (Resident 1's bathroom, second floor activity room, first floor activity room, public restrooms, Resident 7 (R7) kitchenette). This failure placed 36 of 36 residents and staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included…

On 11/10/2025 at 10:24 AM, in the activity room on the first floor, at the public resident accessible sink, the hot water temperature was 126.6 degrees F. There was steam observed rising from the running hot water and was hot to touch.

In an observation on 11/10/2025 at 10:43 AM, the public resident accessible bathroom across from the administrator's office hot water temperature was 128.6 degrees F.

On 11/10/2025 at 10:45 AM, in the resident dining room the public resident accessible sink's hot water temperature was 127 degrees F.

In an observation on 11/10/2025 at 10:47 AM, the public resident accessible bathroom next to the elevator had a hot water temperature of 129.4 degrees F.

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On 11/10/2025 at 10:58 AM, in the activity kitchenette on the second floor the public resident accessible sink's hot water temperature was 127.8 degrees F.

On 11/10/2025 at 11:20 AM, in R1's bathroom the hot water from the sink was 132.7 degrees F. There was steam rising as the hot water ran and was hot to touch. R1 stated they used the public bathrooms in the hallway and that the water was hot at times.

On 11/10/2025 at 11:32 AM, Staff J, Maintenance Supervisor, stated they did not know that the water temperature regulation was and they were unsure what the water temperatures were set to. Staff J stated they were to check the hot water temperatures for the facility monthly but had not completed it since they started employment on 10/06/2025.

On 11/10/2025 at 11:37 AM, the Department requested a safety plan from the facility about the hot water temperatures being above the regulation of 120 degrees F.

In an interview on 11/10/2025 at 3:10 PM, Resident 5 (R5) stated that the water in the facility got really hot and then cooled down.

Record review of the facility's Safety Plan, dated 11/10/2025, that was sent to the Department on 11/10/2025 at 12:37 PM, documented that maintenance lead was notified about the elevated temperatures. The hot water system was adjusted to reduce the temperature to ensure resident areas were within regulatory range of 105 degrees F to 120 degrees F, hot water temperatures were rechecked, and temporary signage at affected sinks were posted that showed "hot water caution water temperatures being adjusted, use with care".

In an observation on 11/12/2025 at 10:00 AM, the public accessible bathroom across from the administrator's office had a water temperature of 122.5 degrees Fahrenheit.

On 11/12/2025 at 10:01 AM, on the first-floor activity area public sink's hot water temperature was 122.2 degrees F.

On 11/12/2025 at 10:52 AM, inside R1's bathroom, the hot water temperature at the sink was 104.7 degrees F.

In an observation on 11/12/2025 at 11:45 AM, the public resident accessible bathroom next to the elevator had a water temperature of 104.9 degrees F.

In an observation on 11/12/2025 at 12:23 PM, R7's, water temperature in their kitchen

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was 103.0 degrees F.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, stated maintenance or whomever was delegated, was responsible for checking the facility's hot water temperatures monthly.

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, Westhaven Villa is or will be in compliance with this law and / or regulation on (Date) JAN 8 26 .

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

Administrator (or Representative) 12/5/25 Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 observation, interview and record review, the facility failed to ensure residents medications were administered in a safe manner for 6 of 6 residents (Resident 1, 8, 9, 10, 11, and 13). The facility failed to notify the residents physician and monitor the resident after 1 of 2 residents (Resident 2) refused their medications and for 1 of 2 sampled residents (Resident 7) medications were not available for administration. These failures placed 36 of 36 residents at risk for medical complications and not getting medication as prescribed.

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was 103.0 degrees F.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, stated maintenance or whomever was delegated, was responsible for checking the facility's hot water temperatures monthly.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(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 observation, interview and record review, the facility failed to ensure residents medications were administered in a safe manner for 6 of 6 residents (Resident 1, Resident 8, Resident 9, Resident 10, Resident 11, and Resident 13). The facility failed to notify the residents physician, as required, and monitor the resident after 1 of 2 residents (Resident 2) refused their medications and for 1 of 2 sampled residents (Resident 7) medications were not available for administration. These failures placed 36 of 36 residents at risk of medical complications and not getting medication as

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prescribed.

Findings included…

Record review of the facility policy titled, "Missing, Refused or unavailable medication procedure," undated, documented if medications were refused, not delivered from the pharmacy the following steps were to be taken contact the pharmacy about an emergency three to five day supply. Notify the medical doctor that the medication was not available or why the medication was refused. Facility staff were to request a hold order from the medical doctor until the medication arrived. Place residents on alert charting to monitor for side effects of not receiving the medication. Request family follow up with the medical doctor if a refill order was needed. Fill out an incident report if medication dose was unavailable. Document on the MAR (medication administration record) why the medication was not available. The facility was to follow up daily with the pharmacy or the family until the medication was obtained.

Record review of the facility policy titled, "Alert Charting," undated, documented all changes in medication required an enhanced monitoring of the resident and potential care changes. The Medication Aide would place the resident on alert. The RCC (Resident Care Coordinator) would review resident vitals and alert charting and digital signs they reviewed the information. Documentation of the observed status of the resident would be completed once daily unless otherwise specified. The RCC could extend the alert charting if needed or directed by a medical professional.

Refused Medication

Resident 2 (R2)

Record review of R2's Resident Info [information] Sheet, undated, showed R2 moved into the facility on [redacted]/2023. R2 had a diagnosis of [redacted]

Record review of R2's Service Agreement, dated 09/17/2025, showed it was R2's working care plan. The medical care management section showed that the facility did all R2's medications. The facility always assisted with medications per PCP (primary care provider) orders and always administered insulin per PCP orders. The facility communicated with the PCP as needed.

Record review of R2's Primary Health Care Provider's Initial Orders, dated 12/29/2022, showed that resident refusal of prescribed orders would be shared with the PCP after 3 consecutive refusals.

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Record review of R2's Medication Administration Record (MAR), dated 10/01/2025 through 10/31/2025, documented that R2 had an order to use their true metrix air glucose meter (device used to check blood sugars) three times a day and R2 refused 22 of 31 days. R2 had an order to take Novolog (rapid acting insulin) three times a day and R2 refused 28 of 31 days. R2 had an order to take Lantus Solostar (long lasting insulin) two times a day and R2 refused two of 31 days.

Record review of R2's MAR, dated 11/01/2025 through 11/09/2025, documented R2 had an order to use their true metrix air glucose meter three times a day and R2 refused five of nine days. R2 had an order to take Novolog three times a day and R2 refused six of nine days.

In an interview on 11/12/2025 at 2:48 PM, Staff C, Medication Aide, stated that they were familiar that R2 refused their medications often. Staff C stated that R2's PCP should be notified if they refused their medications. Staff C stated that R2 was on alert charting often. Staff C stated that R2 would pick and choose what insulin they wanted to take based on their blood sugar.

