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 Retirement Community
1952 N Granite St
Spokane, WA 99207

RE: Riverview Retirement Community License # 2469

Dear Administrator:

This letter addresses Compliance Determination(s) 80581 (Completion Date 07/16/2026) and 77525 (Completion Date 05/19/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/16/2026 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-2660-2, RCW 70.129.140.1, WAC 388-78A-2240, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2140-5, WAC 388-78A-2090, WAC 388-78A-2090-1, WAC 388-78A-2090-1-a, WAC 388-78A-2090-1-b, WAC 388-78A-2090-1-c, WAC 388-78A-2090-2, WAC 388-78A-2090-2-a, WAC 388-78A-2090-2-b, WAC 388-78A-2090-2-c, WAC 388-78A-2090-3, WAC 388-78A-2090-4, WAC 388-78A-2090-4-a, WAC 388-78A-2090-4-b, WAC 388-78A-2090-5, WAC 388-78A-2090-5-a, WAC 388-78A-2090-5-b, WAC 388-78A-2090-5-c, WAC 388-78A-2090-6, WAC 388-78A-2090-6-a, WAC 388-78A-2090-6-b, WAC 388-78A-2090-6-c, WAC 388-78A-2090-6-d, WAC 388-78A-2090-6-e, WAC 388-78A-2090-7, WAC 388-78A-2090-7-a, WAC 388-78A-2090-7-b, WAC 388-78A-2090-7-c, WAC 388-78A-2090-7-c-i, WAC 388-78A-2090-7-c-ii, WAC 388-78A-2090-7-d, WAC 388-78A-2090-8, WAC 388-78A-2090-8-a, WAC 388-78A-2090-8-b, WAC 388-78A-2090-8-b-i, WAC 388-78A-2090-8-b-ii, WAC 388-78A-2090-9, WAC 388-78A-2090-10, WAC 388-78A-2090-11, WAC 388-78A-2090-11-a, WAC 388-78A-2090-11-b, WAC 388-78A-2090-11-c, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d, WAC 388-78A-2420-1, WAC 388-78A-2484-1

The Department staff who did the on-site verification:
Patricia Eddy, Community Licensor

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

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

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

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 05/13/2026, 05/14/2026 and 05/15/2026 of:

Riverview Retirement Community
1952 N Granite St
Spokane, WA 99207

The following sample was selected for review during the unannounced on-site visit: 6 of 26 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Patricia Eddy, Community Licensor
Carla Rose, NCI Community Licensor

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

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

Statement of Deficiencies	License #: 2469	Compliance Determination # 77525
Plan of Correction	Riverview Retirement Community	Completion Date
Page 2 of 18	Licensee: Riverview Lutheran Retirement Community of Spokane	05/19/2026

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.

Residential Care Services — 05/28/2026 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.

Tara L Samuel — Administrator (or Representative)

June 5, 2026 — Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide timely lunch service, ensure residents received necessary eating assistance, and ensure caregivers were attentive to residents' needs during mealtime for 3 of 5 sampled residents (Resident 1, 2, and 4). These failures resulted in prolonged waiting times for meal service and unmet needs, and placed residents at risk for a decreased quality of life .

Findings included...

Review of Resident 1's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 08/15/2025, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed the facility staff would assist the resident with activities of daily living and were to ensure all of the resident's physical needs were met.

Review of Resident 2's NSA, dated 02/04/2026, showed the resident was diagnosed with

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

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide timely lunch service, ensure residents received necessary eating assistance, and ensure caregivers were attentive to residents' needs during mealtime for 3 of 5 sampled residents (Resident 1, 2, and 4). These failures resulted in prolonged waiting times for meal service and unmet needs, and placed residents at risk for a decreased quality of life .

Findings included…

Review of Resident 1's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 08/15/2025, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed the facility staff would assist the resident with activities of daily living and were to ensure all of the resident's physical needs were met.

