STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

10/06/2025

SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Rd SE
SALEM, OR 97317

RE: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY # 1793

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 66029 (Completion Date 10/06/2025) and 53674 (Completion Date 05/29/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/06/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

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

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

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

(c) When the resident has an injury requiring the intervention of a practitioner.

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 ;

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(6) When authorizations to release health care information are not obtained, or when an external health care provider is unresponsive to the assisted living facility's efforts to coordinate services, the assisted living facility must:

(a) Document the assisted living facility's actions to coordinate services;

(c) Address known associated risks in the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

The Department staff who did the On Site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D

Residential Care Services
Investigation Summary Report

Provider/Facility: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1793
Compliance Determination #: 53674
Investigator: Carol Gijima
Investigation Date(s): 01/27/2025 through 05/29/2025
Complainant Contact Date(s): 04/30/2025

Provider Type: Assisted Living Facility

Intake ID: 161467
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Resident not receiving care
2. Inadequate staffing

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Collateral Contacts Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the records of the named resident Discharged records Medication administration records (MAR) Staff progress notes Medical records Incident log / reports,

Investigation Summary:
1. Per record review, interviews with residents, collateral contacts and staff the facility failed to provide care and services to residents. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/14/2025.
2. Per record review, interviews with residents and staff, the facility failed to ensure that they had enough staff to provide care and services for residents. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies

dated 05/14/2025.

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: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1793
Compliance Determination #: 53674
Investigator: Carol Gijima
Investigation Date(s): 01/27/2025 through 05/29/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 157707
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Resident sustained fracture after fall

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Collateral Contacts Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the records of the named resident Discharged records Medication administration records (MAR) Staff progress notes Medical records Incident log / reports,

Investigation Summary:
1. Per record review, interviews with resident's representative and staff, facility failed to conduct assessments and implement fall interventions. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/14/2025.

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: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1793
Compliance Determination #: 53674
Investigator: Carol Gijima
Investigation Date(s): 01/27/2025 through 05/29/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 156756
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1.Residents not receiving care
2. Not enough staff

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Collateral Contacts Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the records of the named resident Discharged records Medication administration records (MAR) Staff progress notes Medical records Incident log / reports,

Investigation Summary:
1. Per record review, interviews with residents, collateral contacts, and staff, the facility failed to provide resident services. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/14/2025.
2. Per record review, interviews with residents, collateral contacts, and staff, there was not sufficient information to support failed practice.

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
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 1793	Compliance Determination #53674
Plan of Correction	SILVER CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 13	Licensee: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	05/29/2025

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 complaint investigation on 01/27/2025 and 05/14/2025 of:

SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
17607 91ST AVENUE E
PUYALLUP, WA 98375

This document references the following complaint number(s): 156756, 157707, 158077, 161467

The following sample was selected for review during the unannounced on-site visit: 4 of 0 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

Statement of Deficiencies | License #: 1793 | Compliance Determination #: 53674
Plan of Correction | SILVER CREEK RETIREMENT & ASSISTED LIVING | Completion Date
Page 2 of 13 | Licensee: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC | 05/29/2025

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 — 06/02/2025 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) — 6/18/2025 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interviews and records review, the Assisted Living Facility (ALF) failed to evaluate and take appropriate action when there was a change in a resident's physical condition after developing a pressure injury for 1 of 3 sampled residents (Resident 1 [R1]). This failure resulted in Resident 1 developing pressure injuries to multiple sites and a delay in treatment that led to their hospitalization.

Findings included...

Record review of the Characteristics Roster dated 01/27/2025 showed that R1 was admitted to the ALF on [redacted] 2024 with diagnoses to include [redacted]. An initial assessment dated 08/05/2024 and another assessment dated 10/13/2024 showed that R1 did not have any wounds or skin issues.

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 — 06/02/2025 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) — Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

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(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interviews and records review, the Assisted Living Facility (ALF) failed to evaluate and take appropriate action when there was a change in a resident's physical condition after developing a pressure injury for 1 of 3 sampled residents (Resident 1[R1]). This failure resulted in Resident 1 developing pressure injuries to multiple sites and a delay in treatment that led to their hospitalization.

Findings included...

