STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

11/25/2025

PEND OREILLE COUNTY PUBLIC HOSPITAL
RIVER MOUNTAIN VILLAGE ASSISTED LIVING
714 W Pine Street
NEWPORT, WA 99156-9046

RE: RIVER MOUNTAIN VILLAGE ASSISTED LIVING # 1613

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 69283 (Completion Date 11/25/2025) and 66328 (Completion Date 10/02/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/25/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1613	Compliance Determination # 66328
Plan of Correction	RIVER MOUNTAIN VILLAGE ASSISTED LIVING	Completion Date
Page 1 of 4	Licensee: PEND OREILLE COUNTY PUBLIC HOSPITAL	10/02/2025

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 follow-up on 09/29/2025 of:
RIVER MOUNTAIN VILLAGE ASSISTED LIVING
608 W 2nd St
Newport, WA 99156

This document references the following SOD dated: 10/02/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 81 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1613	Compliance Determination # 66328
Plan of Correction	RIVER MOUNTAIN VILLAGE ASSISTED LIVING	Completion Date
Page 2 of 4	Licensee: PEND OREILLE COUNTY PUBLIC HOSPITAL	10/02/2025

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 — 10/14/2025 (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) — 10/16/2025 (Date)

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a resident's prescribed medications in a timely manner for 2 of 3 residents (Residents 2 and 3). This failed practice resulted in missed medications for the residents and placed the residents at risk for unmanaged symptoms and a decreased quality of life.

Findings included...

<Resident 2>

Review of an undated care plan for Resident 2 showed that the resident required staff assistance with ordering medications.

Review of a hospital discharge summary for Resident 2, dated [redacted]/2025, showed that the resident had suspected depression (a condition associated with low mood, aversion to activity, and loss of interest). The hospital discharge summary showed that Resident 2 had chronic anemia (a condition where the body does not have enough red blood cells to carry oxygen effectively). Further review of Resident 2's hospital discharge summary showed that the resident had intermittent constipation (a condition characterized by infrequent or difficult bowel movements).

Review of a Medication Administration Record (MAR) for Resident 2, dated September of 2025, showed that the resident's escitalopram (a medication used to treat depression) was not available on 09/26/2025 and 09/27/2025. The MAR showed that Resident 2's folic acid (a supplement that supports several bodily functions including the production of new red blood cells) was not available on 09/26/2026, 09/27/2025, 09/28/2025, 09/29/2025, and 09/30/2025. Further review of the MAR showed that Resident 2's polyethylene glycol (a medication used to treat constipation) was not available on 09/26/2025, 09/27/2025, 09/28/2025, and 09/29/2025.

In an interview on 10/01/2025 at 11:23 AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 2 moved into the facility on [redacted]/2025. CC1 stated that the facility called them on 09/27/2025 and told them that they did not have medications for Resident 2 because the hospital had not sent Resident 2 with any medications when they discharged from the hospital. CC1 stated that they called the pharmacy on 09/27/2025 to pay the deductible for Resident 2's medications with the understanding that the facility was going to pick the medications up, but they never did. CC1 stated they themself picked up Resident 2's medications on [redacted]/2025, four days after the resident admitted to the facility. CC1 stated they believed the facility was responsible for obtaining Resident 2's medications.

<Resident 3>

Review of an undated care plan for Resident 3 showed that the resident required staff assistance with ordering medications. The care plan showed that Resident 3 had multiple heart conditions.

Review of a MAR for Resident 3, dated September of 2025, showed that the resident's thiamine (a supplement that maintains proper function of the nervous system, heart, and brain) was not available on 09/18/2025 or from 09/21/2025 through 09/29/2025.

In an interview on 10/02/2025 at 3:28 PM, Staff A, Oversight Registered Nurse, stated that Resident 3's thiamine was supposed to come from the pharmacy within 24-36 hours of the resident's admission to the facility. Staff A stated that a communication breakdown may have caused the delay in obtaining Resident 3's thiamine.

This is an uncorrected deficiency previously cited on 08/11/2025.