On 11/10/2025 at 12:52 PM, the Department requested all R2's progress and alert charting notes from 10/01/2025 – 11/10/2025.

Record review of R2's Resident Alert, dated 10/12/2025, showed R2 refused their insulin on 10/12/2025 and was monitored until 10/14/2025.

On 11/13/2025 at 8:57 AM, the Department requested all R2's October and November faxes related to R2's medication refusals.

Record review of R2's facsimile, dated 10/12/2025, Staff C reported to R2's PCP they refused their Novolog.

Record review of R2's facsimile, dated 10/15/2025, Staff G, Medication Aide reported to R2's PCP they refused their Novolog and noted R2 said they do not need it. There was no documented PCP response to review.

Non-available Medication

Resident 7 (R7)

Record review of R7's Resident Info Sheet, undated, documented that R7 moved into the facility on [redacted]/2025 and had multiple medical diagnoses which included [redacted] and [redacted]

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[redacted].

Record review of R7's Service Agreement, dated 10/31/2025, documented that it was R7's working care plan. The medical care management section showed that all shifts at the facility assisted R7 with their medications per PCP orders and communicated with R7's PCP as needed.

Record review of R7's MAR, dated 10/01/2025 through 10/31/2025, documented that R7 was out of the facility from 10/06/2025 through 10/09/2025. R7 had an order to take Omeprazole (medication that decreased the amount of stomach acid) one capsule daily. R7 missed their Omeprazole medication from 10/01/2025 through 10/18/2025. The exceptions section documented that the Omeprazole medication had not yet been delivered by the pharmacy. The exceptions section documented that on 10/20/2025 the facility staff were waiting for refill from R7's PCP. R7 had an order for Torsemide (medication to treat fluid retention which can be caused by heart failure) to take one tablet daily. R7 missed their Torsemide medication from 10/14/2025 through 10/31/2025. The exceptions section documented that the Torsemide medication had not yet been delivered by the pharmacy. On 10/17/2025 the notes section documented the facility faxed R7's PCP to get a refill of the Torsemide medication. On 10/22/2025 the notes section documented that the PCP would not refill the Torsemide medication until they saw R7.

Record review of R7's MAR, dated 11/01/2025 through 11/09/2025, documented that R7 had an order for Torsemide to take 1 tablet daily. R7 missed their Torsemide medication from 11/02/2025 through 11/05/2025. The exception section documented that the medication had not yet been delivered by the pharmacy.

Record review of a facsimile, dated 10/16/2025, documented Staff G, inquired about refill orders for R7's Omeprazole and Torsemide medications.

On 11/10/2025 at 12:52 PM, the Department requested all R7's progress and alert charting notes from 10/01/2025 through 11/10/2025.

Record review of R7's Resident Progress Notes, dated 10/06/2025 through 10/31/2025, showed no progress notes related to R7's missed Omeprazole and Torsemide medications.

Record review of R7's Resident Alerts, dated 10/06/2025 through 11/10/2025, showed no alert notes related to R7's missed Omeprazole and Torsemide medications.

In an interview on 11/12/2025 at 2:37 PM, Staff C, stated that if a resident missed a medication or refused a medication the protocol was the same and that they would need to notify the physician via fax. Staff C stated that the resident would be placed on alert for a minimum of three days to monitor for adverse side effects. Staff C stated

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they sometimes reordered residents their medications. and when they reordered medications, they ensured it was ordered before the medication was out to make sure there was no time lapse without the medication.

On 11/13/2025 at 12:35 PM, Staff B, Resident Care Coordinator, stated the medication aides were to put the resident on alert if they refused their medication or if a medication was not available for administration as the facility policy shows.

Medication Administration

Record review of the Department's publication titled, "Fundamentals of Caregiving 3rd Edition", dated 2011, documented the five rights of medication that guide the medication aides actions anytime they helped a resident with their medications included right medication, right client, right dose, right route, and right time. The medication aide was to complete the five right checks when they first took the medication out of storage, again when moving it from the original container to the medication cup, and when you finally put the medication back into the storage area. The medication aides were to check the five rights of medication each time they performed medication assistance or administration, follow medication labels, and follow physician orders.

Record review of the facility's policy titled, "Medication Administration", undated, documented staff would upon administration of medication to a resident document the medication name, time, and dosage administered to the resident and ensure resident took the medication according to the prescription.

In an observation on 11/10/2025 at 12:15 PM, on the second floor, Staff G, Medication Aide, walked out of Resident 8's (R8) room and walked to the medication cart in the hallway that did not have a computer or a MAR sitting on top. Staff G stated that they were passing the noon time medications to the residents. Staff G reached inside their shirt pocket and pulled out the medication cart keys. Staff G unlocked the medication cart and opened the drawer. Staff G pulled a plastic wrapper that was for Resident 9 (R9). Staff G opened the packet and poured the medication into a white paper medication cup, poured a cup of water, shut the drawer, and locked the medication cart. Staff G while pulling the medication out for R9 did not review any type of MAR and just opened the plastic package and poured it into a cup. Staff G was only able to show the list of medications that were listed on the plastic package what medications they were administering to the residents. Staff G entered R9's room and handed R9 the medication cup and water. Staff G left the room and returned to the medication cart at 12:19 PM. Staff G reached inside their shirt pocket, pulled the medication cart keys out and unlocked the medication cart, and opened the drawer and pulled out Resident 10's (R10) medication from the medication cart, poured them into a white paper medication cup, poured a cup a water, and then locked the medication cart. Staff G continued to not have a MAR or a computer on the medication cart to check the orders and sign out the medication. Staff G stated the residents MAR's were electronic and that there was only one computer for the two medication carts and the computer currently was on the other medication cart. Staff G entered R10's room, handed the cup of water and the

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medication cup to R10. Staff G returned to the medication cart at 12:31 PM, Staff G was not observed to review the residents MAR or sign out the medications for R8, R9, and R10.

On 11/13/2025 at 11:35 AM, Staff B, Resident Care Coordinator, stated the medication aides' were required to follow the five rights of medication administration that included checking the resident medication to the MAR to ensure it was the right resident, right medication, right dose of medication, right time, and right route (how the medication was to be administered) with each medication administration. Staff B stated there was one computer for two medication carts and the medication aide was expected to transfer the computer to whichever cart they were administering medication out of.