Record review of the Characteristics Roster dated 01/27/2025 showed that R1 was admitted to the ALF on [redacted]/2024 with diagnoses to include [redacted] and [redacted]. An initial assessment dated 08/05/2024 and another assessment dated 10/13/2024 showed that R1 did not have any wounds or skin issues.

During an interview on 01/07/2025 at 2:27pm, Collateral Contact 1 (CC1), Home Health Nurse, stated that R1 had a broken shoulder in November 2024 and was unable to push or pull himself in and out of bed. CC1 stated that the facility did not do anything to address his change in condition which left him bed-bound and fully dependent on staff. CC1 stated that R1 was left in bed for extended periods of time and developed multiple pressure injuries to the right hip and sacrum. CC1 stated that R1 informed them that staff never came in to reposition them unless R1 called. CC1 stated that for over three weeks, the facility did not communicate with the provider for any treatment orders. CC1 stated that they sent R1 to the hospital on [redacted] 2024 (first contact with home health) because the condition of his wounds was extensive and needed to be debrided (the process of removing dead tissues from a wound). CC1 stated that they asked Staff B, Registered Nurse, if there was any monitoring of R1's condition or wound care ordered even if R1 could communicate his needs, Staff B told them, "There is only one of me."

During an interview on 01/09/2025 at 2:55pm, Collateral Contact 3 (CC3), Anonymous Staff, stated that there were residents that "go unattended each shift," that staff couldn't help all of them. CC3 stated that residents with pressure injuries were not being seen or given treatment by the nurse and were not being repositioned. CC3 stated that Staff B was aware of R1's pressure injuries as staff had notified them but Staff B didn't care to do anything until the wound got worse.

During an interview on 01/27/2025 at 11:20am, Staff B was asked what the process was for a change in condition for residents. Staff B stated that they assessed residents, implemented temporary service plans to address the change and placed residents on alert monitoring. Staff B was asked if and what kind of monitoring or assessments were done after R1 injured his arm, Staff B stated that nothing was done as the resident was independent and able to make his needs known. When asked why there was no evaluation or intervention to address a change in R1's condition. Staff B stated that R1 refused to be assisted. When asked how R1 developed the pressure injuries, Staff B stated that R1 had an injury on his arm, had a cast placed and couldn't reposition himself. Staff B was asked if pressure injuries could have been prevented had the facility addressed his change in functional status from 11/05/2024 until discovery of the pressure injuries on 12/04/2024. Staff B stated that R1 "didn't want to call" for assistance. Staff B was asked what was done for R1 between the discovery of the pressure injuries on 12/04/2024 until [redacted] 2024. Staff B stated nothing as they had been having difficulty getting hold of the doctor. When asked what their process was to get residents treatment when a provider was unavailable, Staff B did not provide an answer. Staff B stated that an urgent mobile clinic was called to see R1 on 12/06/2024 but R1 cancelled. When asked if the facility followed up with the patient or the mobile clinic to see if there were any new orders that needed to be initiated, Staff B stated, "I didn't because I expected him to go through with it". Staff B stated, "I thought he (R1) would share that info." Staff B was asked how they managed R1's wound from the time it was discovered until R1 was sent to the hospital, Staff B stated that they didn't perform any wound care per their policy. Staff B was asked if it was possible that deterioration of R1's wounds could have been prevented had they completed a wound assessment or change in condition assessment and sought treatment early. Staff B stated "possibly... what was I supposed to do?" Staff B stated that the CC1 sent R1 to

the hospital on [redacted] 2024 after seeing the condition of the wound and R1 returned to the facility three days later. When asked if R1 had any treatment, monitoring or repositioning orders from the hospital upon return, Staff B stated that the hospital sent debridement orders that were "beyond scope." Staff B stated that R1 was supposed to perform the treatments. Staff B did not provide an answer when asked how R1 was to perform wound treatments on their buttocks and with a broken arm. When asked if they could not perform wound treatments as a registered nurse, Staff B stated that they couldn't perform the treatments daily, and the treatments were not a delegated task. Staff B stated R1 was sent back to the hospital on [redacted] 2025 as "I couldn't maintain daily dressing changes." When asked what was being done for the wound between his return on [redacted] 2024 and being sent out again on [redacted] 2025, Staff B stated, "I was just looking at it... I didn't do treatment...just boarder dressing and it (wound) broke down further." When asked if there was an assessment and change in service plan for the wounds, Staff B stated, "I didn't document it, so I guess it was my fault."