Statement of Deficiencies	License #: 1613	Compliance Determination # 66328
Plan of Correction	RIVER MOUNTAIN VILLAGE ASSISTED LIVING	Completion Date
Page 4 of 4	Licensee: PEND OREILLE COUNTY PUBLIC HOSPITAL	10/02/2025

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, RIVER MOUNTAIN VILLAGE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) ~~10/16/2025~~ 11/14/2025

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

Jenny Cooper — Administrator (or Representative)

10/16/25 — Date

Residential Care Services
Investigation Summary Report

Provider/Facility: RIVER MOUNTAIN VILLAGE ASSISTED LIVING
License/Cert.#: 1613
Compliance Determination #: 63739
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 188476
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/06/2025 through 08/11/2025
Complainant Contact Date(s): 08/06/2025, 08/12/2025

Allegation(s):
Inadequate diabetic care.

Investigation Methods:

Sample:
Total residents: 79
Resident sample size: 3
Closed records sample size: 0

Observations:
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Director of Residential Care Services
RN Nurse Delegator
Resident
Resident Representative
Alleged Victim's Representative
Medication Technician

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plan
*Medication administration records
*Hospital after-visit summaries
*Staff credentials
*Staff training records
*Progress notes

Investigation Summary:
Record review and interview showed that the Alleged Victim's blood sugar was not checked according to their negotiated service agreement. Record review and interview showed that the Alleged Victim's diabetic medications were not available

to them in a timely manner. Failed practice identified and cited under WAC 388-78A-2160 Implementation of the negotiated service agreement, and WAC 388-78A-2240 Nonavailability of medications.

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
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8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 08/06/2025 of:

RIVER MOUNTAIN VILLAGE ASSISTED LIVING
608 W 2nd St
Newport, WA 99156

This document references the following complaint number(s): 188476

The following sample was selected for review during the unannounced on-site visit: 3 of 79 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

J Salquist
Residential Care Services

08/18/2025
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.

Jenny Cooper DRCS
Administrator (or Representative)

8/27/2025
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a resident's prescribed medication in a timely manner for 1 of 3 residents (Resident 1). This failure contributed to Resident 1 being hospitalized for unmanaged blood glucose.

Findings included...

Review of a negotiated service agreement for Resident 1, dated [redacted]/2025, showed the resident required assistance with ordering their medications.

Review of a hospital after-visit summary for Resident 1, dated [redacted]2025, showed that Resident 1 had diabetes (a disease that results in too much sugar in the blood). The summary showed that Resident 1 was treated for severe hyperglycemia (high blood sugar) during their hospital stay. The summary showed that Resident 1 had a doctor's order for their blood sugar to be checked three to four times daily.

Review of a progress note for Resident 1, dated [redacted]/2025 at 3:00 PM, showed the resident admitted to the facility on that day at approximately 2:30 PM.

Review of a medication administration record (MAR) for Resident 1, dated July of 2025, showed that on [redacted]/2025, the resident's short-acting insulin (a medication used 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-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a resident's prescribed medication in a timely manner for 1 of 3 residents (Resident 1). This failure contributed to Resident 1 being hospitalized for unmanaged blood glucose.

Findings included…

Review of a negotiated service agreement for Resident 1, dated [redacted]/2025, showed the resident required assistance with ordering their medications.

Review of a hospital after-visit summary for Resident 1, dated [redacted]/2025, showed that Resident 1 had diabetes (a disease that results in too much sugar in the blood). The summary showed that Resident 1 was treated for severe hyperglycemia (high blood sugar) during their hospital stay. The summary showed that Resident 1 had a doctor's order for their blood sugar to be checked three to four times daily.

Review of a progress note for Resident 1, dated [redacted]/2025 at 3:00 PM, showed the resident admitted to the facility on that day at approximately 2:30 PM.

Review of a medication administration record (MAR) for Resident 1, dated July of 2025, showed that on [redacted]/2025, the resident's short-acting insulin (a medication used to

regulate blood sugar levels in the blood) was not administered at 5:00 PM or 9:00 PM as ordered.

Review of a progress note for Resident 1, dated [redacted]/2025 at 9:49 PM, showed that Resident 1's medication was not available.

Review of a progress note for Resident 1, dated [redacted]/2025 at 10:13 PM, and written by Staff A, Medication Technician, showed the resident arrived at the facility with no medications and no insulin. The note showed that when Staff A discovered Resident 1 was diabetic, they tested the resident's blood sugar and it was over 600 (a high blood sugar level that can lead to coma if untreated). Further review of the note showed that Staff A was directed by Staff B, Registered Nurse, to grab a new, unused long-acting insulin of the same type from another resident's supply. The note showed that Staff A administered the insulin, rechecked Resident 1's blood sugar, and it was still over 600.