Review of Resident 2's NSA, dated 02/04/2026, showed the resident was diagnosed with

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

“[redacted].” Further review showed the resident wandered and that staff were to distract the resident by offering pleasant diversions, structured activities, food, conversation, television, or a book.

Review of Resident 4’s NSA, dated 11/06/2025, showed that the resident was diagnosed with [redacted] and [redacted]. Further review showed staff were to ensure that all of the resident’s physical needs were met.

In an interview on 05/13/2026 at 10:30 AM, Staff H, Administrator, stated that lunch service began at 11:30 AM.

In an interview on 05/13/2026 at 11:45 AM, Staff K, Dietary Service Aide, stated that lunch was ready to be served but that they were were waiting on the caregivers in the dining room to assist with service.

Observations of lunch service on 05/13/2026 at 11:45 AM showed the following:

11:45 AM – Three caregivers were assigned to assist 15 residents in the dining room. Resident 2 and Resident 4 waited for lunch to be served.
11:55 AM – Resident 1 sat at a table and waited for lunch. After six minutes, Resident 1 left the table.
11:45 AM through 12:11 PM- Staff K frequently looked out into the dining room and waited on caregivers to notify them to start meal service. The three caregivers intermittently served drinks and stood in the kitchenette talking to each other while residents waited for lunch to be served.
12:11 PM – The first plate was served to a resident. Resident 2 began walking around the dining room. A caregiver redirected Resident 2 back to their table where they continued to display restless behaviors and shuffled their silverware and place setting around.
12:15 PM – Resident 4 began walking around the dining room and hallway.
12:22 PM – Resident 2 was served a plate of food, 37 minutes after they were seated.
12:25 PM – Resident 4 was served their meal.
12:30 PM – A caregiver located Resident 1 and walked them back to a table in the dining room. In an interview at that time, Resident 4 stated they often had long wait times for meals.
12:34 PM – Resident 1 was served lunch and given a set of plastic utensils in a sealed package. Resident 1 struggled to open the wrapped utensils for four minutes. Once Resident 1 opened the package of utensils, they attempted to eat rice off a plastic knife. Resident 1 then attempted to eat crumbs and grains of rice off the table with their fingers.

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

12:40 PM – Resident 2 fell asleep at their table and had not eaten their lunch. A caregiver took the resident back to their room.
12:44 PM – Resident 1 attempted to eat a cookie with a fork.

Observation of the meal service on 05/13/2026 showed the three caregivers served drinks and meals to residents but did not offer any additional assistance to residents.

Observations of lunch service on 05/14/2026 at 11:50 AM showed the following:

11:50 AM – Three caregivers were assigned to assist 18 residents in the dining room.
11:52 AM – Resident 4 told a caregiver they were thirsty.
11:52 AM through 12:15 PM- Staff K frequently looked out into the dining room and waited on caregivers to notify them to start meal service.
12:02 PM – Staff began to fill drinks for residents. Resident 4's drink was filled, ten minutes after they reported that they were thirsty.
12:16 PM – The first plate was served to a resident. Resident 1 was given a set of plastic utensils in a sealed package. Resident 1 struggled to open the wrapped utensils for six minutes. Further observation showed no staff assistance was offered.

Observation of the meal service on 05/14/2026 showed the three caregivers served drinks and meals to residents but did not offer any additional assistance to residents.

In an interview on 05/14/2026 at 3:05 PM, Resident 4 stated that they wished staff would be more attentive to their needs.

In an interview on 05/14/2026 at 3:30 PM, Staff H indicated that they were unaware of the long wait times for meal service and that care staff had not been attentive to resident needs. Staff H stated that care staff should have opened Resident 1's utensils.

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 Retirement Community is or will be in compliance with this law and / or regulation on
(Date) July 3, 2026

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

Administrator (or Representative) Sara L Samuel Date June 5, 2026

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

12:40 PM – Resident 2 fell asleep at their table and had not eaten their lunch. A caregiver took the resident back to their room.
12:44 PM – Resident 1 attempted to eat a cookie with a fork.