During an interview on 01/27/2025 at 12:00pm, Staff A, Administrator, was asked how R1 developed pressure injuries. Staff A stated that on 11/05/2024, R1 "broke his arm" in an accident with spouse and on 12/04/2024, R1 developed a wound. Staff A stated that prior to the accident with his arm, R1 was able to transfer himself in and out of bed, as well as reposition himself. When asked if there were any assessments or interventions put in place to ensure that he didn't develop a pressure injury while he couldn't use his arm, Staff A stated that R1 preferred to lie on his back, that R1 "couldn't lie on the left side and was hard to maneuver in bed due to his stature."

During an interview on 01/28/2025 at 10:05, Collateral Contact 4 (CC4), Anonymous Staff, stated that they did not have enough staff to care for all the residents. CC4 stated that R1 developed a pressure injury sometime after he sustained an injury to his arm. CC4 stated they (staff) "kept telling the nurse (Staff B) but she didn't do anything." CC4 stated that Staff B "didn't care...told him (R1) to reposition himself." When asked if R1 could reposition himself, CC4 stated that prior to the injury, R1 was able to but not after. When asked if there were any interventions in place to assist R1 or when to reposition him, CC4 stated that there were no interventions and staff were told that R1 "can call if he needs anything." CC4 stated that experienced caregivers would reposition R1 frequently, but the wound got worse.

During an interview on 03/03/2025 at 2:23pm, Collateral Contact 2 (CC2), Primary Care Provider's Registered Nurse, stated that they were notified by R1 about the pressure ulcer and a tele-visit (a doctor's appointment using a video call) was conducted on 11/22/2024. CC2 stated that the provider was not able to visualize the wound, and the provider ordered wound care services.

During an interview on 03/10/2025 at 2:07pm, R1 stated that he injured his arm in November 2024 and was unable to use it as the arm was in a splint and sling. R1 stated that staff would not check on him unless he called, and that he would spend hours lying on his right side and ended up developing pressure injuries. R1 stated he had the pressure injury sometime in November after he injured his arm and was unable to complete tasks on his own. R1 stated that prior to the arm injury he was independent

and didn't need much staff assistance. R1 stated that when the caregiver discovered the pressure injury, they notified Staff B. R1 stated that Staff B did not look at the wound once and didn't do anything about it. R1 stated that Staff B told him to reposition himself every two hours. When asked if he was able to reposition himself with an injured arm, R1 stated that he was not. R1 stated he needed two people to assist him and had informed staff that he needed more help and that the only thing he could do was feed himself. R1 stated that Staff B told him that the facility didn't have the staff to perform wound care. R1 stated that Staff B was "very neglectful" as they did not manage the wound. R1 stated that they had been asking Staff B to get in contact with home health as they had previously worked with them, but Staff B didn't do anything for a long time even as caregivers were reporting it.

During an interview on 05/29/2025 at 2:30pm, R1 stated that they were discharged from the hospital on [redacted]2025 and transferred to a skilled rehabilitation center with orders for a wound vac (a dressing and suction device used to promote wound healing). R1 stated that they received wound vac treatment for 3 months before being discharge to a different assisted living facility on [redacted] 2025.

Review of R1's progress notes from September 2024 to January 2025 showed that on 11/05/2024, R1 went to the hospital and had a cast placed on his left arm after an accident in his powerchair. Progress notes were as follows:
11/05/2024 at 11:42pm and 11/06/2024 at 4:48am showed that R1 needed "2-person transfer due to his injury."
11/06/2024 at 3:20pm showed R1 complained that he couldn't do anything on his own besides eating.
12/04/2024 at 9:09pm, progress note stated that R1 had pressure ulcers to his sacrum (lower bony structure at the bottom of the spine) and left hip, that R1 "has been told he needs to turn every 2 hrs.... "
12/16/2024 at 4:37pm showed R1's wound had deteriorated. Wound was covered with gentle boarder gauze (a type of dressing that covers the wound to protect it from other surfaces). The wound bed consists of eschar (tan, brown or black dead tissues caused by unrelieved pressure).
There were no progress notes that documented the refusal of assistance from R1.

