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

05/12/2026

Spring Ridge Retirement, LLC

Spring Ridge Retirement, LLC
6856 E Portland Ave
Tacoma, WA 98404

RE: Spring Ridge Retirement, LLC License # 2160

Dear Administrator:

This letter addresses Compliance Determination(s) 77172 (Completion Date 05/12/2026) and 73986 (Completion Date 03/12/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/12/2026 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-2474-2-c, WAC 388-112A-0400-4-b, WAC 388-112A-0400-4-c, WAC 388-112A-0400-5, WAC 388-78A-2210-2-b, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Susan Carmichael, Nursing Consultant Institutional

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

Sincerely,

Laurie Anderson

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

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Statement of Deficiencies	License #: 2160	Compliance Determination # 73985
Plan of Correction	Spring Ridge Retirement, LLC	Completion Date
Page 1 of 6	Licensee: Spring Ridge Retirement, LLC	03/12/2026

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

The department completed data collection for the unannounced on-site full inspection on 03/09/2026, 03/10/2026 and 03/12/2026 of:

Spring Ridge Retirement, LLC
6856 E Portland Ave
Tacoma, WA 98404

The following sample was selected for review during the unannounced on-site visit: 7 of 60 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

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

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

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As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Laurie Anderson
Residential Care Services

03/17/2026
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)

3/17/2026
Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(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 ; and

(c) Mental health specialty training as described in WAC 388-112A-0450 .

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 sampled staff (Staff D) met all the training requirements for long-term care workers. This failure placed all 60 residents at risk of harm and receiving care from untrained staff.

Findings included...

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Review of the facility's personnel files showed the facility hired Staff D (Medication Technician) on 11/25/2024. There was no documentation that showed Staff D completed specialty training for dementia and mental health within 120 days of hire, as required.

During an interview on 03/09/2026 at 2:00 PM, Staff C, Administrative Assistant, stated that they were aware Staff D did not complete their specialty training within the required time frame.

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, Spring Ridge Retirement, LLC is or will be in compliance with this law and / or regulation on (Date) 04/24/2026

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

Administrator (or Representative) _____ Date 3/17/2026

WAC 388-78A-2210 Medication services.

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

(b) Develop and implement systems that support and promote safe medication service for each resident.

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and implement a safe medication system to ensure 3 of 7 sampled residents (Resident 1, Resident 3, and Resident 7) received medications as prescribed. These failures placed all residents at risk of harm and a potential decline in their health.

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Findings included...

RESIDENT 1
Review of Resident 1's January 2026 Medication Administration Record (MAR) showed an order for Oxycodone (a medication used to treat pain), 5 mg (milligram) tablet with a start date of 11/27/2025, and an end date of 01/26/2026, to be taken at 8:00 AM. Instructions on the MAR showed that staff should not administer the Oxycodone if Resident 1's respiration rate (how many times a person breathes in a minute) was 10 or below or had difficulty staying awake. There was no documentation on the MAR that showed staff checked Resident 1's respiration rate or ensured that Resident 1 was not drowsy prior to administering the medication.

Review of Resident 1's January 2026, February 2026, and March 2026 MARs showed an order for 2.5 ml (milliliters) of Oxycodone, 5 mg/5 ml solution to be taken one time per day at 8:00 AM with a start date of 01/26/2026. Instructions on the MAR showed that staff should not administer the medication if Resident 1's respiration rate was 10 or below or had difficulty staying awake. There was no documentation on the MARs that showed staff checked Resident 1's respiration rate or ensured that Resident 1 was not drowsy prior to administering the medication.

During an interview on 03/10/2026 at 3:00 PM, Staff B, Licensed Nurse/Resident Care Coordinator, acknowledged staff did not document Resident 1's respiration rate was checked prior to the administration of the Oxycodone.

RESIDENT 3
Review of Resident 3's January 2026, February 2026, and March 2026 MARs showed an order dated 09/06/2024 to check Resident 3's blood sugar/glucose level (a method used to test blood sugar levels that requires piercing the skin). The MARs showed an order to administer Lispro insulin three times a day with meals based on a "sliding scale" (a method of adjusting insulin dosage based on blood glucose levels). The sliding scale insulin order showed that for a blood sugar level of 80 or lower, "hold" (not give) Resident 3's insulin and notify the RN (Registered Nurse). The order then required ALF staff to "treat" the low blood sugar by giving certain foods to raise Resident 3's blood sugar level and to recheck Resident 3's blood sugar level in 15 minutes.

Review of Resident 3's January 2026 MAR showed that based on the sliding scale order, staff administered the incorrect dose of insulin seven times. There was no documentation on nine occasions that showed staff checked Resident 3's blood sugar, and no documented reason why the blood sugars were not checked. There was no documentation on two occasions that showed staff notified the RN when Resident 3's blood sugar was under 80, or that staff treated Resident 3's low blood sugar level as required.

Review of Resident 3's February 2026 MAR showed that based on the sliding scale staff administered the incorrect dose of insulin three times. There was no documentation on

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six occasions that showed staff checked Resident 3's blood sugar, and no documented reason why the blood sugars were not checked.

Review of Resident 3's March 2026 MAR showed that based on the sliding scale staff administered the incorrect dose of insulin one time on 03/03/2026. There was no documentation on 03/04/2026 that showed staff checked Resident 3's blood sugar, and no documented reason why the blood sugar was not checked. There was no documentation on 03/06/2026 that showed staff notified the RN when Resident 3's blood sugar was under 80, or that staff treated Resident 3's low blood sugar level as required.

RESIDENT 7
Review of Resident 7's February 2026, and March 2026 MARs showed an order dated 02/27/2026 to check Resident 7's blood sugar level, The MARs showed an order to administer Humalog insulin four times a day with meals and bedtime based on a "sliding scale". The sliding scale insulin order showed that for a blood sugar of 80 or lower, "hold" Resident 7's insulin and to notify the RN. The order required staff "treat" the low blood sugar by giving certain foods to raise their blood sugar and to recheck Resident 7's blood sugar in 15 minutes.

Review of Resident 7's February 2026 MAR showed Resident 7's blood sugar was 75 on 02/28/2026. There was no documentation that showed staff notified the RN when Resident 7's blood sugar was under 80, or that staff treated Resident 7's low blood sugar level as required.

Review of Resident 7's March 2026 MAR showed Resident 7's blood sugar was 75 on 03/03/2026. There was no documentation that showed staff notified the RN when Resident 7's blood sugar was under 80, or that staff treated Resident 7's low blood sugar level as required. Resident 7's March 2026 MAR showed that based on the sliding scale order, staff administered the incorrect dose of insulin two times on 03/07/2026.

During an interview on 03/10/2026 at 2:45 PM, Staff B stated that they needed to address Resident 3 and Resident 7 medication errors with the facility staff.

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Spring Ridge Retirement, LLC is or will be in compliance with this law and / or regulation on (Date) 04/26/2026

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

Administrator (or Representative) — Date: 3/17/2026

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