Observation of the meal service on 05/13/2026 showed the three caregivers served drinks and meals to residents but did not offer any additional assistance to residents.

Observations of lunch service on 05/14/2026 at 11:50 AM showed the following:

11:50 AM – Three caregivers were assigned to assist 18 residents in the dining room.
11:52 AM – Resident 4 told a caregiver they were thirsty.
11:52 AM through 12:15 PM- Staff K frequently looked out into the dining room and waited on caregivers to notify them to start meal service.
12:02 PM – Staff began to fill drinks for residents. Resident 4's drink was filled, ten minutes after they reported that they were thirsty.
12:16 PM – The first plate was served to a resident. Resident 1 was given a set of plastic utensils in a sealed package. Resident 1 struggled to open the wrapped utensils for six minutes. Further observation showed no staff assistance was offered.

Observation of the meal service on 05/14/2026 showed the three caregivers served drinks and meals to residents but did not offer any additional assistance to residents.

In an interview on 05/14/2026 at 3:05 PM, Resident 4 stated that they wished staff would be more attentive to their needs.

In an interview on 05/14/2026 at 3:30 PM, Staff H indicated that they were unaware of the long wait times for meal service and that care staff had not been attentive to resident needs. Staff H stated that care staff should have opened Resident 1's utensils.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

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

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain medications in a timely manner for 1 of 5 sampled residents (Resident 4). This failure resulted in missed medications for Resident 4 and placed them at risk for health complications.

Findings included…

Review of the facility's undated policy titled, "Reordering of Medications," showed that staff were to ensure medications were reordered in a timely manner for continuity of medication administration.

Review of Resident 4's assessment, dated 11/04/2025, showed that the resident required medication assistance and that staff would order and dispense medications to the resident. Further review showed that the resident was diagnosed with [redacted] and [redacted].

Review of Resident 4's March 2026 and April 2026 Medication Administration Records (MARs) showed that the resident had an order for cholecalciferol (vitamin D3), mirtazapine (medication for depression, insomnia, and anxiety), and memantine (medication for dementia) twice daily. Further review showed that the medications were documented as "meds not arrived from pharmacy" as follows:

- Cholecalciferol: 03/16/2026 - 03/21/2026
- Mirtazapine: 03/10/2026 thru 03/12/2026 and 03/14/2026 thru 03/25/2026
- Memantine: two doses on 03/21/2026, two doses on 03/22/2026, one dose on 3/23/2026, and one dose on 4/23/2026

Review of Resident 4's progress notes showed the following:

- On 03/16/2026, staff documented that the resident was showing signs of increased anxiety and frequently went to the medication cart requesting medications.

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

- On 03/18/2026; staff reported to the resident's provider that the resident's anxiety continued to worsen. In another note on the same day, the resident told their provider that their "mental health is not well" and that they were having worsening anxiety and depression.
- On 03/23/2026, facility made contact with the pharmacy about mirtazapine and memantine on 03/23/2026.

In an interview on 05/15/2026 at 2:01 PM, Staff G, Director of Clinical Wellness, stated they did not know why the doses of the medications were not reordered timely. Staff G stated they did not have any documentation of contact to the pharmacy regarding mirtazapine and memantine prior to the progress note dated 03/23/2026. Staff G stated they did not have any documentation of contact to the pharmacy regarding cholecalciferol.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date) July 3, 2026.

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

Tara L. Samuel
Administrator (or Representative)

June 5, 2026
Date

WAC 388-78A-2210 Medication services.

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that medications were administered as ordered to 1 of 5 sampled residents (Resident 2). The failure resulted in missed medication for Resident 2 and placed them at risk of health

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

- On 03/18/2026, staff reported to the resident's provider that the resident's anxiety continued to worsen. In another note on the same day, the resident told their provider that their "mental health is not well" and that they were having worsening anxiety and depression.
- On 03/23/2026, facility made contact with the pharmacy about mirtazapine and memantine on 03/23/2026.