There were no evaluations and or assessments provided to review a change in condition when R1 injured his arm on 11/05/2024 or when R1 developed a pressure injury.

There was no temporary service plans provided to review interventions implemented after R1 sustained an injury to left arm or when they developed a pressure injury on 12/04/2024.

Record review of R1's provider (Primary Care Physician, PCP) notes dated 11/22/2024 showed that R1 was seen on 11/22/2024 via tele-visit with concerns of a pressure injury that developed after sustaining an arm injury. The notes further states that resident "is very immobilized now." A referral for home health was made by the PCP.

Record review of hospital records dated [redacted]/2024 showed that R1 had pressure injuries to the right hip with dusky discoloration (a dull, grayish) and purulent drainage (signs of wound infection), sacrum, and an unstageable right heel (a wound that has full skin and tissue loss, with wound base covered with tan, brown, black or green dead tissue).

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7/13/2025 .

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

M Vulgall
Administrator (or Representative)

6/18/2025
Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

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

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

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

(c) When the resident has an injury requiring the intervention of a practitioner.

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;

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to complete an assessment within 14 days after admission and when there was a change in condition for 2 of 3 sampled residents (Resident 1 & 2 [R1 &2]). This failure resulted

Record review of hospital records dated [redacted]2024 showed that R1 had pressure injuries to the right hip with dusky discoloration (a dull, grayish) and purulent drainage (signs of wound infection), sacrum, and an unstageable right heel (a wound that has full skin and tissue loss, with wound base covered with tan, brown, black or green dead tissue).

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY 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-2100 On-going assessments. The assisted living facility must:

(1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

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

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

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

(c) When the resident has an injury requiring the intervention of a practitioner.

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 ;

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to complete an assessment within 14 days after admission and when there was a change in condition for 2 of 3 sampled residents (Resident 1 & 2 [R1 & 2]). This failure resulted

in Resident 1 not having a service plan informing staff how to provide services and resulted in Resident 2 not having their needs met and sustaining multiple falls.

Findings included...

388-78A-2090
Full assessment topics.
The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

Resident 1
Record review of the characteristics roster dated 01/27/2025 showed that R1 was admitted to the ALF on [redacted]/2024 with diagnoses to include [redacted] and [redacted]. A pre-move in assessment dated 07/08/2024 showed that R1 needed staff assistance with dressing, bathing, toileting, and transfers. There was no assessment conducted within 14 days to review.

Resident 2
Record review of the characteristics roster dated 01/27/2025 showed that R2 was admitted to the ALF on [redacted]/2024 with diagnoses to include [redacted] and [redacted]. A pre-move in assessment dated the day of move in showed that R2 had experienced a fall before moving into the facility and that R2 did not need any assistance with activities of daily living. Progress notes on day of admission, [redacted]2024, showed that R2 was admitted to the facility after sustaining a non-injury fall. Progress notes on day of admission, [redacted]2024, showed that R2 was admitted to the facility after sustaining a non-injury fall. On the first night at the facility on [redacted]2024, "staff to encourage fluids, provide room trays, toileting, medication... , observe for mood/how resident is adjusting/unmet need." On 11/23/2024 R2 was found on the floor (no direction or interventions),11/26/2024 with staff to observe for latent injuries, pain or weakness.

Review of the facility incident reports between September - December 2024 showed that R2 sustained falls on [redacted]2024, 11/14/2024 and 11/26/2024 with no interventions except that the fall would be recorded in the service plan. There was no assessment conducted within 14 days to review for fall prevention measures.

During an interview on 04/24/2025 at 3:16pm, Staff B, Registered Nurse, stated that the facility completed pre-move in assessments, within 14 days of resident moving in, after 90 days, quarterly and annually. Staff B stated that there would be no reason assessments would not be completed timely unless they (Staff B) were sick. Staff B stated "everyone should have one (assessment). Staff B was asked if R1's pressure injuries would have been prevented if R1 had timely assessments and interventions to include repositioning when he admitted. Staff B stated that R1 was independent and

didn't need any staff assistance. When asked why Residents R2's assessments were not completed within 14 days, Staff B stated that they didn't know why R1 didn't have an assessment, and that R2 had been sent to the hospital within 14 days of admission and was therefore unable to complete it. When asked when R2 was admitted to the facility and when they were sent to the hospital, Staff B stated that R2 was admitted to the facility on [redacted]2024 and was sent to the hospital on 11/20/2024. When Staff B was informed that 11/20/2024 was over 14 days, Staff B stated, "I get very busy, I miss these things and it's unfortunate."

