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

Van Mall Retirement, LLC
Van Mall Retirement
7808 NE 51ST ST
VANCOUVER, WA 98662

RE: Van Mall Retirement License # 2702

Dear Administrator:

This letter addresses Compliance Determination(s) 78508 (Completion Date 06/03/2026) and 68398 (Completion Date 04/16/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/03/2026 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-2160, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-2

The Department staff who did the on-site verification:
Jason Rose

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Van Mall Retirement
Provider Type: Assisted Living Facility
License/Cert.#: 2702
Compliance Determination #: 68398
Intake ID: 199511
Investigator: Jason Rose
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 11/06/2025 through 04/16/2026
Complainant Contact Date(s):

Allegation(s):

1. Neglect: Resident/ Patient. Neglect. Resident fell and spent a day on the floor without facility intervention.
2. Other: Quality of care/ treatment. Facility failed to provide negotiated safety checks and meal escorts.
3. Administration/ personnel. Facility has insufficient staffing to fulfil negotiated services.

Investigation Methods:

Sample:
Total residents: 85
Resident sample size: 8
Closed records sample size: 3

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration/ Med carts/ Medication room.
Kitchen
Food preparation

Interviews:
Identified residents
residents
resident families/ representatives
Executive Director.
Director of nursing.
Caregivers.
Med techs.
Medication carts/ controlled medications/ log books.
Kitchen/ refrigerator/ freezer/ pantry.
Dinning hall.
Kitchen staff.

Record Reviews:
service plans/ temporary service plans.
Incident reports/ investigations.

alert charting.
Medication Administration Records (MARs)
physician orders/ communication.
Pharmacy communications.

Investigation Summary:

1. Neglect: Resident/ Patient. Neglect. Assess/Monitor: Resident fell and spent a day on the floor without facility intervention. Failed practice. 388-78A-2160. Facility failed to provide agreed upon services.
2. Other: Quality of care/ treatment. Care Plan not followed. Facility failed to provide negotiated safety checks and meal escorts. Failed practice, 388-78A-2160. Facility failed to provide agreed upon safety checks and meal escorts.
3. Administration/ personnel. Facility has insufficient staffing to fulfil negotiated services. Unable to prove staffing was cause of failed practice.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Van Mall Retirement
Provider Type: Assisted Living Facility
License/Cert.#: 2702
Compliance Determination #: 68398
Intake ID: 203677
Investigator: Jason Rose
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 11/06/2025 through 04/16/2026
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Facility failed to reconcile medication orders in a timely fashion resulting in a resident receiving the wrong doses of medications.
2. Pharmaceutical services: Resident received the wrong doses of medications.

Investigation Methods:

Sample:
Total residents: 85
Resident sample size: 8
Closed records sample size: 3

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Kitchen
Food preparation

Interviews:
Identified residents
residents
resident families/ representatives
Executive Director.
Director of nursing.
Caregivers.
Med techs.
Medication carts/ controlled medications/ log books.
Kitchen/ refrigerator/ freezer/ pantry.
Dinning hall.
Kitchen staff.

Record Reviews:
service plans/ temporary service plans.
Incident reports/ investigations.
alert charting.
Medication Administration Records (MARs)
physician orders/ communication.

Pharmacy communications.

Investigation Summary:

1. Quality of Care/Treatment: Facility failed to reconcile medication orders in a timely fashion resulting in a resident receiving the wrong doses of medications. Failed practice. 388-78A-2210. Facility failed to implement prescribed medication changes.

2. Pharmaceutical services: Resident received the wrong doses of medications. Failed practice. 388-78A-2210. Facility failed to implement prescribed medication changes.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Van Mall Retirement
Provider Type: Assisted Living Facility
License/Cert.#: 2702
Compliance Determination #: 68398
Intake ID: 207250
Investigator: Jason Rose
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 11/06/2025 through 04/16/2026
Complainant Contact Date(s):

Allegation(s):

1. Nursing services: Facility med tech failed to identify proper insulin medications.
2.Quality of care/treatment: Facility gave the wrong insulin to a resident.

