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
Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

RE: Riverside Place License # 2363

Dear Administrator:

This letter addresses Compliance Determination(s) 77638 (Completion Date 05/19/2026) and 74749 (Completion Date 03/24/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/19/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Riverside Place
Provider Type: Assisted Living Facility
License/Cert.#: 2363
Compliance Determination #: 74749
Intake ID: 215628
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/24/2026 through 03/24/2026
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a resident fall with injury.

Investigation Methods:

Sample:
Total residents: 26
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Residents
Nursing Staff
Management

Record Reviews:
Medical records
Incident investigation
Facility policies
Negotiated Service Agreements
Progress Notes/Alert Charting

Investigation Summary:
Quality of Care/Treatment: Facility failed to investigate, and document investigative actions to rule out the possibility of abuse when resident had incident in community. Failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ]

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N/A

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Statement of Deficiencies	License #: 2363	Compliance Determination # 74749
Plan of Correction	Riverside Place	Completion Date
Page 1 of 4	Licensee: Caring Places Management, LLC	03/24/2026

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

The department completed data collection for an unannounced on-site complaint investigation on 03/24/2026 of:

Riverside Place
1649 Broadway Ave
Hoquiam, WA 98550

This document references the following complaint number(s): 215628

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 investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

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Statement of Deficiencies	License #: 2363	Compliance Determination # 74749
Plan of Correction	Riverside Place	Completion Date
Page 2 of 4	Licensee: Caring Places Management, LLC	03/24/2026

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

03/27/2026
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)

4/6/26
Date

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

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

(2) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on record review and interview, the memory care facility failed to investigate, document investigative actions/findings, and protect the resident after a resident sustained an injury during an incident for 1 of 3 residents reviewed (Resident 1, (R1)). This failure placed R1 at risk for the potential ongoing physical abuse.

Findings Included...

Review of an undated facility policy titled "Resident Incidents and Investigations" showed that all incidents required a thorough investigation to determine if any abuse occurred. It stated that the investigation would consist of collected information that described the incident, how the incident occurred, and how to prevent future occurrences. It stated that a thorough investigation would enable the facility to identify and document who, what, when, where, why, and how the incident happened, including the cause or source of the incident, and is not complete until all of these questions are considered. It stated that evidence collected would include witness statements, chart notes, and incident reports. It stated that interviews would be conducted for the following individuals to determine what happened: the reported victim, reported perpetrator, staff in the immediate area, roommates, visitors and/or family. The policy stated that any staff could initiate the investigation, but it was the responsibility of the Resident Care Coordinator (RCC) to complete the investigation.

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Review of R1's Face Sheet showed that the resident admitted to the facility on [redacted]/2017.

Review of R1's Incident Report/Investigation form, dated 03/08/2026, showed the following instructions to staff: "A complete investigation seeks to discover and document observable facts that have the potential to describe what exactly happened, why it happened, and what might be done in the future to prevent it from happening again. Furthermore, it directs the communication of these facts and prevention efforts to all critical participants. Please use additional attached pages or progress notes, if necessary, to document witness statements and to completely describe the environment in which the incident occurred."

Review of the Incident Report dated 03/08/2026, showed R1 had an unwitnessed fall. It stated, "[R1] was found on the floor during nightly rounds. There appeared to be red discharge on the floor." A description of the injury sustained by R1 stated, "discharge coming from the face." Under the section "Observable symptoms of abuse," under "Physical Abuse," "none of the above" was checked. Under the Analysis and Conclusion section of the Incident Report, it stated, "[R1] will get self-up from bed without help at times. Staff is encouraged to increase safety checks 4 [four] - 6 [six] times a shift. No suspicions of abuse, neglect, or exploitation." There was no additional information documented on how the incident occurred, and there were no attached documents or witness statements attached to the report.

Review of R1's progress notes showed no documentation describing the incident or how it happened. Further review showed no interviews were documented related to the investigation.

During an interview on 03/24/2026 at 10:15 AM, Staff B, Resident Care Coordinator, stated that they were not at the facility during the incident. Staff B summarized the investigation if he incident involving R1 as "[Staff] went into the room and found [R1] face down on the floor and noticed a lot of blood. They called EMS (Emergency Medical Services), and they took [R1] to the hospital. [The Hospital] said [R1] had a nose fracture which caused [R1] to have two black eyes." Staff B stated that the medication aide (Med Aide) that was working the day and time of the incident did not document anything in the resident record regarding the incident. Staff B stated that the only incident documentation that was completed was the incident report. Staff B stated that they had to question the staff who relieved the Med Aide on the next scheduled shift to try and determine what occurred, but did not document the interviews. Staff B was asked how they were able to rule out the possibility of physical abuse if R1 was not able to be interviewed, no other interviews were conducted, and they had no knowledge of how the event occurred: Staff B replied they did not know.

During an interview on 03/24/2026 at 11:25 AM, Staff A, Administrator, was asked if they thought that the investigation conducted into R1's incident was sufficient enough to rule out any possibility of physical abuse. Staff A stated, "Yes" because there were

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check boxes on the back of the incident report that gave some information of the environment regarding the incident. Staff A was asked if they could definitively state that there was no possibility of physical abuse with the information gathered and documented during the investigation and replied that they could not.

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, Riverside Place is or will be in compliance with this law and / or regulation on (Date) April 22nd 2026

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

Administrator (or Representative) — Date: 4/6/26

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