In an interview on 05/15/2026 at 2:01 PM, Staff G, Director of Clinical Wellness, stated they did not know why the doses of the medications were not reordered timely. Staff G stated they did not have any documentation of contact to the pharmacy regarding mirtazapine and memantine prior to the progress note dated 03/23/2026. Staff G stated they did not have any documentation of contact to the pharmacy regarding cholecalciferol.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that medications were administered as ordered to 1 of 5 sampled residents (Resident 2). The failure resulted in missed medication for Resident 2 and placed them at risk of health

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

complications.

Findings included...

Review of Resident 2's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA) dated 02/04/2026, showed the resident was diagnosed with [redacted]. Further review showed that the facility provided medication administration assistance due to the resident's impaired cognition.

Review of Resident 2's March 2026, April 2026, and May 2026 Medication Administration Records (MARs) showed the resident's blood pressure was checked three times a day. The MARs showed an order for hydralazine (medication to lower blood pressure) to be administered PRN (as needed) when the resident's Systolic Blood Pressure (SBP, top number of the blood pressure) was greater than 160. Further review showed the resident's hydralazine was not administered, when their SBP was greater than, 160 nine times in March 2026, four times in April 2026, and three times in May 2026.

In an interview on 05/15/2026 at 11:55 AM, Staff F, Medication Technician, stated that Resident 2's PRN hydralazine should have been administered when the SBP was above 160.

In an interview on 05/15/2026 at 12:15 PM, Staff G, Director of Clinical Wellness, stated that they were unaware of blood pressures being out of parameters for Resident 2. When asked if MARs were audited to ensure that parameters were being followed, Staff G stated they did not audit MARs for parameters unless the medication technician notified them of concerns. Staff G reviewed MARs for Resident 2 and confirmed there were no orders to hold the hydralazine when the resident's SBP was greater than 160 and they were unsure why medication technicians had not administered the hydralazine.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date) July 3, 2026.

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

Administrator (or Representative) Tara L. Samuel Date June 5, 2026

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

complications.

Findings included…

Review of Resident 2's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA) dated 02/04/2026, showed the resident was diagnosed with [redacted]. Further review showed that the facility provided medication administration assistance due to the resident's impaired cognition.

Review of Resident 2's March 2026, April 2026, and May 2026 Medication Administration Records (MARs) showed the resident's blood pressure was checked three times a day. The MARs showed an order for hydralazine (medication to lower blood pressure) to be administered PRN (as needed) when the resident's Systolic Blood Pressure (SBP, top number of the blood pressure) was greater than 160. Further review showed the resident's hydralazine was not administered, when their SBP was greater than, 160 nine times in March 2026, four times in April 2026, and three times in May 2026.

In an interview on 05/15/2026 at 11:55 AM, Staff F, Medication Technician, stated that Resident 2's PRN hydralazine should have been administered when the SBP was above 160.

In an interview on 05/15/2026 at 12:15 PM, Staff G, Director of Clinical Wellness, stated that they were unaware of blood pressures being out of parameters for Resident 2. When asked if MARs were audited to ensure that parameters were being followed, Staff G stated they did not audit MARs for parameters unless the medication technician notified them of concerns. Staff G reviewed MARs for Resident 2 and confirmed there were no orders to hold the hydralazine when the resident's SBP was greater than 160 and they were unsure why medication technicians had not administered the hydralazine.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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:

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and document appropriate behavioral interventions in the resident's negotiated service agreement, for 2 of 5 residents (Resident 3 and 4). This failure placed the residents at risk of their behavioral needs not being met.

Findings included...

<Resident 3>

Review of Resident 3's undated face sheet showed that the resident had diagnoses of [redacted] and [redacted]

Review of Resident 3's April 2026 and May 2026 Medication Administration Records (MARs) showed the resident had an order for sertraline (medication for depression) daily.