Investigation Methods:

Sample:
Total residents: 85
Resident sample size: 8
Closed records sample size: 3

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Kitchen
Food preparation

Interviews:
Identified residents
residents
resident families/ representatives
Identified residents
residents
resident families/ representatives
Executive Director.
Director of nursing.
Caregivers.
Med techs.
Medication carts/ controlled medications/ log books.
Kitchen/ refrigerator/ freezer/ pantry.
Dinning hall.
Kitchen staff.

Record Reviews:
service plans/ temporary service plans.
Incident reports/ investigations.
alert charting.

Medication Administration Records (MARs)
physician orders/ communication.
Pharmacy communications.

Investigation Summary:

1. Nursing services: Facility med tech failed to identify proper insulin medications. Failed practice. 388-78A-2210. Facility gave incorrect medication.
2.Quality of care/treatment: Facility gave the wrong insulin to a resident. Failed practice. 388-78A-2210. Facility gave incorrect medication.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 11/06/2025, 03/04/2026, 11/18/2025, 11/21/2025, 12/19/2025 and 04/07/2026 of:

Van Mall Retirement
7808 NE 51ST ST
VANCOUVER, WA 98662

This document references the following complaint number(s): 199511, 200198, 200113, 201186, 201090, 203677, 205003, 205031, 205993, 207250, 212636, 213996

The following sample was selected for review during the unannounced on-site visit: 8 of 85 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Jason Rose

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

Statement of Deficiencies	License #: 2702	Compliance Determination # 68398
Plan of Correction	Van Mall Retirement	Completion Date
Page 2 of 6	Licensee: Van Mall Retirement, LLC	04/16/2026

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

04/23/2026
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

4/27/2026
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on document review and interview, the facility failed to provide services agreed upon for 1 of 4 sampled residents (Resident 1). This failure resulted in Resident 1 not being escorted to the dining room and was not found for hours after a fall and placed the resident at risk for unmet care needs, injury, and a decreased quality of life.

Findings included...

Record review of document titled "Service Plan Report," dated 10/03/2025, showed staff will escort Resident 1 (R1) to all meals.

Record review of document titled "Resident Temporary Care Plan," dated 10/03/2025, showed R1 is to be escorted to all meals.

Record review of facility fall investigation for R1, dated 10/23/2025 at 4:20 PM, showed that R1 was found on the floor on 10/23/2025, by a family member, and that R1 stated "I have been on the floor since like 6:30 AM."

On 11/13/2025 at 12:50 PM, Collateral Contact 1 (CC1) stated they had been trying to

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 _____

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on document review and interview, the facility failed to provide services agreed upon for 1 of 4 sampled residents (Resident 1). This failure resulted in Resident 1 not being escorted to the dining room and was not found for hours after a fall and placed the resident at risk for unmet care needs, injury, and a decreased quality of life.

Findings included…

Record review of document titled “Service Plan Report,” dated 10/03/2025, showed staff will escort Resident 1 (R1) to all meals.

Record review of document titled “Resident Temporary Care Plan,” dated 10/03/2025, showed R1 is to be escorted to all meals.

Record review of facility fall investigation for R1, dated 10/23/2025 at 4:20 PM, showed that R1 was found on the floor on 10/23/2025, by a family member, and that R1 stated “I have been on the floor since like 6:30 AM.”

On 11/13/2025 at 12:50 PM, Collateral Contact 1 (CC1) stated they had been trying to

Statement of Deficiencies	License #: 2702	Compliance Determination # 68398
Plan of Correction	Van Mall Retirement	Completion Date
Page 3 of 6	Licensee: Van Mall Retirement, LLC	04/16/2026

contact R1 throughout the day [10/23/2025] and went to check on them. CC found R1 on the ground around 4:30 PM. CC1 stated R1 was alert and oriented and reported being on the floor since 6:30 AM.

On 11/21/2025 at 12:20 PM, R1, while talking about their recent fall, stated their phone was on the end table by their bed and saw that it was 6:30 AM when they got out of bed, lost their balance, and fell. R1 reported no one could hear them yell as they are at the end of a hallway. R1 was not worried because they expected a morning check or staff to take them to breakfast. No one came until CC1 arrived at approximately 4:00 PM.