In an observation on 11/13/2025 at 11:41 AM, while walking with Staff B, we walked past the two medication carts that were on the first floor parked up against the wall just outside of the Administrators office. Staff G was standing at the medication cart on the right that did not have a computer, and the medication cart on the left had a computer that was closed shut. Staff G was observed to be checking a female resident their blood sugar monitoring. Staff B stated Staff G should have the computer open, on and the residents electronic MAR open when they were administering medications to verify the physician orders to the medication or treatment were correct and matched prior to administering and then sign them out. At 11:44 AM, Staff G was standing at the medication cart on the first floor by the administrator's office. Staff G pulled the medication drawer out, grabbed Resident 1's (R1) medication package, poured them into a white paper cup, and then handed them to R1 to take. Staff G continued to have the only computer that was on the left side medication cart closed without looking at the R1 electronic record when they pulled R1's medication out. R1 took them and then handed Staff G back the mediation cup that they threw away in the trash. R11 came up to Staff G at the medication cart without the computer on top. Staff G opened the medication cart, pulled out Resident 11's (R11) plastic package of medication, poured them into the cup and locked the medication cart. Staff G handed the medication cup to R11 and they took them. Staff G was not observed to have the computer on or R11's MAR open to review the orders to the medication listed on the package to the orders that were on R11's MAR prior to administering R11's medication. Staff G reached into the shirt pocket, pulled out the medication cart keys, unlocked the medication cart and pulled out Resident 13's (R13) medication and poured them into a white medication cup. The computer remained closed, and Staff G did not have R13's MAR pulled up to ensure the medications they were administering were signed out on the MAR and verified they were correct prior to Staff G handed the white cup of medications to R13. As of 11:50 AM, Staff G was not observed to check the resident's medication that were pulled out of the medication cart to the residents prescribed physician orders on the MAR to ensure and verify the medication they administer were correct.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, stated it was required and an expectation that the residents electronic MAR was to be open on the facility computer on the medication cart while the medication aide was administering resident's medication to ensure and verify the medications administered were correct and matched the physician orders.

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Statement of Deficiencies	License #: 2152	Compliance Determination # 68489
Plan of Correction	Westhaven Villa	Completion Date
Page 10 of 27	Licensee: Caring Places Management, LLC	11/21/2025

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) [signature] Date 12/5/25

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(c) Maintain and provide staff persons with the necessary training, supplies, equipment, and personal protective equipment for preventing and controlling the spread of infections by:

(ii) Ordering supplies when necessary.

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide necessary handwashing supplies in 5 of 5 resident care areas (laundry room, Resident 1's [R1] room, Resident 4's [R4] room, Resident 11's [R11] room and Resident 13's [R13] room). The facility failed to implement infection control practices by staff not performing hand hygiene during resident care for 3 of 3 staff (Staff G, Staff C, and Staff F) observed. These failures placed all 36 of 36 residents, staff, and visitors at risk for spread of infectious disease or illness.

Findings included...

Record review of CDC's fact sheet titled, "About Hand Hygiene at Work", dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to

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Findings included…

Record review of CDC's fact sheet titled, "About Hand Hygiene at Work", dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to

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prevent the spread of germs and keep employees healthy.

Record review of the facility's Infection Control policy, dated 02/17/2016, documented hand washing was the single most important measure for preventing the spread of infection and disease. All staff would be responsible for carrying out the hand washing policy. Staff would wash their hands after handling soiled laundry or items with body fluids and housekeeping tasks, before handling medications, before and after helping residents with personal care tasks of daily living, whenever you change from doing a "dirty" to a "clean" task, whenever hands are obviously soiled and the use of gloves do not replace hand washing. Hands should be washed before and after touching the resident, immediately if hands are soiled with blood or other body fluids and immediately after removing gloves. Staff were expected to perform hand washing that included removing all rings, run water and stand away from the sink, put hands and wrists in the running water to allow the germs to run off the fingers, apply soap and lather hands together, rinse hands well for a full minute, dry hands with paper towels, and then turn the water off with paper towel and discard.

Hand Washing

In an observation on 11/10/2025 at 12:15 PM, on the second floor, Staff G, Medication Aide, walked out of Resident 8's room and walked to the medication cart in the hallway that had a bottle of hand sanitizer on top. Staff G reached inside their shirt pocket and pulled out the medication cart keys. Staff G unlocked the medication cart and opened the drawer. Staff G was not observed to perform hand hygiene prior to opening the medication cart. Staff G pulled a plastic package with medication inside for Resident 9 (R9). Staff G opened the packet and poured the medication into a white paper medication cup, poured a cup of water, shut the drawer, and locked the medication cart. Staff G entered R9's room and handed R9 the medication cup and water. Staff G left the room and returned to the medication cart at 12:19 PM. Staff G reached inside their shirt pocket, pulled the medication cart keys out and unlocked the medication cart, and opened the drawer. Staff G was not observed to perform hand hygiene after they returned to the medication cart. Staff G pulled out Resident 10's (R10) medication from the medication cart, poured them into a white paper medication cup, poured a cup of water, and then locked the medication cart. Staff G entered R10's room, handed the cup of water and the medication cup to R10. R10 handed back the empty white cup that their medication was in back to Staff G that they threw in the trash. Staff G returned to the medication cart where they answered the black phone that was ringing. Staff G ended the call, reached into their shirt pocket, pulled out the medication cart keys, unlocked the cart, and opened the drawer. Staff G was not observed to perform hand hygiene after being in R10's room and since returning to the medication cart. As of 12:31 PM, Staff G was not observed to have performed hand hygiene between the resident's medication administrations observed.

In an observation on 11/12/2025 at 11:56 AM, Staff G was standing at the medication cart with hand sanitizer on top. Staff G handed R10 their medications. R10 took her medications and Staff G took back the water cup and the medication cup from R10 and disposed them into the trash. Staff G reached into their shirt pocket pulled out the medication cart keys, unlocked the medication cart, opened the second drawer and

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pulled out another resident's plastic package of medication and poured them into a white paper medication cup. Staff G was not observed to perform hand hygiene after discarding R10's used trash and before getting out R12's medication. Staff G was observed to type on the medication cart computer, locked the medication cart, grabbed R12's cup of medication and cup of water, entered the dining room, and gave them to R12 to take. While R12 took their medications, Staff G was observed to lean their hand on the dining room table and then took the used medication and water cup back from R12. Staff G returned to the medication cart, threw the used medication and water cups into the trash, reached into their shirt pocket, pulled out the medication cart keys, opened the drawer, grabbed a resident's eye drop medication bottle out. Staff G was not observed to perform hand hygiene since they returned back to the medication cart from administering R12's medications. Staff G grabbed a new pair of gloves out of the box, and grabbed the medicated eye drops, locked the medication cart and entered the dining room. Staff G returned to the medication cart with the same gloves and eye drops. As of 12:03 PM, Staff G had not performed any kind of hand hygiene when they were in between resident's medication passes.

