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

926 DELAWARE LLC
DELAWARE PLAZA RETIREMENT INN
926 Delaware St
Longview, WA 98632

RE: DELAWARE PLAZA RETIREMENT INN License # 1574

Dear Administrator:

This letter addresses Compliance Determination(s) 77070 (Completion Date 05/12/2026) and 72186 (Completion Date 03/18/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/12/2026 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-2130-3-a, WAC 388-78A-2130-3-b

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

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: DELAWARE PLAZA RETIREMENT INN
License/Cert.#: 1574
Compliance Determination #: 72186
Investigator: Jacob Ubl
Investigation Date(s): 01/27/2026 through 03/18/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 208110
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Quality of Care/Treatment: Allegation that the facility was not meeting the needs of a resident Alleged Victim.

2. Nursing Services: Allegation that the facility was not coordinating nursing care for an resident Alleged Victim.

3. Resident/Patient/Client Assessment: Allegation that the facility had not assessed resident Alleged Victim's needs correctly.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Medication administration Food preparation
Interviews:	Identified resident Identified staff Residents staff Social services staff Family members Laundry staff Kitchen staff
Record Reviews:	Medical records Incident investigation State reporting log Hospital records Facility policies Staff patterns

Investigation Summary:

1. Quality of Care/Treatment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

2. Nursing Services: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

3. Resident/Patient/Client Assessment: Failed practice identified. The facility had not assessed resident Alleged Victim's needs correctly.

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 01/27/2026 and 03/18/2026 of:

DELAWARE PLAZA RETIREMENT INN
926 Delaware St
Longview, WA 98632

This document references the following complaint number(s): 208110

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

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

03/30/2026
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.

Shawna Cronk
Administrator (or Representative)

03/31/2026
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update the residents Negotiated Service Agreement (NSA) within a reasonable time when the NSA no longer adequately addressed the resident's assessed needs for 1 of 3 residents (Resident 1) reviewed for change in condition. This failure placed the resident at risk for health complications due to not updating the residents' NSA to address the resident's assessed needs.

Findings included...

Review of an undated face sheet showed Resident 1 (R1) was admitted to the facility on [redacted]/2025 and documented R1 had a diagnosis of [redacted].

Record review of R1's NSA, dated [redacted]/2025, showed R1 was independent with meal feedings. The NSA did not show that R1 had an assessed need or plan for dental care, monitoring weights, hospice care, skin monitoring, wound care, or laundry services.

Record review of R1's NSA, dated 12/18/2025, showed the facility was to provide moderate assistance with meal feedings and moderate assistance with dental care twice daily for R1. The NSA did not show that R1 had an assessed need or plan for monitoring weight loss, hospice care, skin monitoring, wound care, or laundry services.

In an interview on 01/09/2026 at 2:08 PM, Collateral Contact 1 (CC1), private pay nurse, stated that R1's daughter hired them to assess R1 on 01/07/2026 to determine if R1 qualified to move to another long term living location. CC1 stated that on their 01/07/2026 assessment of R1 they found R1 required maximum assistance with feeding. CC1 stated that R1 required maximum assistance with dental care. CC1 stated that no one was completing R1's laundry. CC1 discovered several wound throughout R1's skin. CC1 stated that R1 was bed bound, did not walk, and did not have the manual dexterity to do any task with their hands to care for themselves in general.

Interview with multiple staff (Staff A, C, D and E), conducted on 01/27/2026, revealed staff all stated R1's laundry was completed by their friend, CC2.

In an interview on 01/29/2026 at 3:19 PM, Staff B stated that R1's laundry was being completed by CC2 during the time that R1 lived at the facility until R1 transitioned to hospice services around 12/27/2025 then the facility took over doing R1's laundry services.

In an interview on 02/06/2026 at 2:40 PM, Collateral Contact 2 (CC2), friend of R1, stated that they never did laundry for R1 during the time that R1 lived at the facility, facility staff never asked them to do R1's laundry and facility staff never even talked with them about R1's laundry. CC2 stated that R1 could not self feed and R1 needed maximum assistance with feeding during the entire meal. CC2 stated that R1 was obviously was losing weight at the facility as R1 appeared significantly increasingly malnourished. CC2 stated that R1's dental always appeared in need of cleaning every time CC2 visited R1 at the facility and R1 required staff to completely do their dental care. CC2 stated that R1 was bed bound, did not walk, and was not able to care for themselves requiring total care.