Staff B was asked if they assessed R2 when she was admitted, especially since R2 had a fall on the night of admission. Staff B stated R2 was admitted with a history of falls, and that now R2 has a diagnosis that explained all her falls. Staff B was asked if falls could have been prevented had R2 been assessed sooner, Staff B stated that it was possible. Staff B was asked if the cause of R2's falls would have been determined had they conducted an assessment within the 14 days and implemented interventions. Staff B stated that they were not a doctor and could not diagnose, that "nobody knows why she (R2) was falling."

During an interview on 04/28/2025 at 1:22pm, Staff A, Administrator stated Staff B conducts a pre-move in assessments, initial and quarterly. Staff A stated that they would not know why assessments would not be completed.

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law, and / or regulation on (Date) 7/13/2025

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

M. Kugall
Administrator (or Representative)

6/18/2025
Date

WAC 388-78A-2360 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(6) When authorizations to release health care information are not obtained, or when an external health care provider is unresponsive to the assisted living facility's efforts to coordinate services, the assisted living facility must:

(a) Document the assisted living facility's actions to coordinate services;

(c) Address known associated risks in the resident's negotiated service agreement.

didn't need any staff assistance. When asked why Residents 1&2's assessments were not completed within 14 days, Staff B stated that they didn't know why R1 didn't have an assessment, and that R2 had been sent to the hospital within 14 days of admission and was therefore unable to complete it. When asked when R2 was admitted to the facility and when they were sent to the hospital, Staff B stated that R2 was admitted to the facility on [redacted]2024 and was sent to the hospital on 11/28/2024. When Staff B was informed that 11/28/2024 was over 14 days, Staff B stated, "I get very busy, I miss these things and it's unfortunate."

Staff B was asked if they assessed R2 when she was admitted, especially since R2 had a fall on the night of admission. Staff B stated R2 was admitted with a history of falls, and that now R2 has a diagnosis that explained all her falls. Staff B was asked if falls could have been prevented had R2 been assessed sooner, Staff B stated that it was possible. Staff B was asked if the cause of R2's falls would have been determined had they conducted an assessment within the 14 days and implemented interventions. Staff B stated that they were not a doctor and could not diagnose, that "nobody knows why she (R2) was falling."

During an interview on 04/28/2025 at 1:22pm, Staff A, Administrator stated Staff B conducts a pre-move in assessments, initial and quarterly. Staff A stated that they would not know why assessments would not be completed.

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY 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-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(6) When authorizations to release health care information are not obtained, or when an external health care provider is unresponsive to the assisted living facility's efforts to coordinate services, the assisted living facility must:

(a) Document the assisted living facility's actions to coordinate services;

(c) Address known associated risks in the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on records review and interviews, the Assisted living facility (ALF) failed to coordinate timely with a resident's provider or document when the provider was unresponsive when a resident developed pressure injuries for 1 of 1 sampled residents (Resident 1 [R1]). This failure resulted in Resident 1's services being delayed leading to worsening of the wounds and hospitalization.

Findings included...

Record review of the after-visit summary dated 11/22/2024 with the primary care provider showed that there was a presence of a pressure injury at the 11/22/2024 tele-visit.

Record review of the characteristics roster dated 01/27/2025 showed that R1 was admitted to the ALF on [redacted]/2024 with diagnoses to include [redacted] and [redacted]. An assessment dated 10/13/2024 showed that R1 did not have any wounds or skin issues.

Review of R1's progress notes from September 2024 to January 2025 showed that on 11/05/2024, R1 went to the hospital and had a cast placed on his left arm after an accident in his powerchair. Progress notes showed that after the injury, R1 was getting assistance from two staff as R1 was unable to perform per normal routine. On 12/04/2024 progress notes showed that R1 had pressure ulcers (wound injuries to skin resulting from prolonged pressure to the area) to his sacrum (lower bony structure at the bottom of the spine) and left hip and that R1 "has been told he needs to turn every two hours."