On 11/13/2025 at 11:22 AM, Staff D, Caregiver, stated that if their hands were visibly soiled when they were providing resident care in their apartment, they would use the soap in the room. Staff D stated the soap is typically the resident supply and that the facility does not provide paper towels in the resident care area apartments. Staff D stated they were to wash their hands all the time, before and after care, and after taking off their gloves.

In an observation on 11/13/2025 at 11:44 AM, Staff G was standing at the medication cart on the first floor by the administrator's office. Staff G pulled the medication drawer out, grabbed R1's medication package, poured them into a white paper cup, and then handed them to R1 to take. R1 took them and then handed Staff G back the mediation cup that they threw away in the trash. Staff G did not perform hand hygiene after disposing R1's used medication cup into the trash. R11 came up to Staff G, when Staff G opened the medication cart, pulled out a plastic package of medication and poured them into the cup, locked the medication cart. Staff G handed the medication cup to R11 and they took them. Staff G was not observed to perform hand hygiene prior to getting R11's medication out of the medication cart. Staff G reached into the shirt pocket, pulled out the medication cart keys, unlocked the medication cart and pulled out Resident 13's (R13) medication and poured them into a white medication cup. Staff G handed the white cup to R13 that took the medication and handed the white medication cup back to Staff G that grabbed it and threw it in the trash. Staff G locked the medication cart and walked away to the dining room. As of 11:50 AM, Staff G was not observed to perform any hand hygiene throughout the medication administration.

Hand Washing Supplies

In an observation on 11/10/2025 at 11:02 AM, the only hand washing sink located inside of the laundry room showed when the soap dispenser was pushed no soap was dispensed.

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In an observation on 11/10/2025 at 11:25 AM, in R1's care area apartment at the kitchenette and bathroom sink, there was no facility provided paper towels or soap available for the staff to wash their hands. R1 stated the dawn dish soap at the sink was purchased by themselves.

On 11/10/2025 at 1:13 PM, Staff C, Medication Aide, stated that when they completed laundry at the facility they donned (put on) gloves before they handled soiled laundry. Staff C stated that they washed their hands after they handled soiled laundry, before they touched clean laundry, and before they moved on to another task.

In an observation on 11/10/2025 at 2:01 PM, Staff C was inside of the laundry room. The Department confirmed the soap dispenser still did not dispense any soap. Staff C wore gloves as they folded laundry. Staff C doffed (took off) their gloves and did not perform hand hygiene before they donned another pair of gloves. Staff C placed clean laundry into a basket. Staff C transferred laundry from the washing machine into the dryer. Staff C took soiled laundry outside of the basket on the ground and loaded it into the washing machine. Staff C doffed their gloves, did not perform hand hygiene before they donned another pair of gloves and started to fold laundry and placed the laundry inside of a bag. Staff C went to the dryer and cleaned out the lint trap. Staff C took clothes out of the washing machine and placed them into the dryer. With their gloved hands Staff C got a marker and wrote the room number onto a magnet and placed the magnet on top of the washing machine. Staff C got soiled laundry out of black bag on the ground in a basket and added it into the washing machine. Staff C pushed the button on the automatic soap dispenser to add soap into the washing machine. Staff C doffed their gloves. With their bare hands Staff C got the maker they previously touched with their soiled gloves and wrote a room number onto the magnet. Without hand hygiene Staff C left the laundry room. Staff C went to the front of the building and retrieved a bag outside before they returned inside.

In an interview on 11/12/2025 at 10:04 AM, Resident 11 (R11), stated that the facility did not provide soap or paper towels in their apartment for the staff to use and that they purchase those supplies themselves. Resident 1 (R1) stated they did not have facility supplied paper towels in their apartment for the staff to use.

In an interview and observation on 11/12/2025 at 12:42 PM, Staff F, Caregiver, was in the laundry room. At 12:42 PM, Staff F donned gloves and then they folded laundry. Staff F said when they washed resident laundry they wore gloves. Staff F said they wore gloves when they touched soiled laundry and switched over the laundry. Staff F said they washed their hands before they touched the marker, they used to write down resident information on the magnet. Staff F doffed their gloves and did not perform hand hygiene before they took clothes out of the washing machine and placed them into the dryer.

In an interview and observation on 11/12/2025 at 12:42 PM, Staff F confirmed that they helped residents go to the bathroom. Staff F stated that they washed their hands inside of the resident room before they left. Staff F was unaware if the facility provided soap and paper towels inside of the resident rooms for the facility staff to use. Staff F stated

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that they used whatever soap, paper towels, or hand towel was inside of the resident room.

In an observation on 11/12/2025 at 3:01 PM, inside R4's care area apartment bathroom and kitchenette sink, there was no facility provided paper towels or soap available for the staff to wash their hands with. R4 stated the soap that they had at the sinks were purchased by their family.

In an observation on 11/13/2025 at 11:40 AM, inside R13's care area apartment bathroom, there was a black paper towel dispenser hung up on the wall by the sink. Staff B, Resident Care Coordinated, pushed the soap dispenser in the bathroom and soap dispensed. Staff B then rinsed the soap off their hand and waved their hand in front of the sensor on the paper towel holder. There was no noise or paper towels dispensed. Staff B stated the facility did not have the key to open the dispenser to replenish the paper towels for the staff to use. There were no other paper towels available for staff to use. Staff B was unsure if the facility was going to be supplying paper towels to all the resident care area apartments to have available for staff to wash their hands with.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, stated staff were expected to wash their hands all the time that included before and after providing care, in between medications, after glove removal, and in between residents. Staff A stated the facility did supply soap and paper towels to every resident care area apartment for the staff to use. Staff were expected to use the closes sink to wash their hands if they were soiled.

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) [signature] Date 12/5/25

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

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that they used whatever soap, paper towels, or hand towel was inside of the resident room.

In an observation on 11/12/2025 at 3:01 PM, inside R4's care area apartment bathroom and kitchenette sink, there was no facility provided paper towels or soap available for the staff to wash their hands with. R4 stated the soap that they had at the sinks were purchased by their family.

In an observation on 11/13/2025 at 11:40 AM, inside R13's care area apartment bathroom, there was a black paper towel dispenser hung up on the wall by the sink. Staff B, Resident Care Coordinated, pushed the soap dispenser in the bathroom and soap dispensed. Staff B then rinsed the soap off their hand and waved their hand in front of the sensor on the paper towel holder. There was no noise or paper towels dispensed. Staff B stated the facility did not have the key to open the dispenser to replenish the paper towels for the staff to use. There were no other paper towels available for staff to use. Staff B was unsure if the facility was going to be supplying paper towels to all the resident care area apartments to have available for staff to wash their hands with.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, stated staff were expected to wash their hands all the time that included before and after providing care, in between medications, after glove removal, and in between residents. Staff A stated the facility did supply soap and paper towels to every resident care area apartment for the staff to use. Staff were expected to use the closes sink to wash their hands if they were soiled.