On 11/21/2025 at 12:47 PM, Staff A, Licensed Practical Nurse, stated that the facility failed to escort R1 to meals on the day they fell and was found by their family member on 10/23/2025 and that the lack of escorting the resident was "on us."

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, Van Mall Retirement is or will be in compliance with this law and / or regulation on (Date) 5/22/2026

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

Administrator (or Representative) — Date 4/27/2026

WAC 388-78A-2210 Medication services.

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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

contact R1 throughout the day [10/23/2025] and went to check on them. CC found R1 on the ground around 4:30 PM. CC1 stated R1 was alert and oriented and reported being on the floor since 6:30 AM.

On 11/21/2025 at 12:20 PM, R1, while talking about their recent fall, stated their phone was on the end table by their bed and saw that it was 6:30 AM when they got out of bed, lost their balance, and fell. R1 reported no one could hear them yell as they are at the end of a hallway. R1 was not worried because they expected a morning check or staff to take them to breakfast. No one came until CC1 arrived at approximately 4:00 PM.

On 11/21/2025 at 12:47 PM, Staff A, Licensed Practical Nurse, stated that the facility failed to escort R1 to meals on the day they fell and was found by their family member on 10/23/2025 and that the lack of escorting the resident was “on us.”

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, Van Mall Retirement 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.

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview, record review and observation, the facility failed to develop and implement systems that support and promote safe medication services and provide medications as prescribed for 2 of 11 residents (Resident 2 and 3) reviewed. This failure resulted in Resident 3 receiving the wrong type of insulin at the wrong time that required frequent overnight monitoring to prevent potentially life threatening complications and placed both Resident 2 and 3 at risk for harm.

Findings included…

Record review of facility policy titled “Procedure. Medication Charting,” revised 01/01/2021, showed staff are to give mediations as ordered and to follow the “six rights” of medication assistance which are: the right mediation, the right dosage, the right route, the right time, right resident and right documentation.

Delayed medication changes.

Review of facility resident records for Resident 2 (R2) showed the facility admitted the resident on [redacted]/2022 with diagnoses that include [redacted].

Review of facility service plan report, facility version of the Negotiated Service Agreement (NSA), for R2, date initiated 05/26/2025, showed the resident required medication assistance and staff will ensure medications are ordered as prescribed and administered three times daily.

Record review of Resident 2’ (R2) document titled “After Visit Summary,” dated 11/07/2025, showed following changes to R2’s medications:

- Aspirin (heart health) daily.
- Gabapentin (Medication to treat nerve pain) from a 300 milligram (mg) pill daily, to three 100 mg pills at night.
- Hydralazine (a medication for blood pressure control) decreased from 50 mg tablets three times daily to 25 mg tablets three times daily.
- Metoprolol (a medication for blood pressure control) increased from 25 mg tablets twice daily to 50 mg tablets twice daily.

Record review of R2’s Medication Administration Record (MAR), dated November 2025,

showed the following:

- Aspirin started on 11/12/2025.
- Gabapentin started on 11/11/2025.
- Hydralazine 50 mg dose was given daily until 11/18/2025 and decreased to 25 mg on 11/19/2025.
- Metoprolol 25 mg dose was given daily until the morning of 11/18/2025 and increased to 50 mg the evening of 11/18/2025.

Record review facility document titled "Medication Error Incident report," dated 11/18/2025, showed that R2 had medication errors from 11/08/2025 to 11/18/2025.

Record review of a facility fax sent to R2's physician on 11/18/2025, stated that the "Resident did not start medication changes with Hydralazine and Metoprolol… will start medication changes tomorrow (11-19-25)."

Record review facility document titled "Medication Error Incident report," dated 11/18/2025, showed "found order for changes in resident's blood pressure medications. resident had not started medication changes due to pharmacy inputted medications wrong into the EMAR [electronic medication administration record] and not having right doses of medication."

Incorrect medication.

Review of facility resident records for R3 showed the facility admitted the resident on [redacted]/2025 with diagnoses that include [redacted].

Review of facility NSA for R3, date initiated 09/13/2025, showed the resident required medication administration four times daily, which included staff administration of ordered insulin, and that staff will ensure medications are ordered as prescribed.