There was no documentation in R1's record to show that the provider was notified of the pressure injury when it was discovered.

During an interview on 01/07/2025 at 2:27pm, Collateral Contact 1 (CC1), Home Health Nurse, stated that R1 had a broken their shoulder in November 2024 and was unable to perform their normal functions. CC1 stated that R1 informed them that they (R1) had to call their doctor to be seen for the wounds because the facility wasn't notifying the doctor. CC1 stated that for over three weeks, the facility did not communicate with the provider for any treatment orders and that they sent R1 to the hospital because the condition of his wounds was extensive and needed to be debrided (the process of removing dead tissues from a wound). CC1 stated that they asked Staff B, Registered Nurse, why there had not been any treatment or timely notification of the doctor and

Staff B told them that R1 was able to communicate their own needs.

During an interview on 01/27/2025 at 11:20am, Staff B stated that the pressure injury was discovered on 12/04/2024. When asked if the doctor was notified, Staff B stated the provider was notified but that they were not responsive, and that the facility had trouble getting orders. Staff B was unable to state when the doctor was notified of the wounds. Staff B did not provide an answer as to the facility's policy when providers were not responsive or available to address the resident's needs.

During an interview on 01/27/2025 at 12:00pm, Staff A, Administrator, was asked who was notified of R1's pressure injuries. Staff A stated, "I am pretty sure his doctor." When asked if that would be charted in R1's records, Staff A stated it should be, and that Staff B would know more about that.

During an interview on 03/03/2024 at 2:23pm, Collateral Contact 2 (CC2), Registered Nurse, stated that the facility did not notify the provider of R1's wounds. CC2 stated that the resident was the one who notified them and set up an appointment for 11/22/2024. CC2 stated that the resident was the one who informed the provider that they had a pressure injury on their sacrum.

During an interview on 03/10/2025 at 2:07pm, R1 stated they had wounds since November 2024, sometime after they had injured their arm. R1 stated they had to call the doctor themselves about the wound and had a tele-visit towards the end of November 2024 as Staff B refused to do anything.

During an interview on 04/24/2025 at 1:28pm, Collateral Contact 5 (CC5), Anonymous Staff, stated that Staff B was not doing anything about R1's wound. CC5 stated that Staff B had "wanted me to dress the wound and I refused." CC5 stated that they were concerned about the wound and didn't think the doctor was notified because there were no treatment orders except to cover it and it kept getting worse. CC5 stated that they told R1 to call 911 themselves to get the wound looked at.

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7/13/2025.

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

M. Kilgall
Administrator (or Representative)

6/18/2025
Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that they had sufficient staff to provide resident care and services for 1 of 3 sampled residents (Resident 1 [R1]). This failure resulted in Resident 1 not getting repositioned that placed them at risk of developing pressure injuries.

Findings included...

Record review of the characteristics roster dated 01/27/2025 showed that R1 was admitted to the ALF on [redacted]/2024 with diagnoses to include [redacted] and [redacted]. A pre-move in assessment dated 07/08/2024 and an assessment dated 10/13/2024 showed that R1 did not have any wounds or skin issues. Progress notes dated 11/06/2024 and 11/06/2024 showed that R1 needed two staff to assist with activities of daily living after sustaining an arm injury on 11/05/2024. A progress note dated [redacted]/2024 showed that R1 was sent to the hospital for worsening wounds.

Records from an after-visit summary with primary care provider on 11/22/2024 showed that R1 had a pressure injury.

A service agreement dated 12/04/2024 did not show an increase in staff assistance for R1 due to a left arm injury. There was no documentation to show treatment orders for wound management.

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY 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-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that they had sufficient staff to provide resident care and services for 1 of 3 sampled residents (Resident 1 [R1]). This failure resulted in Resident 1 not getting repositioned that placed them at risk of developing pressure injuries.

Findings included...

Record review of the characteristics roster dated 01/27/2025 showed that R1 was admitted to the ALF on [redacted]2024 with diagnoses to include [redacted] and [redacted]. A pre-move in assessment dated 07/08/2024 and an assessment dated 10/13/2024 showed that R1 did not have any wounds or skin issues. Progress notes dated 11/05/2024 and 11/06/2024 showed that R1 needed two staff to assist with activities of daily living after sustaining an arm injury on 11/05/2024. A progress note dated [redacted]/2024 showed that R1 was sent to the hospital for worsening wounds.