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Administrator (or Representative) Date

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(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

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(iii) Include all food and snacks served that contribute to nutritional requirements;

(v) Provide a variety of foods; and

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure menus were posted in resident accessible areas, residents were notified when food substitutions were made, were provided alternate choices, and changes on the original menu were documented for 1 of 1 facility kitchens reviewed. This failure placed 36 of 36 residents at risk of nutritional needs not being met and diminished quality of life.

Findings included…

Record review of the facility “Weekly Menu”, dated 11/09/2025 through 11/15/2025, showed on 11/10/2025 breakfast was ham and cheese omelet squares, fresh fruit, 100% juice, and whole grain toast. Lunch was green salad, cube steak and gravy, turkey roast with stuffing, parmesan mashed potatoes, garlic carrots, baked roll, and peach cobbler. Dinner was cheddar corn chowder, fish and chips, egg salad sandwich, southern coleslaw, and four fruit medley. On 11/12/2025 breakfast was brown sugar French toast, egg of choice, fresh fruit, and 100% juice. Lunch was green salad, sour cream crusted fish, glazed baked ham, parsley potatoes, seasoned broccoli, baked roll, and pecan pie bars. Dinner was classic chicken noodle soup, Reuben sandwich, Hungarian pork over rice, fresh fruit salad, pickled beets, and cinnamon fruit turnover. On 11/13/2025 breakfast was sausage breakfast muffins, fresh fruit, and 100% juice. Lunch was green salad, pepper steak, turkey with lemon thyme sauce, white and wild rice pilaf, chef’s steamed vegetables, baked roll, and pear crisp.

11/10/2025

In an observation on 11/10/2025 at 11:05 AM, the whiteboard inside of the dining room showed in handwritten letters breakfast was scrambled eggs, bacon, and peaches. Lunch was pork roast, sweet potatoes, and green beans. Dinner was deli turkey sandwich, macaroni salad, and fruit.

On 11/10/2025 at 11:10 AM, Staff H, Dietary Aide, stated that for lunch they made pork roast, sweet potato, green beans, and banana cake for dessert. Staff H stated they could not provide the Department with a current menu for the week to review as they

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didn't have one and that they made meals that day based upon the food the facility had on hand. Staff H stated Staff I, Dietary Manager, would bring the menu with them on 11/11/2025 afternoon as today was Staff I's day off. Staff H stated the residents at the facility did not worry about what was on the menu and as long as they received three meals a day. Staff H stated the residents needed to let the kitchen know one and a half hours before the meal if they wanted something different to eat.

On 11/10/2025 at 1:13 PM, Staff C, Medication Aide, stated that if the residents did not want to eat what was scheduled to be served, they needed to notify the kitchen staff at least 1 hour in advance.

In an interview on 11/10/2025 at 3:10 PM, Resident 5 (R5) stated that the facility did not deliver them a menu. R5 stated the facility staff sometimes wrote the menu on the whiteboard. R5 stated if they did not want to eat what was served, they were supposed to notify the facility in advance. R5 stated if they did not tell the facility in advance they wanted something different to eat, then they were out of luck.

11/12/2025

On 11/12/2025 at 10:04 AM, Resident 11 (R11), stated most of the time the daily menu was written up on the whiteboard in the dining room for the resident to review. R11 stated the facility did not post or distribute a weekly menu to the residents to know what was being served. R11 stated that morning they were served scrambled eggs, sausage, and sliced apples cups. Resident 1 (R1) stated they were served pancakes and two sausage links. At 10:41 PM, R11 stated the facility was serving baked ham for lunch that day. At 11:53 Am, Resident 14 (R14), stated the facility does not post the weekly menu for them to review and just the written daily menu on the whiteboard. At 12:03 PM, Resident 15 (R15) was sitting at the dining room table closest to the whiteboard and stated they were unsure what dinner was as there was nothing posted or written on the whiteboard. R15 stated the facility does not post the weekly menu's and only knows what is being served with what the whiteboard shows, but it was not always updated.

In an observation on 11/12/2025 at 11:46 AM, the whiteboard inside of the dining room showed breakfast was pancakes, sausage and fruit, and for Lunch was ham, mashed potatoes with gravy, carrots, a roll with Jello or a brownie for dessert. Dinner meal was not written on the whiteboard for the residents to know what was being served. Throughout the dining room, around the whiteboard, and in the lobby area outside of the dining room, there was no weekly menu posted for the residents to review.

In an observation on 11/12/2025 at 12:02 PM, Staff K, Caregiver, started to serve resident's lunch. Staff K automatically brought each resident a plate that contained ham, potatoes with gravy, carrots, and a roll. At 12:14 PM, Staff D, Caregiver, brought residents a brownie for dessert and informed the residents if they wanted, they could have Jello instead.

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In an observation on 11/12/2025 at 2:30 PM, the whiteboard inside of the dining room showed dinner was chicken noodle soup, fruit salad, biscuit, and turnovers.

11/13/2025

In an observation on 11/13/2025 at 10:20 AM, the whiteboard inside of the dining room showed breakfast was biscuits and sausage gravy with orange slices. Lunch was turkey roast, seasoned rice, zucchini, roll, and pear crisp for dessert and there was no dinner written on the whiteboard. There was no posted weekly menu to review.

In an interview on 11/13/2025 at 11:22 AM, Staff D, Caregiver, stated the meals for the day were written on the whiteboard that was in the dining room. Staff stated there was a monthly menu in the kitchen, but it was not accessible for the residents to review.

In an observation on 11/13/2025 at 12:50 PM, Resident 7 (R7), was delivered a room tray that contained turkey, rice, zucchini, roll, and a pear crisp. At 1:00 PM, R7 stated that they cannot eat this.