Review of a progress note for Resident 1, dated 07/24/2024 at 9:53 AM, showed the facility was still waiting for Resident 1's medications.

Review of a progress note for Resident 1, dated 07/24/2025 at 12:43 PM, showed the facility was still waiting for Resident 1's short-acting insulin.

Review of a progress note for Resident 1, dated 07/24/2025 at 4:34 PM, showed the facility was still waiting for Resident 1's short-acting insulin.

Review of a progress note for Resident 1, dated 07/24/2025 at 10:02 PM, showed the facility was still waiting for Resident 1's short-acting insulin.

Review of a MAR for Resident 1, dated July of 2025, showed that on 07/24/2025, all four doses of short-acting insulin for that day were missed at 8:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM. Review of the MAR showed that Resident 1 had blood sugars of at least 600 on 07/24/2025 at 5:00 PM and 9:00 PM. Further review of the MAR showed that Resident 1's 8:00 AM and 12:00 PM doses of short-acting insulin were missed again on 07/25/2025.

In an interview on 08/11/2025 at 2:20 PM, Staff A stated the facility did not have all of Resident 1's medications when they admitted, including the resident's insulin. Staff A stated they did not know why Resident 1's medications had not arrived on time.

Statement of Deficiencies	License #: 1613	Compliance Determination #:63739
Plan of Correction	RIVER MOUNTAIN VILLAGE ASSISTED LIVING	Completion Date
Page 4 of 6	Licensee: PEND OREILLE COUNTY PUBLIC HOSPITAL	08/11/2025

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, RIVER MOUNTAIN VILLAGE ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 8/18/2025

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

Jenny Cooper DRS — Administrator (or Representative)

8/27/2025 — 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 interview and record review, the facility failed to provide the diabetic care and services agreed upon in the resident's negotiated service agreement for 1 of 1 resident (Resident 1). This failure placed Resident 1 at increased risk for health complications related to unmanaged blood sugar levels.

Findings included...

Review of a hospital after-visit summary for Resident 1, dated [redacted]/2025, showed that Resident 1 had diabetes (a disease that results in too much sugar in the blood). The summary showed that Resident 1 was treated for severe hyperglycemia (high blood sugar) during their hospital stay. The summary showed that Resident 1 had a doctor's order for their blood sugar to be checked three to four times daily.

Review of a negotiated service agreement for Resident 1, dated [redacted]/2025, showed that staff were to check Resident 1's blood sugar as ordered by the doctor.

Review of a progress note for Resident 1, dated [redacted]/2025 at 5:00 PM, showed the resident admitted to the facility on that day at approximately 2:30 PM.

Review of a progress note for Resident 1, dated [redacted]/2025 at 10:13 PM, and written by Staff A, Medication Technician, showed that when Staff A discovered Resident 1 was

Plan/Attestation Statement

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Administrator (or Representative) Date

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Findings included…

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Review of a negotiated service agreement for Resident 1, dated [redacted]/2025, showed that staff were to check Resident 1's blood sugar as ordered by the doctor.

Review of a progress note for Resident 1, dated [redacted]/2025 at 3:00 PM, showed the resident admitted to the facility on that day at approximately 2:30 PM.

Review of a progress note for Resident 1, dated [redacted]/2025 at 10:13 PM, and written by Staff A, Medication Technician, showed that when Staff A discovered Resident 1 was

diabetic, they tested the resident's blood sugar and it was 600 (a high blood sugar level that can lead to coma if untreated). The progress note showed that Staff A rechecked Resident 1's blood sugar at shift change, and it was still over 600.

Review of a medication administration record (MAR) for Resident 1, dated July of 2025, showed that Resident 1's blood sugar was not checked again until 07/24/2025 at approximately 12:00 PM.

In an interview on 08/06/2025 at 8:22 AM, Collateral Contact (CC1), Resident Representative, stated that Resident 1 had been diabetic for a long time, and they believed Resident 1's blood sugar was supposed to be checked with meals and at bedtime. CC1 stated they thought staff might not be checking Resident 1's blood sugar when they were supposed to.

In an interview on 08/11/2025 at 2:20 PM, Staff A stated they did not think the order for staff to check Resident 1's blood sugar was initially on the resident's MAR. Staff A stated they were unsure if anyone else checked Resident 1's blood sugar before they did. Staff A stated Resident 1 was thirsty a lot and that was what prompted Staff A to check the resident's blood sugar on [redacted]2025.

