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

SHARON CARE CENTER INC
SHARON CARE CENTER ASSISTED LIVING
1509 HARRISON AVE
CENTRALIA, WA 98531

RE: SHARON CARE CENTER ASSISTED LIVING License # 1428

Dear Administrator:

This letter addresses Compliance Determination(s) 76311 (Completion Date 04/15/2026) and 72401 (Completion Date 02/24/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/15/2026 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-2100-2-b-i, WAC 388-78A-2100-2-b-ii

The Department staff who did the on-site verification:
Maria Salas, ALF Complaint Investigator

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: SHARON CARE CENTER ASSISTED LIVING
Provider Type: Assisted Living Facility
License/Cert.#: 1428
Intake ID: 207782
Compliance Determination #: 72401
Region/Unit #: RCS Region 3 / Unit E
Investigator: Maria Salas
Investigation Date(s): 02/04/2026 through 02/24/2026
Complainant Contact Date(s):

Allegation(s):
Facility report of resident to resident altercation

Investigation Methods:

Sample:	Total residents: 108 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Medical records State reporting log Incident investigation Staff training records

Investigation Summary:
Based on record review and interview the facility failed to address changes in condition of resident. 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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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 02/04/2026 of:

SHARON CARE CENTER ASSISTED LIVING
1509 HARRISON AVE
CENTRALIA, WA 98531

This document references the following complaint number(s): 207782, 209358

The following sample was selected for review during the unannounced on-site visit: 3 of 108 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF 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

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

03/04/2026
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)

3-5-26
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete an assessment due to a resident's change in behavior for 1 of 3 residents (Resident 1 (R1)). This failure placed R1 at risk for not having behaviors assessed so appropriate interventions could be initiated and placed other residents at risk of physical and psychological harm due to aggressive behaviors.

Findings included...

Record review of facility resident records for Resident 1 (R1) showed an admission date of [redacted]/2024. R1 had a history of dementia (a loss of cognitive function thinking, remembering, and reasoning).

Record review of R1's assessment, dated 09/25/2025, documented that R1 had memory loss related to dementia, was an elopement risk, had a history of paranoia, and that R1 suffered delusions that their things were stolen. The assessment did not document a history of physically aggressive behaviors towards others related to overstimulation.

Record review of R1's negotiated service plan, dated 09/28/2025, showed that R1 had communication problems related to impaired cognition, required extended time to respond and for staff to reduce environmental stimulation. R1 used psychotropic (drugs that affect a person's mental state) medications for dementia with behaviors. R1 had behaviors related to paranoia that his belongings were stolen and suffered delusions. Interventions included explaining all procedures prior to starting and allowing time for R1 to adjust.

Review of progress notes for R1 documented the following:

- On 11/15/2025 at 6:40 pm, R1 became bothered by another resident clapping so R1 grabbed the other resident and started shaking them. Notes document that staff were to keep both residents separated.
- On 11/29/2025 at 9:51 am, R1 showed signs of increased agitation towards staff.
- On 12/31/2025 at 9:14 am staff documented that R1 was the aggressor in a resident-to-resident altercation when R1 became annoyed with a resident in the memory care unit, pushing them to the ground and then knocking them on the head. Staff interventions implemented were to keep residents separated.
- On 01/13/2026 at 6:12 am staff documented that R1 was yelling at staff and on reapproach had become "louder and more aggressive."

Review of facility records showed no change of condition assessment was completed for R1 due to the increase in aggressive behaviors.

On 02/04/2026 at 1:30 pm Staff A, Executive Director (ED), stated the assessment is what generates the service plan, this is also the care plan, and then a simplified version is printed for the care staff to follow as the care plan. Staff A stated that they had recently admitted residents who were more disruptive than usual, such as the two residents R1 had been in the altercations with.

On 02/04/2026 at 3:28 pm, Staff B, Director of Nursing Services (DNS), stated they complete assessments as needed. Staff B stated R1's last assessment was completed on 09/25/2025 and documented behaviors of paranoia, no mention of aggressive behaviors when overstimulated. Staff B stated that aggressive behaviors would have been considered a change in condition since R1 had not had a history of that type of behavior previously, no change in condition assessment had been completed. Staff B that the safety interventions that had been put in place were to keep R1 away from the residents R1 had been in an altercation with.

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, SHARON CARE CENTER ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 3-20-26 .

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

Administrator (or Representative) — Date: 3-5-26