STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Riverview Lutheran Retirement Community of Spokane
Riverview Terrace
1801 E Upriver Dr
Spokane, WA 99207

RE: Riverview Terrace License # 2405

Dear Administrator:

This letter addresses Compliance Determination(s) 80323 (Completion Date 07/13/2026) and 76251 (Completion Date 05/20/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/13/2026 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-2640-1-a, WAC 388-78A-2130-3, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-5-b, WAC 388-78A-2130-5-d, WAC 388-78A-2130-6, WAC 388-78A-2130-6-a, WAC 388-78A-2130-6-a-i, WAC 388-78A-2130-6-a-ii, WAC 388-78A-2130-6-b

The Department staff who did the on-site verification:
Sandra Fast, Community Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Terrace
Provider Type: Assisted Living Facility
License/Cert.#: 2405
Compliance Determination #: 76251
Intake ID: 219871
Investigator: Sandra Fast
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 04/22/2026 through 05/20/2026
Complainant Contact Date(s): 04/21/2026

Allegation(s):

1) The identified resident had multiple falls between January and March 2026.
2) The identified resident needed more assistance than was being provided.
3) Resident overdosed on ibuprofen that they had in their room.

Investigation Methods:

Sample:	Total residents: 117 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies Personnel files Staff training records

Investigation Summary:

1. The facility did not follow their process for updating the residents comprehensive assessment. A citation was issued according to Washington Administrative Code (WAC) 388-78A-2460 (1)(a)
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2. The facility did not follow their process for updating the residents negotiated service plan. A citation was issued according to Washington Administrative Code (WAC) 388-78a-2130 (3)(a)(b), (5)(b)(d), (6)(a)(i)(ii)(b)
3. Review of the identified resident's medication safety assessments showed that they had been assessed to be safe to independently take their own medications at the time they experienced a low red blood cell condition that may have been caused by too much, "as needed," anti-inflammatory medication. Review of the residents hospital records showed that the resident was on a scheduled anti-coagulant medication and reported also taking an over the counter anti-inflammatory, "at least every 4 hours most days." The resident did not allow diagnostic testing at that time, so the cause of the condition was not confirmed. The identified resident's representative interviewed stated that an as needed anti-inflammatory was found in the resident's bathroom medicine cabinet and removed. Sampled staff interviewed stated that residents who self-administered their medications were assessed yearly to ensure they were safe to continue doing so. The staff further stated that residents' representatives were instructed that the facility must control and administer all residents' medications including over the counter medications once the resident was no longer safe to do so, and that all medications, including over the counter medications, must have an order from their healthcare provider for the facility to be able to administer them. No failed facility practice was identified.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2405	Compliance Determination #76251
Plan of Correction	Riverview Terrace	Completion Date
Page 1 of 5	Licensee: Riverview Lutheran Retirement Community of Spokane	05/20/2026

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 04/22/2026 of:

Riverview Terrace
1801 E Upriver Dr
Spokane, WA 99207

This document references the following complaint number(s): 219871

The following sample was selected for review during the unannounced on-site visit: 4 of 117 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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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.

Scotti Bowers IDR Program Manager Signed for Region 1
Residential Care Services

07/13/2026
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)

07/16/2026
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that appropriate persons were notified regarding a change in physical condition for 1 of 4 residents (Resident 1). This failure placed Resident 1 at risk of uninformed care.

Findings included...

Review of the facility's policy titled, "Resident Assessment, Negotiated Service Plan, and Care Conferences," dated 08/20/2025, showed that a comprehensive assessment would be done within the timeframes required under Washington Administrative Code (WAC) regulations and include significant health conditions and diagnoses.

Review of an email communication by Staff A, Director of Clinical Wellness, dated 04/28/2026, showed that when a resident had a significant change in condition for more than two weeks, a full change of condition assessment was done.

Review of Resident 1's facility comprehensive assessment, dated 01/22/2026 at 9:36 AM, showed that the resident had a history of falls and was at risk for falling. The assessment noted a significant change in the resident's physical condition that included

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marked deconditioning (a decline in physical function caused by prolonged inactivity, bed rest, or a sedentary lifestyle), weakness, and not calling for assistance.

