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

Centralia Point Operating Company LLC
Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

RE: Centralia Point Assisted Living and Memory Care License # 2609

Dear Administrator:

This letter addresses Compliance Determination(s) 80033 (Completion Date 07/07/2026) and 76179 (Completion Date 05/11/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/07/2026 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-2660-1

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit E
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Centralia Point Assisted Living and Memory Care
License/Cert.#: 2609
Compliance Determination #: 76179
Investigator: Pamela Horlick
Investigation Date(s): 04/21/2026 through 05/11/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 220173
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Resident/Patient/Client Rights: Report of residents Power of Attorney not being allowed on facility premises to visit resident.
2. Quality of Life: Report of residents Power of Attorney not being allowed on facility premises to visit resident.
3. Dietary Services: Report of resident dietary order not being followed.
4. Pharmaceutical Services: Report of resident not getting ordered medications.

Investigation Methods:

Sample:
Total residents: 56
Resident sample size: 4
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents
Family members
Business office manager
Executive Director
Regional Director of Operations

Record Reviews:
State reporting log
Incident investigation
Facility policies
Progress Nots
Care Plan
Temporary Care Plan
Emails
Roster

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Investigation Summary:

1. Resident/Patient/Client Rights: Facility restricted residents family from visiting resident in residents home. Failed practice identified.
2. Quality of Life: Facility restricted residents family from visiting resident in residents home. Failed practice identified.
3. Dietary Services: After interview with resident, facility provided soft food diet and provided soft foods when taking medication. Unable to substantiate failed practice.
4. Pharmaceutical Services: After interview with resident, no concerns related to pharmaceutical services. Unable to substantiate failed practice.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Centralia Point Assisted Living and Memory Care
License/Cert.#: 2609
Compliance Determination #: 76179
Investigator: Pamela Horlick
Investigation Date(s): 04/21/2026 through 05/11/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 220018
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of care/treatment: Report of a residents representative being trespassed from the community.

Investigation Methods:

Sample:
Total residents: 56
Resident sample size: 4
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents
Family members
Business office manager
Executive Director
Regional Director of Operations

Record Reviews:
State reporting log
Incident investigation
Facility policies
Progress Nots
Care Plan
Temporary Care Plan
Emails
Roster

Investigation Summary:
Quality of care/treatment: Facility restricted residents family from visiting resident in residents home. Failed practice identified.

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Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Centralia Point Assisted Living and Memory Care
License/Cert.#: 2609
Compliance Determination #: 76179
Investigator: Pamela Horlick
Investigation Date(s): 04/21/2026 through 05/11/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 220390
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of care/treatment: Report of an altercation between two residents in the community.

Investigation Methods:

Sample:
Total residents: 56
Resident sample size: 4
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents
Family members
Business office manager
Executive Director
Regional Director of Operations

Record Reviews:
State reporting log
Incident investigation
Facility policies
Progress Nots
Care Plan
Temporary Care Plan
Emails
Roster

Investigation Summary:
Quality of care/treatment: Facility followed their process after an altercation occurred by monitoring residents, placing interventions and making appropriate

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notifications. Unable to substantiate failed practice.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Centralia Point Assisted Living and Memory Care
License/Cert.#: 2609
Compliance Determination #: 76179
Investigator: Pamela Horlick
Investigation Date(s): 04/21/2026 through 05/11/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 220508
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Administration/Personnel: Report of staff in fear of management.
2. Resident/Patient/Client Rights: Report of residents Power of Attorney not being allowed on facility premises to visit resident.

Investigation Methods:

Sample:
Total residents: 56
Resident sample size: 4
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents
Family members
Business office manager
Executive Director
Regional Director of Operations

Record Reviews:
State reporting log
Incident investigation
Facility policies
Progress Nots
Care Plan
Temporary Care Plan
Emails
Roster

Investigation Summary:

1. Administration/Personnel: Unable to find failed facility practice.

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2. Resident/Patient/Client Rights: Facility restricted residents family from visiting resident in residents home. Failed practice 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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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2609	Compliance Determination # 76179
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 1 of 5	Licensee: Centralia Point Operating Company LLC	05/11/2026

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 04/21/2026 of:

Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

This document references the following complaint number(s): 220173, 220390, 220018, 220508

The following sample was selected for review during the unannounced on-site visit: 4 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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 #: 2609	Compliance Determination # 76179
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 2 of 5	Licensee: Centralia Point Operating Company LLC	05/11/2026

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

Clinton Fridley, RN
Residential Care Services

05/20/2026
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.

Dawnielle Sweeney
Administrator (or Representative)

5-20-2026
Date

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were able to receive visits from their chosen representative for 1 of 3 residents (Resident 1 [R1]) reviewed. This failure resulted in R1 being denied access to their primary support person and only family, causing emotional distress and placing R1 at risk for continued isolation and a reduced quality of life.

Findings included...

RCW 70.129.090 Advocacy, access, and visitation rights.
(1) The resident has the right and the facility must not interfere with access to any resident by the following:
(f) Subject to reasonable restrictions to protect the rights of others and to the resident's right to deny or withdraw consent at any time, resident representative, immediate family or other relatives of the resident, and others who are visiting with the consent of the resident;
(2) The facility must provide reasonable access to a resident by the resident representative or an entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

Record review of R1's facility provided document titled, "Resident Bill of Rights," dated 06/01/2023, showed residents have the right to communicate privately with any person of choice.