In an interview on 02/10/2026 at 9:13 AM, R1 stated needing maximum assistance feeding while living at the ALF only being able to open their mouth and chew. R1 stated they experienced significant weight loss in the short time that they lived at the facility. R1 stated that they needed staff to fully do her dental care as she could not even assist a little. R1 stated that they had wounds and skin breakdown while they lived at the facility. R1 stated that no one did their laundry in the time they lived at the facility. R1 stated that they were bed bound, did not walk, and needed staff to do everything for them as they could not do any self care.

In an interview on 02/10/2026 at 10:01 AM, Collateral Contact 3 (CC3), R1's daughter

and representative, stated that they visited R1 on 01/07/2026 and R1 had was visibly malnourished and had lost significant weight in a short time at the facility. CC3 stated that R1 needed to be entirely fed. CC3 stated that R1 required maximum assistance with dental care. CC3 stated that they had seen several wounds on R1 on 01/07/2026. CC3 stated that they asked Staff A and Staff B why R1's laundry wasn't being done and they responded that they thought CC2 was doing R1's laundry. CC3 stated that R1 was bed bound, did not walk, and did not have the manual dexterity to do any task with their hands to care for themself. CC3 stated that after 12/18/2026 the facility never attempted to coordinate with them on updating or increasing R1's care needs on R1's NSA even though R1's health was declining and their care needs were increasing.

In an interview on 02/11/2026 at 3:43 PM, Collateral Contact 4 (CC4), R1's grandson and representative, stated that they visited R1 at the facility frequently, multiple times a week, and noticed that R1's care needs were increasing and the facility needed to do more care for R1 than was on the NSA. CC4 stated that R1 lost obvious visible significant weight during their stay at the facility. CC4 stated that R1 required maximum assistance with feeding yet the NSA only had R1 as inaccurately needing moderate assistance. CC4 stated that R1 required maximum assistance with dental care yet the NSA only had R1 as inaccurately needing moderate assistance. CC4 stated that R1 was getting wound care treatment around the time that R1 transitioned to hospice services. CC4 stated that they complained to Staff A, several times, about staff not following through laundry services and Staff A said they would correct it by adding it to the NSA but it continued to happen the entire time R1 lived at the facility. CC4 stated that after 12/18/2026 the facility never attempted to coordinate with them on updating or increasing R1's care needs on R1's NSA even though R1's health was declining and their care needs were increasing. CC4 stated that R1 was bed bound, did not walk, and required total care.

In an interview on 03/18/2026 at 11:04 AM, Staff B stated that the facility failed to update R1's NSA after 12/18/2026 to include increasing care to maximum assistance with meal feedings and dental care. Staff B stated that R1's NSA also failed to be updated to include addressing R1's care needs of weight loss monitoring, hospice care, skin monitoring, wound care, and laundry services that R1 should have been assessed as needing at the facility. Staff B stated the failure occurred because they just forgot to update R1's NSA after 12/18/2026 and that R1 had a rapidly changing and challenging situation that was hard to keep up with. Staff B stated that they had spent so much of their time keeping up with R1's changing care needs and prioritized that care making updating R1's NSA "the last thing I was worried about".

In an interview on 03/18/2026 at 11:04 AM, Staff A stated that the facility failed to update R1's NSA after 12/18/2026 to include maximum assistance with meal feedings and dental care. Staff A stated that R1's NSA failed to address R1's care needs of weight loss monitoring, hospice care, skin monitoring, wound care, and laundry services that R1 should have been assessed as needing at the facility. Staff A stated that R1 started on hospice services on 12/26/2025 so the NSA should have been updated around that date to include hospice as part of R1's documented care. Staff A didn't know why the failure occurred and reported intentions to make a plan with Staff B to ensure the failure does not reoccur. Staff A stated that R1's situation was problematic as the facility had

to navigate around difficult family dynamics, R1's fast health decline, and R1's tough behaviors.

The facility was unable to produce a record to show that an updated NSA was completed after 12/18/2026 to address R1s needs of maximum assistance with meal feedings, maximum assistance dental care, weight monitoring, hospice care, skin monitoring, wound care, or laundry services for R1.

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, DELAWARE PLAZA RETIREMENT INN is or will be in compliance with this law and / or regulation on (Date) 05/01/2026 .

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

Shawna Cronk

Administrator (or Representative)

03/31/2026

Date