Review of Resident 3's progress notes showed the following:

- On 04/12/2026, the resident was agitated.
- On 04/14/2026, the resident was very resistive to staff and on alert (increased monitoring) for aggressive behavior.
- On 04/15/2026, the resident was on alert for agitation and behavior.

In an interview on 05/14/2026 at 1:00 PM, Staff L, Nurse Assistant Certified (NAC), stated Resident 3 had aggressive behaviors, became irritable quickly, and required reapproaching to avoid aggressive responses.

In an interview on 05/14/2026 at 3:20 PM, Collateral Contact 1, Resident 3's representative, stated the resident had increased behavioral issues recently.

Review of Resident 3's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 05/08/2026, showed no documented interventions for

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

depression, agitation, or aggression.

<Resident 4>

Review of Resident 4's assessment, dated 11/04/2025, showed that the resident was diagnosed with [redacted] and [redacted].

Review of Resident 4's progress notes showed the following:

- On 03/04/2026, staff reported to the resident's provider that the resident had worsening anxiety and depression symptoms, had been excessively eating due to anxiety, and frequently appeared bored but did not want to participate in activities. On the same day, the resident reported to their provider that their mood was "kind of down," they had low motivation to participate in activities, and wanted to adjust their psychiatric medications.
- On 03/05/2026, the resident showed increased anxiety, frequently approached staff requesting medications, and had increased food-seeking behaviors.
- On 03/16/2026, the resident showed increased anxiety and frequently approached staff requesting medications.
- On 03/18/2026, staff reported to the resident's provider that the resident's anxiety continued to worsen. On that same day, the resident told their provider that their "mental health is not well," they had worsening anxiety and mild depression, and were not participating in many activities.
- On 04/01/2026, staff reported to the resident's provider that the resident had ongoing anxiety, often fixated on things, frequently reported they did not feel good and asked for medication with no specific symptoms of illness. On the same day, the resident told their provider that they were, "pretty depressed and a little anxious."
- On 04/28/2026, staff reported to the resident's provider that the resident continued to have frequent behaviors, such as pacing and obsessing about somatic symptoms.
- On 04/29/2026, the resident had medication seeking behaviors.
- On 04/30/2026, the resident had medication seeking behaviors.

In an interview on 5/14/2026 at 3:05 PM, Resident 4 stated that they struggled with having dementia and wished staff would be more attentive to their needs.

Review of Resident 4's NSA, dated 11/06/2025, showed no documented interventions for behavioral issues, depression, or anxiety.

In an interview on 05/15/2026 at 12:06 PM, Staff H, Administrator, stated that Resident 3 and Resident 4 should have had behavioral interventions in their NSAs due to their

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

diagnoses and was not aware that the residents' NSAs did not have interventions. In an interview at the same time, Staff I, Assistant Campus Administrator, stated that staff often asked for help managing Resident 3 and Resident 4's behaviors.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date) July 3, 2026.

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

Tara L. Stewart
Administrator (or Representative)

June 5, 2026
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

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

diagnoses and was not aware that the residents' NSAs did not have interventions. In an interview at the same time, Staff I, Assistant Campus Administrator, stated that staff often asked for help managing Resident 3 and Resident 4's behaviors.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

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

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

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

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that full assessments were completed within 14 days of admission for 2 of 2 residents (Resident 3 and 6) sampled for recent admission. This failure placed the residents at risk of not receiving needed care and services.

Findings included...

Review of the facility's characteristic roster showed that Resident 3 was admitted to the facility on [redacted]/2026 and that Resident 6 was admitted on [redacted]/2026.

Review of the facility's Audit Report, dated 05/15/2026, showed that Resident 3 's 14-day full assessment was locked (completed) on 04/30/2026, 30 days after they had been admitted.

Review of the facility's Audit Report, dated 05/15/2026, showed that Resident 6 's 14-day full assessment was locked on 05/08/2026, 37 days after they admitted.

In an interview on 05/15/2026 at 12:06 PM, Staff H, Administrator, stated that they were aware of late assessments.