In an observation and interview on 11/13/2025 at 11:10 AM, Staff I stated that they were unsure why Staff H stated they could not provide a current menu for the Department to review on 11/10/2025. Staff I stated they created menus at least 1 month in advance. Staff I stated they tried to make what was scheduled on the menu but at times ingredients were not delivered for the meal and the menu would be changed. Staff I stated they could not provide the Department with a menu that noted when menu changes occurred and what the changes were. Staff I stated the activities department passed out weekly menus to the residents. Staff I stated the facility printed out a large weekly menu for the residents to reference. Staff I confirmed a large weekly menu was not currently posted. Staff I stated facility staff wrote down the daily menu on the whiteboard in the dining room for residents to reference. Staff I stated if the residents did not want to eat what was planned on being served then they needed to notify the kitchen staff at least 1 hour in advance. Staff I confirmed only breakfast and lunch was written on the whiteboard. Staff I acknowledged dinner was not posted and therefore residents did not have the opportunity to notify staff in advance if they did not want what was going to be served for dinner. Staff I stated that on the white board in the dining room it stated breakfast was biscuits and sausage gravy with orange slices. Staff I had a physical copy of the weekly menu and confirmed sausage biscuit muffins, fresh fruit, and 100% juice were supposed to be served. Staff I stated there was a change to the menu because Staff H was late and needed to make something fast for the residents to eat. Staff I stated they always edited the original menu before it was posted to reflect 1 main entrée instead of the 2 main entrees listed. Staff I looked that for lunch there were 2 main entrees which included pepper steak or turkey with lemon thyme sauce. Staff I stated the facility would never make both entrees for the residents to choose from. Staff I stated the facility seldom had steak or turkey to serve. When asked why an alternative entrée was not provided for the residents to choose from, Staff I stated the facility had an alternative any time menu where residents could order items such as soup, salad, and sandwiches instead of the entrée that was served. Staff I stated the facility posted the menu outside of the dining room on the wall. Observation

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of the wall outside of the dining room showed no alternative anytime menu posted. Staff I confirmed the anytime menu was not posted to review.

On 11/13/2025 at 11:42 AM, Staff M, Life Enrichment Coordinator, stated they did not deliver weekly menus to the residents. Staff M stated facility staff hand wrote what was on the menu on the whiteboard inside of the dining room.

On 11/13/2025 at 1:10 PM, Staff A, Administrator, stated the facility posted weekly menus in a frame for the residents to review by the whiteboard. When Staff A was asked to physically show the Department the menu, Staff A stated they overheard Staff I say that the current weekly menu was not posted. Staff A stated they knew Staff I edited the weekly menu to only reflect 1 choice in entrée but were unsure why Staff I did so.

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Administrator (or Representative) [signature] Date 12/5/25

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:

(b) Basic;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 3 sampled staff (Staff E) had completed their facility orientation upon hire. The facility failed to ensure 2

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of the wall outside of the dining room showed no alternative anytime menu posted. Staff I confirmed the anytime menu was not posted to review.

On 11/13/2025 at 11:42 AM, Staff M, Life Enrichment Coordinator, stated they did not deliver weekly menus to the residents. Staff M stated facility staff hand wrote what was on the menu on the whiteboard inside of the dining room.

On 11/13/2025 at 1:10 PM, Staff A, Administrator, stated the facility posted weekly menus in a frame for the residents to review by the whiteboard. When Staff A was asked to physically show the Department the menu, Staff A stated they overheard Staff I say that the current weekly menu was not posted. Staff A stated they knew Staff I edited the weekly menu to only reflect 1 choice in entrée but were unsure why Staff I did so.

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(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 3 sampled staff (Staff E) had completed their facility orientation upon hire. The facility failed to ensure 2

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of 2 sampled Staff (Staff B and Staff C) completed their annual continued education units (CEU). These failures placed 36 of 36 residents at risk for staff not being trained on updated medical information and staff being unaware of facility protocols and expectations upon hire.

Findings included…

Facility Orientation

Washington Administrative Code (WAC) 388-112A-0200 “What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.”

Record review of the facility’s Employee Human Resources List, undated, documented Staff E, Medication Aide, started employment at the facility on 09/24/2025.

Record review of Staff E’s Orientation Training List, dated 01/20/2021, documented that Staff E completed the orientation training on 07/21/2022.

On 11/13/2025 at 10:51 AM, Staff L, Office Manager, stated Staff E left employment for five months and was rehired at the facility on 09/24/2025. Staff L stated they did not have Staff E complete a new facility orientation as the facility’s handbook states if an employee leaves employment and returns within 6 months all the new hire paperwork does not need to be completed. Staff L stated Staff E first employment start date was on 07/21/2022.

Continued Education Units

WAC 388-112A-0611 “(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:(i) A certified home care aide;(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);(iii) A certified nursing assistant;(iv) A person with special education training and an endorsement granted by the Washington state office of superintendent of public instruction, as described in RCW 28A.300.010; and(v) An assisted living facility administrator or the administrator designee as provided under WAC 388-112A-0060.(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.(c) The continuing education requirements of this section do not apply to a registered nurse, a licensed practical nurse, and an advanced registered nurse practitioner licensed under chapter 18.79 or 18.80 RCW, even if voluntarily certified as a home care aide under chapter 18.88B RCW.(d) If exempt from certification under RCW 18.88B.041, a long-term care worker must complete and provide documentation of 12 hours of continuing education within 45 calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; and(i) Must complete 12

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hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or(ii) If the 45 calendar day time period allows the long-term care worker to complete continuing education in January or February of the following year, the credit hours earned will be applied to the calendar year in which the long-term care worker was hired.(e) If the birthday following initial certification as a home care aide or nursing assistant (NA-C) is less than a full year from the date of initial certification, no continuing education will be due for the first renewal period.(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed."

On 11/10/2025 at 10:44 AM, during a general tour of the facility by the employee time clock that was next to the office manager's office, there was a sign posted that showed "CEU's all caregivers must do 12 CEU's per year it is advised that doing 1 per month is the easiest way to get them completed".

Record review of the facility's Employee Human Resources List, undated, documented Staff B, Resident Care Coordinator, started employment at the facility on 08/19/2022 with their birthday on August 2nd.

Record review of the facility's Employee Human Resources List, undated, documented Staff C, Medication Aide, started employment at the facility on 03/15/2023 with their birthday on May 30th.

On 11/12/2025 at 8:45 AM, the Department requested to review Staff B's CEU dated 08/02/2024 through 08/02/2025 and Staff C's CEU's for dated 05/30/2024 through 05/30/2025 for review.

Record review of the CEU's provided for Staff B, documented that Staff B had 4.75 hours completed during the dates 08/02/2024 through 08/02/2025 provided.

Record review of the CEU's provided for Staff C, documented that Staff B had 9.75 hours completed during the dates 05/30/2024 through 05/30/2025 provided.

On 11/13/2025 at 10:51 AM, Staff L stated Staff B and themselves remind the staff every month during the employee meeting and post signs that they were required to finish one CEU class per month. Staff L stated at the beginning of each month, they will print all the employees certificates that were finished and file in their employee file and add to the training tracker.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, acknowledged that Staff B did not have their required 12 CEU's completed by their birthday on 08/02/2025.

As of 11/14/2025 at 5:30 PM, there were no further CEU's provided for Staff B and Staff C.

Basic training & Dementia certificates

WAC 388-112A-0080 "Who is required to complete the seventy-hour long-term care worker basic training and by when? …(5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the

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seventy-hour long-term care worker basic training.