In an interview on 04/21/2026, Collateral Contact 2 (CC2), Representative, stated that Resident 1 had, "a rash of falls," starting in January 2026. CC2 stated that Resident 1 would forget to call for assistance and would wait until their needs were urgent then try to ambulate (walk) without assistance and fall. CC2 stated that they were not notified of the resident's recent comprehensive assessment, dated 01/22/2026, until March 2026.

In an interview on 05/12/2026 at 3:15 PM Collateral Contact 1 (CC1), Department of Social and Health Services Case Manager, stated that they found out on 03/24/2026 that Resident 1 had an updated comprehensive assessment, dated 01/22/2026, due to recent changes in their mental and physical condition. CC1 stated that they had not received the document to sign and had no knowledge of the resident's change in condition.

In an interview on 05/14/2026 at 1:01 PM, Staff A stated that the resident's healthcare provider, family member and case manager, must be notified when any comprehensive assessments were done. Staff A further stated that these notifications did not happen for Resident 1's change of condition.

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, Riverview Terrace is or will be in compliance with this law and / or regulation on (Date) 07/03/2026.

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

Administrator (or Representative) — Date: 07/16/2026

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

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(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update a negotiated service agreement following a change in mental and physical needs for 1 of 4 residents (Resident 1) and failed to provide the resident and their representatives with the opportunity to discuss, negotiate and come to an agreed upon plan of care for 1 of 4 residents (Resident 1). This failure precluded the resident and their representative from participating in care planning and placed the resident at risk for unmet mental and physical needs and uninformed care.,

Findings included...

Review of the facility's policy titled, "Resident Assessment, Negotiated Service Plan, and Care Conferences," dated 08/20/2025, showed that the Negotiated Service Plan (NSP, the facility's titled Negotiated Service Agreement), would be reviewed and updated when a resident's condition or needs changed, and following accidents, incidents, or hospitalizations that affected care needs.

Review of Resident 1's facility comprehensive assessment, dated 01/22/2026, showed that the resident had a significant change in physical and mental condition that included marked deconditioning (a decline in physical and mental function caused by prolonged inactivity, bed rest, or a sedentary lifestyle), weakness, and not calling for assistance.

Review of Resident 1's NSP, dated 05/21/2025, showed that it was not updated following the resident's change in condition and comprehensive assessment, dated 01/22/2026, until 03/19/2026.

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In an interview on 04/20/2026 at 4:44 PM Collateral Contact 1 (CC1), Department of Social and Health Services Case Manager, stated that changes had been made to the Resident 1's NSA without their involvement or notification. CC1 further stated that they had not discovered that Resident 1 had a significant change in condition until Resident 1's representative contacted them on 03/24/2026, two months after the resident's change of condition assessment was done.

In an interview on 05/13/2026 at 12:14 PM, Collateral Contact 2 (CC2), stated that that they had requested a care conference in February 2026 after they became concerned about the resident's decline in physical condition and increased apathy and forgetfulness. CC2 stated that the facility made no attempts to schedule a care conference, and that in March of 2026, they had to insist that a care conference be held to address their concerns. CC2 stated they were not notified of Resident 1's March 2026 updated NSP until they incidentally found out when CC1 did an annual assessment on 04/06/2026.

In an interview on 05/14/2026 at 1:01 PM, Staff A, Director of Clinical Wellness, stated that an NSP was typically updated during a resident's care conference and that the resident's representative and case manager (if there was one) were normally present. Staff A stated that NSP's were usually addressed rapidly by care conference, within the week or by the beginning of the following week, after a change in a resident's condition occurred. Staff A stated that all care conference members present would sign and date the NSP at the conclusion of the care conference indicating their agreement to the new NSP and that was how notifications of appropriate parties were documented in the resident's record. Staff A further stated that this process was not followed regarding Resident 1's change in condition and had, "slipped through the cracks."

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, Riverview Terrace is or will be in compliance with this law and / or regulation on (Date) 07/03/2026.

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

Administrator (or Representative) — Date 07/16/2026

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