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

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date) July 3, 2026

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

Administrator (or Representative) Tara L. Samuel Date June 5, 2026

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop a written plan and agreement for family provided medications and treatments for 2 of 2 residents (Resident 1 and 4) . This failure placed the residents at risk for health complications.

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

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop a written plan and agreement for family provided medications and treatments for 2 of 2 residents (Resident 1 and 4) . This failure placed the residents at risk for health complications.

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

Findings included...

<Resident 1>

Review of Resident 1's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 08/15/2025, showed that the resident was diagnosed with [redacted] and received assistance with medications.

Review of Resident 1's March 2026, April 2026, and May 2026 Medication Administration Records (MARs) showed an order for Boost/Ensure shake for malnutrition once daily and that the resident's family would provide the shake. Further review showed the shake was not available for three days in March 2026, one day in April 2026, and one day in May 2026.

In an interview on 05/14/2026 at 2:15 PM, Staff F, Medication Technician, stated that Resident 1's family was responsible for providing the resident's shakes.

Review of Resident 1's Family Assistance with Medications and Treatments plan showed the facility created the plan and obtained verbal consent from the resident's representative on 05/15/2026, two days after the department initiated their inspection.

<Resident 4>

Review of Resident 4's NSA, dated 11/06/2025, showed that the resident was diagnosed with [redacted] and [redacted]. Further review showed the resident received assistance with medications.

Review of Resident 4's March 2026 and April 2026 MARs showed an order for Rexulti (antipsychotic medication for major depressive disorder and agitation associated with Alzheimer's disease). Further review showed that the medication was not available for two doses in March 2026 and two doses in April 2026.

In an interview on 05/15/2026 at 12:06 PM, Staff G, Director of Clinical Wellness, stated that Resident 1's representative provided the Rexulti.

In an interview on 05/15/2026 at 2:01 PM, Staff G stated that they did not have a family

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

plan agreement for Resident 4.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date) July 3, 2026.

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

Sara L. Samuel — Administrator (or Representative)

June 5, 2026 — Date

WAC 388-78A-2420 Record retention.

(1) The assisted living facility must maintain on the assisted living facility premises in a resident's active record(s) all relevant information and documentation necessary for meeting a resident's current assessed needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that current nurse delegation records were maintained on-site for 5 of 5 sampled residents (Resident 1, 2, 3, 4 and 5). This failure prevented delegated staff from having access to current delegation task instructions and placed residents at risk of harm.

Findings included...

Review of Resident 1's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 08/15/2025, showed the resident required nurse delegation for medication administration.

Review of Resident 2's NSA, dated 02/07/2026, showed the resident required nurse delegation for medication administration.

Review of Resident 3's NSA, dated 05/08/2026, showed the resident required nurse delegation for medication administration.

Review of Resident 4's NSA, dated 11/06/2025, showed the resident required nurse delegation for medication administration.

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

plan agreement for Resident 4.

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2420 Record retention.

(1) The assisted living facility must maintain on the assisted living facility premises in a resident's active record(s) all relevant information and documentation necessary for meeting a resident's current assessed needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that current nurse delegation records were maintained on-site for 5 of 5 sampled residents (Resident 1, 2, 3, 4 and 5). This failure prevented delegated staff from having access to current delegation task instructions and placed residents at risk of harm.

Findings included…

Review of Resident 1’s Service Plan Report (the facility’s titled Negotiated Service Agreement, NSA), dated 08/15/2025, showed the resident required nurse delegation for medication administration.

Review of Resident 2's NSA, dated 02/07/2026, showed the resident required nurse delegation for medication administration.

Review of Resident 3's NSA, dated 05/08/2026, showed the resident required nurse delegation for medication administration.

Review of Resident 4’s NSA, dated 11/06/2025, showed the resident required nurse delegation for medication administration.

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

Review of Resident 5's NSA, dated 11/04/2025, showed the resident required nurse delegation for medication administration.