Records from an after-visit summary with primary care provider on 11/22/2024 showed that R1 had a pressure injury.

A service agreement dated 12/04/2024 did not show an increase in staff assistance for R1 due to a left arm injury. There was no documentation to show treatment orders for wound management.

During an interview on 01/07/2025 at 2:27pm, Collateral Contact 1 (CC1), Home Health Nurse, stated that R1 was unable to complete tasks due to a broken arm. CC1 stated that the facility had "about 150-200 residents" with only one nurse who was not able to monitor and care for all these residents. CC1 stated that Staff B, Registered Nurse, performed R1's wound care only once and opted to use a bandage to cover the wounds. CC1 stated that they were informed that there was no staff to care for residents, especially at night, and that they left residents without care. CC1 stated this lack of staff resulted in skin breakdown as staff were not able to follow turning protocols. CC1 stated that when they brought their concerns to Staff B, Registered Nurse, Staff B stated, "I can't take care of him (R1), there is only one of me."

During an interview on 01/09/2025 at 2:55pm, Collateral Contact 3(CC3), Anonymous Staff, stated that the facility had "become a nursing home" with "lots of residents on machines," residents needing two staff to assist and "no increase in staff." CC3 stated that they were short-staffed, and some residents were not attended at all during a shift. CC3 stated "they (staff) can't help them all." CC3 stated that residents fell because they couldn't get to them on time, and others could not be repositioned frequently.

During an interview on 01/27/2025 at 11:20am, Staff B stated that they were not aware of any staffing concerns. Staff B stated that staffing was adequate and that "people call out and its beyond my control." Staff B was asked what the facility did to ensure residents received care even when staff called out, Staff B stated that caregivers could always call the medication technician in case of emergency and that "they can always come in and ask me." When asked about providing wound care to R1, Staff B stated that they couldn't do daily treatments, that there was only one nurse, that they didn't know what else to do and "at the end of the day, I did what I could."

During an interview on 01/27/2025 at 12:00pm, Staff A, Administrator, stated "they had two and a half caregivers and a med technician." When asked if that was enough to provide care for all residents on three floors, Staff A stated that it was enough "according to my budget." On a separate interview on 05/20/2025 at 10:20am, Staff A reported that they have 68 residents just on the ALF side of the facility.

During an interview on 01/28/2025 at 10:05am, Collateral Contact 4 (CC4), Anonymous Staff, stated that they did not have sufficient staff to care for the residents. CC4 stated that residents were "sometimes left wet and we can't get to them." CC4 stated that residents fell because they either cannot get to them on time, or they left them on the toilet to answer other call lights as was the case with R2. CC4 stated that Staff A told them that they had three minutes to answer a call light which was unrealistic.

During an interview on 03/10/2025 at 10:51am, R1 stated that their wounds were not treated because Staff B, Registered Nurse, told them that the facility didn't have money or the staff to do wound care.

Statement of Deficiencies	License # 1793	Compliance Determination # 53674
Plan of Correction	SILVER CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 13 of 13	Licensee: SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	06/29/2025

During an interview on 06/14/2025 at 11:35am, Collateral Contact 7 (CC7), Anonymous Contact, stated that residents did not get their medications timely due to short staff. CC7 stated that staff took a long time to respond and when they do they state that they had an emergency.

During an interview on 06/14/2025 at 12pm, Collateral Contact 8 (CC8), Anonymous contact stated that staff did not respond to their needs timely. CC8 stated that residents leave their rooms if they can, to look for staff.

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7/13/2025.

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

M. Kilgore
Administrator (or Representative)

6/18/2025
Date

During an interview on 05/14/2025 at 11:35am, Collateral Contact 7 (CC7), Anonymous Contact, stated that residents did not get their medications timely due to short staff. CC7 stated that staff took a long time to respond and when they do they state that they had an emergency.

During an interview on 05/14/2025 at 12pm, Collateral Contact 8 (CC8), Anonymous contact stated that staff did not respond to their needs timely. CC8 stated that residents leave their rooms if they can, to look for staff.

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, SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY 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 _____