WAC 388-112A-0400 "What is specialty training and who is required to take it? (1) Specialty training refers to approved curricula that meets the requirements of RCW 18.20.270 and 70.128.230 to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities... (4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows: (b) Dementia specialty training as described in WAC 388-112A-0440...
(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within 120 days of the date of hire."

Record review of the facility's Employee Human Resources List, undated, documented Staff F, Caregiver, started employment at the facility on 05/09/2025.

On 11/13/2025 at 5:42 AM, the Department requested to review Staff F's 70 hour basic training and dementia certificate for review.

On 11/13/2025 at 11:29 AM, Staff A, Administrator, stated Staff F had not completed the 70- hour basic training or the dementia training that was due by 09/06/2025.

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Administrator (or Representative) — Date: 12/5/25

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the

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(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the

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assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document, in the resident's Negotiated Service Agreements (NSA), the plan to provide necessary health support services from outside providers and the plan to provide intermittent nursing services for 5 of 7 residents (Resident 7 [R7], Resident 2 [R2], Resident 5 [R5], Resident 4 [R4], Resident 3 [R3], Resident 6 [R6]). These failures placed the residents at risk for unmet care needs and care and services not being provided per the NSA.

Findings included…

Record review of the facility policy titled, "Service Agreement Policy," undated, showed the agreement must include a written description of who would provide services and what, when, how, and how often services would be provided.

R7

Record review of R7's progress note, dated 10/10/2025, showed Staff B, Resident Care Coordinator, documented Collateral Contact 1 (CC1), R7's friend, had been interfering with R7's care and had attempted to obtain R7's medication list. R7's family reported they had reason to believe CC1 provided R7 with extra medications. Staff B documented CC1 attempted to visit R7 when they were asleep, CC1 had been asked to leave and then CC1 threw themselves on the floor and shouted.

Record review of R7's progress note, dated 10/10/2025, revealed Staff A, Administrator, documented that Staff C, Medication Aide, informed them the night prior that CC1

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brought R7 back to the facility after their hospitalization. CC1 yelled at Staff C and stated they were going to pack R7 items and leave. Staff C explained to CC1 it would not be appropriate as R7 had just been discharged from the hospital, did not have their oxygen, and needed to rest. The following morning CC1 returned and continued to try and take R7 home. CC1 started to yell and laid down on the lobby floor. Ultimately CC1 left the facility. Later in the day R7's family informed facility staff that they were concerned for R7 safety due to CC1's behavior. R7's family was concerned that CC1 changed R7's primary care physician. R7's family reported they found R7 in CC1's home weak and without their oxygen. R7's family reported they had concerns CC1 had administered R7 extra medications.

Record review of R7's outside provider notes, dated 10/30/2025, showed that R7 had a wound and the nurse provided wound care. R7 had been observed to drop their dinner plate on the floor and put whip cream from their Jello into their water.

Record review of R7's progress note, dated 10/30/2025, Staff B documented R7 was weak, lethargic, and unsteady on their feet and needed wheelchair escorts.

Record review of R7's progress note, dated 10/31/2025, Staff B documented R7 was admitted onto hospice services on 10/30/2025.

Record review of R7's Service Agreement, dated 10/31/2025, documented that R7 was on hospice services but did not describe the services received, used a wheelchair (W/C) and four wheeled walker for mobility, could self-propel the wheelchair short distances, and was encouraged to allow staff to escort them in the wheelchair for safety. R7 had a regular diet, required assistance to cut food and could feed themselves independently. R7 was encouraged to eat in the dining room due to a history or coughing and choking during meals and facility staff were to escort R7 to and from the dining room for every meal. No documentation explaining significant other dynamics or interventions noted.

Record review of R7's Health Assessment, dated 11/03/2025, showed the reason for the assessment was based on R7's hospice admission, had increased lethargy (prolonged fatigue), decreased mobility, weakness, increased falls, and now used a wheelchair for mobility.

Record review of R7's outside provider notes, dated 11/04/2025, R7 had little dietary intake, tremors (involuntary movement) in their hand that made it hard for R7 to feed themselves and needed assistance with eating. The hospice nurse provided wound care and would order oxygen, hospital bed, bed rails, and a mattress pad.

On 11/12/2025 at 2:00 PM, Collateral Contact 2 (CC2), R7's power of attorney, stated that R7 was on hospice services, could no longer walk and required more care from the facility staff. CC2 stated that within the last couple of weeks R7 had increased difficulty swallowing liquids and food. CC2 stated that CC1 was R7's long term partner and their relationship was toxic. CC2 said it would be their preference not to have CC1 visit R7.

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CC2 said they understood R7 had the right to visit with whom they wanted.

On 11/12/2025 at 2:37 PM, Staff C, Medication Aide, stated that if a resident was on hospice services the information should be incorporated into the resident's care plan. Staff C stated if a resident received pain management from hospice the facility staff would need to know, and that they would need to look out for signs of pain. Staff C stated R7 was on hospice and that they knew R7 had showering services provided through hospice. Staff C stated CC1 would come into the facility and try and demand information related to R7's care. Staff C stated that when the facility informed CC1 they could not provide them information about R7's care, CC1 threw themselves onto the floor. Staff C stated CC1 would tell visitors and residents who entered the facility that the facility over medicated R7. Staff C stated they heard CC1 had an injury that prevented them from visiting R7. Staff C had been asked what the protocol was if CC1 came back and wanted to visit R7. Staff C stated they were unsure what they were supposed to do the next time CC1 returned to the facility. Staff C stated R7's family had instructed facility staff to tell CC1 it was best for their health to stay in the community and rest versus leaving for a visit. Staff C stated if R7 needed protection from CC1 then it should be incorporated into R7's care plan. CC1 stated all the information they know of CC1 and R7 was through word of mouth.

On 11/13/2025 at 12:44 PM, Staff K, Caregiver, stated that they used resident care plans to obtain information about the residents and their care needs. Staff K stated that if a resident needed assistance with eating, then it would be incorporated into the care plan. Staff K stated they verbally heard information related to R7 and CC1.

An observation on 11/13/2025 at 12:50 PM, R7's door was open, and they were sitting alone at a table to eat lunch. R7's hand and arm visibly shook as they brought an eating utensil to their mouth, their head was slouched over the plate of food. R7's face got so low to the table that they were very close to their face touching their food. Staff D, caregiver, exited another resident's room and was observed in the hallway.

An observation on 11/13/2025 at 12:50 PM showed R7's door was open, and R7 was alone in their room as they sat at a table to eat lunch. R7's hand and arm visibly shook as they brought their utensil to their mouth. R7 head was slouched over their plate of food. R7 face got so low to the table R7 was at risk of their face touching their food.