Review of the nurse delegation records binder on 05/13/2026, showed that the binder had not been updated with any new resident records since 08/01/2025. Review showed that Resident 1's last record was dated 11/01/2024, Resident 2's was dated 08/01/2025, Resident 3 did not have any records, Resident 4 did not have any records, and that Resident 5's was dated 08/01/2025.

In an interview on 05/13/2026 at 3:15 PM, Staff H, Administrator, confirmed that all the residents were nurse delegated due to their significant cognitive impairments. Staff H stated that the Registered Nurse Delegator (RND) uploaded the delegation records into Point Click Care (PCC, the residents' electronic chart) after each visit.

In an interview on 05/14/2026 at 11:25 AM, Staff H stated that they were unable to locate any current nurse delegation records in PCC.

In an interview on 05/14/2026 at 12:00 PM, Staff F, Medication Technician, confirmed that they were delegated to perform nursing tasks. When asked where they would find current delegation records that included step-by-step instructions for each task, Staff F stated they did not know where to find the step-by-step instructions. Staff F attempted to find them in PCC but was unable to locate any delegation records or step-by-step instructions.

In an interview on 05/14/2026 at 3:30 PM, Staff J, Chief Executive Officer, confirmed that delegation records were not uploaded to PCC.

On 05/15/2026 at 08:30 AM, Staff I, Assistant Campus Administrator, provided copies of the current nurse delegation records. Staff I stated that the RND emailed them to the facility the night before.

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

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date) July 3, 2026

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

Administrator (or Representative) Tara L. Samuel Date June 5, 2026

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete initial tuberculosis testing within three days of employment for 1 of 3 staff (Staff B). This failure placed residents at risk of exposure to tuberculosis.

Findings included...

Review of Staff B's, Medication Technician, personnel file showed that they were hired on 02/02/2026. Review showed that an initial Tuberculosis (TB) test was planted (injected) on 02/20/2026.

In an interview on 05/15/2026 at 2:01 PM, Staff I, Assistant Campus Administrator, stated that Staff B's TB test was not completed on time.

This is a recurring deficiency previously cited on 01/15/2025.

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

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete initial tuberculosis testing within three days of employment for 1 of 3 staff (Staff B). This failure placed residents at risk of exposure to tuberculosis.

Findings included...

Review of Staff B's, Medication Technician, personnel file showed that they were hired on 02/02/2026. Review showed that an initial Tuberculosis (TB) test was planted (injected) on 02/20/2026.

In an interview on 05/15/2026 at 2:01 PM, Staff I, Assistant Campus Administrator, stated that Staff B's TB test was not completed on time.

This is a recurring deficiency previously cited on 01/15/2025.

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

Statement of Deficiencies	License #: 2469	Compliance Determination # 77525
Plan of Correction	Riverview Retirement Community	Completion Date
Page 18 of 18	Licensee: Riverview Lutheran Retirement Community of Spokane	05/19/2026

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, Riverview Retirement Community is or will be in compliance with this law and / or regulation on (Date) July 3, 2026

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

Administrator (or Representative) Jara L. Samuel Date June 5, 2026

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

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 Retirement Community is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Riverview Lutheran Retirement Community of Spokane
Riverview Retirement Community
1952 N Granite St
Spokane, WA 99207

RE: Riverview Retirement Community # 2469

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 05/19/2026 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:

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

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

eFax: (509) 921-2426
Email: rcsregion1email@dshs.wa.gov
Optional method:
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (05/19/2026), no later than 07/03/2026 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-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

The facility had not provided their policy regarding Medicaid as a payment source to sampled residents that were admitted prior to 05/01/2025. The facility provided the notice to residents' representatives prior to the conclusion of the inspection.

You Are Not:

• 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:

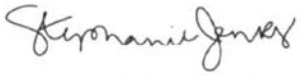
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, 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:

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

• Please contact me at (509)993-7821.

Sincerely,



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

Enclosure

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