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

Spokane Valley Seniors Housing, LLC
Fields Senior Living at Spokane Valley
16512 E Desmet Court
Spokane Valley, WA 99016

RE: Fields Senior Living at Spokane Valley License # 2669

Dear Administrator:

This letter addresses Compliance Determination(s) 84428 (Completion Date 09/29/2026) and 80580 (Completion Date 08/03/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/29/2026 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-2140-3

The Department staff who did the on-site verification:
Amy Wright, NCI Complain 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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Fields Senior Living at Spokane Valley
License/Cert.#: 2669
Compliance Determination #: 80580
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 230450
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 07/16/2026 through 08/03/2026
Complainant Contact Date(s): 07/14/2026, 08/03/2026

Allegation(s):

1. Inadequate personal care.
2. Inadequate assistance with medications.
3. Family not notified of resident changes in condition including nausea/vomiting and weight loss.
4. Provider orders not followed up on timely.
5. Inadequate housekeeping.
6. Untrained staff.
7. Medications left at bedside.

Investigation Methods:

Sample:
Total residents: 120
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter/Alleged Victim's Representative
Director of Resident Services
Memory Care Director
Alleged Victim
Resident
Medication Technician
Resident Representatives

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Medication Services Policy
*Change in Resident Status Policy
*Resident face sheets

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*ADL documentation
*Resident care plans
*Progress notes
*Weight documentation
*Provider visit summaries
*Provider orders
*Hospital after-visit summary
*Medication administration records
*Provider communication
*Staff training records
*Speech therapy notes
*Staff credentials

Investigation Summary:

1. Record review showed that resident care plans failed to identify the frequency at which residents were to be showered. Failed facility practice identified and cited under WAC 388-78A-2140 Negotiated service agreement contents (3).
2. Interview with the Reporter showed that their concern was related to new medication orders not being followed up on timely. See ISR #4.
3. Interview with facility management showed they were knowledgeable about notification requirements when significant changes in resident condition occurred. Record review showed that family notification had occurred timely after the nausea and vomiting started. Record review showed there had not been a significant weight loss. The Alleged Victim was interviewed, and they denied concerns about their care. Interviews with resident representatives showed that they had received routine notifications for concerns involving their loved ones. Staff were observed available to provide family updates when needed. No failed facility practice.
4. The Alleged Victim's Representative was interviewed, and they stated that new lab, imaging, and medication orders had not been followed up on timely. Interview with facility management showed that the facility had a process for receiving and processing new provider orders. Record review showed there had initially been no order for labs, and the provider ordered the imaging studies be done in two weeks, not immediately. Record review showed that new medication orders had been implemented in a timely manner. The Alleged Victim was interviewed, and they denied concerns about their care. Staff were observed available to assist with order processing. No failed facility practice.
5. Facility management was interviewed, and they acknowledged the need for floor staff to have access to cleaning supplies at all times. They provided floor staff with a cleaning cart and had a plan for additional cleaning as needed between weekly scheduled housekeeping of resident apartments. Apartments observed were without excess clutter. Surfaces appeared clean and dust-free, and garbage receptacles had been emptied. Resident representatives were interviewed, and they reported that the facility was generally clean. The Alleged Victim denied concerns about their care. Staff were observed providing housekeeping services. No failed facility practice.
6. Interview with facility management showed they were knowledgeable about care staff training requirements. Record review showed that sampled staff had met training requirements in a timely manner. Record review showed that some staff had additional education and certifications that were not required. Staff observed were respectful and appropriate in their interactions with residents. Residents observed appeared generally well-kept. The Alleged Victim was interviewed, and they reported feeling safe in the facility. No failed facility practice.
7. Interview with the Alleged Victim's Representative showed that they found medication left in the resident's room only once. Interviews with resident representatives showed that they had never observed medications left in their

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loved ones' rooms. Staff interviewed were knowledgeable about the requirement that they observe residents to ensure their medications had been taken. No medications were observed in resident rooms during the facility tour. No failed facility 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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Statement of Deficiencies	License #: 2669	Compliance Determination # 80580
Plan of Correction	Fields Senior Living at Spokane Valley	Completion Date
Page 1 of 4	Licensee: Spokane Valley Seniors Housing, LLC	08/03/2026

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 07/16/2026 of:

Fields Senior Living at Spokane Valley
16512 E Desmet Court
Spokane Valley, WA 99016

This document references the following complaint number(s): 230450

The following sample was selected for review during the unannounced on-site visit: 3 of 120 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain 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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Statement of Deficiencies	License #: 2669	Compliance Determination # 80580
Plan of Correction	Fields Senior Living at Spokane Valley	Completion Date
Page 2 of 4	Licensee: Spokane Valley Seniors Housing, LLC	08/03/2026

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 — 08/11/2026 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) — 8-13-26 Date

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:

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in negotiated service agreements, the frequency at which the residents were to be assisted with bathing for 3 of 3 residents (Residents 1, 2, and 3.) This failed practice placed residents at risk for inadequate assistance with bathing and decreased quality of life.

Findings included...

<Resident 1>

Review of shower documentation for Resident 1, dated May 2026, showed that the resident required reminders for bathing three times weekly. Review of the shower documentation showed that reminders had occurred routinely but there was no documentation to show whether showers had occurred.

Review of shower documentation for Resident 1, dated June 2026, showed that the resident required reminders for bathing three times weekly. Review of the shower documentation showed that reminders had occurred routinely but there was only documentation of three showers having occurred in June.

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In an interview on 07/14/2026 at 12:11 PM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1 had missed showers.

In an interview on 07/27/2026 at 11:27 AM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1 had not consistently received their showers.

Review of an undated Negotiated Service Agreement (NSA) for Resident 1 showed that the resident required standby assistance for bathing. The NSA did not indicate at what frequency Resident 1 was to be assisted with bathing.

<Resident 2>

In an interview on 07/16/2026 at 11:45 AM, Resident 2 stated that they had not always received two showers a week. Resident 2 stated that at times, staff told them they were up for a shower, then it had not happened.

In an interview on 07/27/2026 at 10:59 AM, Collateral Contact 3 (CC3), Resident Representative, stated they were unsure how often Resident 2 was being showered.

Review of an undated NSA for Resident 2 showed that the resident required standby assistance with transferring in and out of the shower. The NSA did not indicate at what frequency Resident 2 was to be assisted with bathing.

<Resident 3>

Review of shower documentation for Resident 3, dated July 2026, showed that showers had occurred only once weekly, though they were scheduled for twice weekly.

In an interview on 07/21/2026 at 2:30 PM, Collateral Contact 4 (CC4), Resident Representative, stated that Resident 2 was showered about once a week.

Review of an undated NSA for Resident 3 showed that the resident required physical assistance with bathing. The NSA did not indicate at what frequency Resident 3 was to be assisted with bathing.

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Plan of Correction	Fields Senior Living at Spokane Valley	Completion Date
Page 4 of 4	Licensee: Spokane Valley Seniors Housing, LLC	08/03/2026

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, Fields Senior Living at Spokane Valley is or will be in compliance with this law and / or regulation on (Date) 9-15-26.

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

Administrator (or Representative) — Date: 8-13-26

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