On 11/13/2025 at 12:50 PM, Staff D, Caregiver, exited another resident room and was in the hallway and stated that they thought R7 had declined to the point where they always needed assistance. Staff D stated that when R7 went into the cafeteria they became confused and needed to eat in their room to prevent confusion. Staff D stated R7 could feed themselves. Staff D stated R7 admitted onto hospice services and was unsure if that hospice information was incorporated into R7's care plan because changes were ongoing. Staff D stated R7 received a new bed, air mattress, oxygen tank, and had a bath aide from hospice. Staff D stated that the resident care plans were in the medication room and staff would look over the resident care plans to get to know the residents. Staff D stated they looked at dates on the care plan to know when a change in a resident's care occurred.

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On 11/13/2025 at 1:02 PM, Staff B, Resident Care Coordinator, stated R7 had been admitted onto hospice services. Staff B stated that they were unaware if R7 required eating assistance. Staff B stated that information about the residents' care should be incorporated into the resident working care plan and facility staff should review working care plans at least quarterly.

R2

Record review of R2's Service Agreement, dated 09/17/2025, showed it was R2's working care plan and that the facility did all R2's medications including assisting with medications per PCP (primary care provider) orders and administration of insulin per orders. No documentation noted mentioning R2's refusal of medications or if R2 required nurse delegation.

Record review of the facility's delegated resident list, undated, documented R2 was on delegation for the following tasks that included blood sugar monitoring and insulin injection administration.

On 11/12/2025 at 2:48 PM, Staff C stated that they were familiar that R2 refused their medication often and that R2 would pick and choose what insulin they wanted to take based on their blood sugars. Staff C stated that R2 refusing their medication was R2's norm. Staff C stated that the information should be incorporated into R2's care plan so staff could refer to it.

R5

Record review of R5's Service Agreement, dated 10/09/2025, showed it was R5's working care plan and required a two wheeled walker for ambulation. No documentation noted regarding R5 receiving home health services.

Record review of R5's outside provider notes, dated 10/20/2025, showed occupational therapy conducted R5's initial evaluation.

Record review of R5's outside provider notes, dated 11/10/2025, showed R5 received occupational therapy and documented R5 demonstrated modified independence with activities of daily living, transfers, and mobility when R5 used their front wheeled walker.

An observation on 11/10/2025 at 2:17 PM, R5 was inside of their apartment with a home health therapist.

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

R3

Record review of R3's resident information sheet, undated, documented that R3 moved into the facility on 10/06/2025.

Record review of R3's Service Agreement, dated 10/22/2025, that was the working care plan, documented R3 required two to three care staff to assist with transfers and was unable to transfer independently. R3 used a wheelchair that they self-propelled with their feet. There was no documentation on the working care plan that R3 required home health therapy services.

Record review of R3's facility coordination notes from local home health provided, dated 10/16/2025, documented that R3 was admitted to home health services and would benefit from skilled intervention to address weakness, poor activity tolerance, pain, and balance deficit. R3 was non ambulatory and wheelchair dependent with oxygen dependent.

Record review of R3's outside provider notes, dated 10/20/2025, documented that R3 had their initial occupation therapy (OT) evaluation and OT was to work with R3 to address deficits in strength, transfer mobility, and continence (ability to hold bowel and bladder without leaking).

Record review of R3's resident progress note, dated 10/23/2025, documented R3 was getting physical and occupational therapy.

Record review of R3's resident alert noted, dated 11/04/2025 at 10:39 PM, documented that R3 refused therapy that day.

R6

Record review of R6's resident information sheet , undated, documented that R6 moved into the facility on 04/19/2024.

Record review of the facility's delegated resident list, undated, documented R6 was on delegation for the following tasks that included hospice, oral mediation, inhaled medications, nebulizer (medication that is inhaled from a misting machine) treatments, and suppository (medication that were administer rectally) medications.

Record review of R6's Service Agreement, dated 07/31/2025, that was the working care plan, documented R6 was not on delegated services.

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

On 11/13/2025 at 12:35 PM, Staff B, Resident Care Coordinator, stated they updated the residents service agreements. Staff B stated they do include on the service agreements and the working one if a resident was on home health or hospice services. Staff B stated they did not include whether the resident was on delegated nursing services. Staff B stated they would document on the service agreement, when a resident refused their medications daily or frequently.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, stated the resident care coordinator and the facility nurse were responsible to update the residents service agreement to the care and service the resident required. Staff A stated on the resident's profile or information sheet would indicate if the resident was on hospice or home health services and the box for nurse delegation would be checked on the service agreement if the resident received those services.

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, Westhaven Villa is or will be in compliance with this law and / or regulation on (Date) Jan 8, 26 .

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

Administrator (or Representative) 12/5/25 Date

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

On 11/13/2025 at 12:35 PM, Staff B, Resident Care Coordinator, stated they updated the residents service agreements. Staff B stated they do include on the service agreements and the working one if a resident was on home health or hospice services. Staff B stated they did not include whether the resident was on delegated nursing services. Staff B stated they would document on the service agreement, when a resident refused their medications daily or frequently.

On 11/13/2025 at 1:11 PM, Staff A, Administrator, stated the resident care coordinator and the facility nurse were responsible to update the residents service agreement to the care and service the resident required. Staff A stated on the resident's profile or information sheet would indicate if the resident was on hospice or home health services and the box for nurse delegation would be checked on the service agreement if the resident received those services.

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, Westhaven Villa 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

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

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

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

Caring Places Management, LLC
Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

RE: Westhaven Villa # 2152

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 11/21/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:
• Wrote the enclosed report; and
• May take licensing enforcement action based on many deficiency listed on the enclosed report; and
• May inspect your program to determine if you have corrected all deficiencies; and
• Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately;
• Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

• Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  o Sign and date the enclosed report;
  o For each deficiency, indicate the date you have or will correct each deficiency;
  o Return the Plan/Attestation Statement and report with signatures to:

Clinton Fridley, Adult Family Home Nurse Field Manager
Residential Care Services
Region 3, Unit E
Preferred methods:

eFax: (360) 992-7969
Email: rcsregion3email@dshs.wa.gov
Optional method:
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

Based on observation and interview, the facility failed to ensure loose handles of the large freezer in kitchen were in good repair. The facility failed to have a system in place to ensure the white fence on the facility premises was free of green film. The facility failed to ensure the second-floor porch area had light for use at night and the thresh hold of a door was secured to the floor. The facility was able to implement system and fix the identified concerns prior to exiting the facility.

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

Based on observation and interview, the facility failed to have a communication system in the back fence enclosed outside courtyard for residents, visitors, and staff to use to summon for assistance. The facility failed to have a working communication system that was outside of the door by the second floor outside patio. The facility was able to have working communication system in both areas identified prior to exiting the facility.

You Are Not:

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

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

If You Have Any Questions:

• Please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

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