Plan/Attestation Statement

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Jenny Cooper DNS — Administrator (or Representative)

8/27/25 — Date

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In an interview on 08/06/2025 at 8:22 AM, Collateral Contact (CC1), Resident Representative, stated that Resident 1 had been diabetic for a long time, and they believed Resident 1's blood sugar was supposed to be checked with meals and at bedtime. CC1 stated they thought staff might not be checking Resident 1's blood sugar when they were supposed to.

In an interview on 08/11/2025 at 2:20 PM, Staff A stated they did not think the order for staff to check Resident 1's blood sugar was initially on the resident's MAR. Staff A stated they were unsure if anyone else checked Resident 1's blood sugar before they did. Staff A stated Resident 1 was thirsty a lot and that was what prompted Staff A to check the resident's blood sugar on [redacted]/2025.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

River Mountain Village 2025 Plan of Correction Tool

Agency Name	**Citation Date**
River Mountain Village	8/18/2025
Submitted by	**Date of POC Submission**
Jenny Cooper, Director of Residential Care Services	8/27/2025
☒ Complaint **Citation** ☐ Survey Inspection	

Citation: (list WAC)	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Describe the *initial or immediate actions* taken:** To achieve compliance with WAC 388-78A-2240 (Non-Availability of Medications) the facility will monitor resident medication supplies weekly, and order as needed to ensure all ordered medications are available. In addition, the facility will call the pharmacy with any low supply to ensure timely delivery. Education provided to nursing staff on timely medication procurement and order entry on 8/26/25 at a special meeting called to address the identified issues. Medication Technicians to receive additional education from nurse delegator 8/27/25 on the new process as well as reviewing admission summaries, the importance of diabetic management, medication availability, and providing thorough shift reports.
How will you apply the correction to all clients you support?	**System or Operational Changes:** Education provided to LNs and MTs on 8/26/25 and 8/27/25 regarding recent deficiencies, plans of correction, and new processes. Line items were added to the "Admission Checklist" to ensure each new resident has medications upon arrival (or day of), to call the pharmacy to ensure timely delivery, and for the oversight nurse to complete an admission review the following day. A copy of the admission checklists will be turned into the DRCS for additional review to ensure completion.
Who will be responsible for implementing changes and monitoring the corrections to ensure the problems do not reoccur?	Jenny Cooper, Director of Residential Care Services, to review admission checklist to ensure completion, maintain resident safety, and adherence to the new process.
Date by which lasting correction will be achieved	9/26/2025
Additional Information	N/A

River Mountain Village 2025 Plan of Correction Tool

Agency Name	**Citation Date**
River Mountain Village	8/18/2025
Submitted by	**Date of POC Submission**
Jenny Cooper, Director of Residential Care Services	8/27/2025
☒ Complaint **Citation** ☐ Survey Inspection	

Citation: (list WAC)	
What *initial or immediate actions* were taken to address concerns affecting clients?	**Describe the *initial or immediate actions* taken:** To achieve compliance with WAC 388-78A-2160 (Implementing Negotiated Service Agreements) the facility will monitor resident medication supplies weekly, and order as needed to ensure all ordered medications are available. In addition, the facility will call the pharmacy with any low supply to ensure timely delivery. Education provided to nursing staff on timely medication procurement and order entry on 8/26/25 at a special meeting called to address the identified issues. Medication Technicians to receive additional education from nurse delegator 8/27/25 on the new process as well as reviewing admission summaries, the importance of diabetic management, medication availability, and providing thorough shift reports.
How will you apply the correction to all clients you support?	**System or Operational Changes:** Education provided to LNs and MTs on 8/26/25 and 8/27/25 regarding recent deficiencies, plans of correction, and new processes. Line items were added to the "Admission Checklist" to ensure each new resident has medications upon arrival (or day of), to call the pharmacy to ensure timely delivery, and for the oversight nurse to complete an admission review the following day. A copy of the admission checklists will be turned into the DRCS for additional review to ensure completion.
Who will be responsible for implementing changes and monitoring the corrections to ensure the problems do not reoccur?	Jenny Cooper, Director of Residential Care Services, to review admission checklist to ensure completion, maintain resident safety, and adherence to the new process.
Date by which lasting correction will be achieved	9/26/2025
Additional Information	N/A