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Record review of facility policy titled, "Policy Visitor Access," undated, showed the community will allow full and free access to individual residents without undue adverse interference in the operation of the community. The community will adhere to all state and federal regulations regarding visitor access.

Record review of facility face sheet for Resident 1 (R1), dated 04/21/2026, showed the facility admitted the resident on [redacted]/2023 with diagnoses that included [redacted].

In an interview on 04/17/2026 at 4:15 PM, Collateral Contact 1 (CC1), R1's Representative, stated they were told by Staff A, Executive Director, they were intimidating and aggressive to all staff. CC1 stated they denied this and asked Staff A if there were any reports in the last three years of them swearing, intimidating, yelling, or threatening and Staff A said no. CC1 stated on 04/10/2026 they received a call from Staff B, Director of Operations, that they did an extensive investigation and concluded that CC1 was intimidating and aggressive to all the staff and that they were being trespassed from the facility and cannot come on the property. CC1 stated this was upsetting because they have a great relationship with the people that work there. CC1 stated this has made them anxious, hurt, and afraid for R1 because they are R1's only family. CC1 stated R1 was very upset and not happy about what was going on.

On 04/21/2026, the Department requested the facility's investigation record for the incident that lead to the facility not allowing CC1 to visit Resident 1 inside the facility. Staff A provided four witness statements. The submitted documents did not include an investigation summary, findings, or documentation of outcomes.

Record review of facility provided document titled "No Trespassing Notice," dated 04/13/2026, showed that R1's representative was directed not to trespass on the premises of the facility R1 resides at. The document was signed by Staff A. The "No Trespassing Notice" was written by the facility and sent to CC1.

In an interview on 04/21/2026 at 09:59 AM, Staff A stated that normally things can be resolved with just a conversation, but this situation was different because it was an ongoing issue that CC1 escalated. Staff A stated CC1 bullied kitchen staff and care staff, and that they had an incident with CC1 getting in their [Staff A] face and no one was around to witness it. Staff A stated Staff B did an investigation and talked to staff. Staff A stated CC1 was trespassed for intimidating, bullying, and harassment of staff. Staff A stated Staff B called the police.

In an interview on 04/29/2026 at 12:18 PM, Staff A stated they thought Staff B was making the report to the police and Staff B thought Staff A was making the report, the police were never contacted. Staff A was asked if R1 had ever had any incidents of

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concern with CC1, Staff A stated not that they were aware of. Staff A stated there had not been any other documented incidents at the facility involving CC1.

In an interview on 04/21/2026 at 2:08 PM, Staff B stated that no other interventions related to CC1's behavior were attempted prior to sending the "No Trespassing Notice." Staff B stated there was no other documentation related to CC1 intimidating staff. Staff B stated the incident between CC1 and Staff A was serious enough that the facility owner would not tolerate it.

In an interview on 04/21/2026 at 11:36 AM, Collateral Contact 2 (CC2), facility staff, stated that they had never observed CC1 being mean to staff and never personally had any incident with CC1 or observed any coworkers having any incident with CC1. CC2 stated they were surprised when CC1 was not allowed on the premises and stated they never saw CC1 yell, curse, be violent, aggressive or disrespectful to staff.

In an interview on 04/21/2026 at 12:04 PM, Collateral Contact 3 (CC3), facility staff, stated CC1 comes to visit R1 and that they had never had any problems with CC1 or their spouse. CC3 stated they had never seen CC1 yell, curse, be aggressive or threaten anyone and stated CC1 is pleasant and helpful.

In an interview on 04/21/2026 at 12:30 PM, Collateral Contact 4 (CC4), facility staff, stated they never saw CC1 be rude, aggressive, or curse at staff.

In an interview on 04/21/2026 at 1:01 PM, Collateral Contact 5 (CC5), facility staff, stated there was one situation they had with CC1 but did not feel intimidated. CC5 stated that during this incident CC1 didn't yell nor were they rude or mad. The incident was not a big deal. CC5 stated they had never seen CC1 yell, curse at or threaten anyone. CC5 stated the conversations that they had with CC1 were all positive. CC5 stated no they haven't seen any altercations with other staff.

In an interview on 04/21/2026 at 12:38PM, R1 stated CC1 was their caretaker and POA (Power of Attorney) and now they are not allowed in the building. R1 stated they are helpless and depend on CC1 and their spouse. R1 stated CC1 and their spouse is all they have. R1 stated this has caused a hardship and they want to spend time with and visit CC1 in their room and this "pisses them off." R1 was asked if CC1 has ever gotten aggressive with them or anyone, they stated no. R1 stated they feel isolated now.

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Statement of Deficiencies	License #: 2609	Compliance Determination # 76179
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 5 of 5	Licensee: Centralia Point Operating Company LLC	05/11/2026

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 6-25-2026 .

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

Administrator (or Representative) Dawnielle Sweeney Date 5-20-2026

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