Record review of Resident 3's (R3) MAR, dated December 2025, showed an order for 30 units of long-acting insulin (medication to control blood sugar) to be administered twice daily, and another order for a short-acting insulin to be given before meals as needed. On 12/30/2025 showed that the evening dose of the long acting insulin showed a MAR code of "11".

On 03/04/2026 at 2:58 PM, Staff A, Licensed Practical Nurse, explained that the MAR code of "11," in R3's MAR, means the medication was not given and links to a note in

Statement of Deficiencies	License #: 2702	Compliance Determination # 68398
Plan of Correction	Van Mall Retirement	Completion Date
Page 6 of 6	Licensee: Van Mall Retirement, LLC	04/16/2026

the progress notes.

Record review of R3's progress notes titled "Alert Charting", dated 12/30/2025 at 9:37 PM, showed resident received the wrong insulin at 8:00 pm on 12/30/2025, received the as needed short-acting insulin instead of the scheduled long-acting insulin and that staff should monitor for low blood sugar, sweating, shakiness, anxiety, dizziness, lightheadedness, headache and blurred vision.

Record review facility incident report dated 01/14/2026 at 3:45 PM, showed that on 12/30/2025 at 9:30 PM, R3 was administered a short acting insulin instead of ordered long acting insulin and staff immediately notified management of the error.

On 03/04/2026 at 3:50 PM, R3 stated staff notified them they received the incorrect insulin, and they had to set an alarm to go off hourly throughout that night to check their blood sugar level to ensure it didn't go low.

This is a recurring deficiency previously cited on 08/01/2025, 06/03/2025 and 04/10/2025.

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, Van Mall Retirement is or will be in compliance with this law and / or regulation on (Date) 5/28/2026

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

Administrator (or Representative) — Date 4/27/2026

the progress notes.

Record review of R3's progress notes titled "Alert Charting", dated 12/30/2025 at 9:37 PM, showed resident received the wrong insulin at 8:00 pm on 12/30/2025, received the as needed short-acting insulin instead of the scheduled long-acting insulin and that staff should monitor for low blood sugar, sweating, shakiness, anxiety, dizziness, lightheadedness, headache and blurred vision.

Record review facility incident report dated 01/14/2026 at 3:45 PM, showed that on 12/30/2025 at 9:30 PM, R3 was administered a short acting insulin instead of ordered long acting insulin and staff immediately notified management of the error.

On 03/04/2026 at 3:50 PM, R3 stated staff notified them they received the incorrect insulin, and they had to set an alarm to go off hourly throughout that night to check their blood sugar level to ensure it didn't go low.

This is a recurring deficiency previously cited on 08/01/2025, 06/03/2025 and 04/10/2025.

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, Van Mall Retirement 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

Point Of Correction

Van Mall retirement

To whom it may concern.

We are writing to formally submit a point of correction regarding the following items noted.

1. **WAC 388-78-A-2160**- Implementation of negotiated service agreement.

Corrective Action:

- The resident service plan has been immediately reviewed with all caregiving staff.
- Staff have been re-educated on the requirement to escort the resident to all meals as documented in the Service plan.
- A visual alert. A Service plan. Has been implemented to clearly indicate escort requirements.
- Shift to shift communication procedures have been reinforced to include review of residents requiring escort assistance.
- Ongoing staff training will include emphasizing following individual individualized service plans.

2. **WAC 388-78A-2210** Medication Services

Corrective Action:

- The community has implemented the following corrective systems to prevent recurrence.
- Reinforced the five rights of medication administration (right resident, right medication, dose, time, route).
- Implemented a required second verification for insulin administration, two staff check.
- Staff training and competency.
- All Med Tech staff completed retraining on medication administration policies, with emphasis on insulin handling and timing.
- Skills competency evaluations were conducted and documented for all staff administering medications.
- Hired ANDS Nurse Consulting to come in training, observe and delegate Med Techs

- Any staff not meeting competency standards were retrained, prior to resuming medication duties.
- Standardized protocols for shift-to-shift communication regarding medication timing and changes were implemented.