STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

PARK VISTA RETIREMENT & ASSISTED LIVING COMMUNITY LLC
PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
3425 BOONE RD SE
SALEM, OR 97317

RE: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY License # 1810

Dear Administrator:

This letter addresses Compliance Determination(s) 46252 (Completion Date 09/03/2024) and 44715 (Completion Date 07/28/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/03/2024 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-2600-1, WAC 388-78A-2600-1-a

The Department staff who did the on-site verification:
Nikolas Jennings, Community Nurse Complaint Investigator

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

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 44715
Investigator: Nikolas Jennings
Investigation Date(s): 07/26/2024 through 07/28/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 138367
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Abuse- Resident/Patient/Client abuse: Residents' hand was slapped by a caregiver while they were giving care.

Investigation Methods:

Sample:	Total residents: 11 Resident sample size: 2 Closed records sample size: 0
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Registered Nurse Nursing staff Memory Care Director Executive Director
Record Reviews:	Medical records Incident investigation Facility policies Staff patterns Alert documentation

Investigation Summary:
1) Abuse- Resident/Patient/Client abuse: Residents' hand was slapped by a caregiver while they were giving care. Based on interview and record review there is sufficient evidence to substantiate that the facility did not implement their abuse policy to protect 11 of 11 residents. Failed facility practice identified.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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

Statement of Deficiencies	License #: 1810	Compliance Determination # 44715
Plan of Correction	PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY	Completion Date
Page 1 of 3	Licensee: PARK VISTA RETIREMENT & ASSISTED LIVING COMMUNITY LLC	07/28/2024

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 07/26/2024 and 07/29/2024 of:

PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
2944 SE LUND AVE
PORT ORCHARD, WA 98366

This document references the following complaint number(s): 138367

The following sample was selected for review during the unannounced on-site visit: 2 of 11 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nikolas Jennings, Community Nurse Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit Z
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.

Jody Just Jody Just Field Services Administrator Region 3
Residential Care Services

07/30/2024
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-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their Abuse, Neglect and Exploitation policy for one of two sampled Residents (Resident 1 [R1]) reviewed for allegations of abuse. This failure placed all 11 of 11 residents living at the facility at risk for abuse, unmet care needs, and diminished quality of life.

Findings included…

Record review of policy titled Abuse, Neglect or Exploitation undated under the subsection Protecting the resident from further harm states “Assure the alleged perpetrator/s is kept away from the resident or other residents.”

Record review of policy titled Abuse, Neglect or Exploitation undated under the subsection reporting states, “Any staff member who has reason to suspect an incident of sexual or physical assault has occurred will report to the CRU hotline 1-800-562-6078 and to the local law enforcement emergency services number as soon as the resident is protected from further harm.”

During an interview on 07/26/2024 at 11:38 AM for Staff B, Community Nurse Consultant, stated that they were aware that Staff D, caregiver, would be continuing to work following allegation of abuse, and they had notified Staff A, Executive director, that Staff D should not be working with vulnerable adults pending an investigation.

During an interview on 07/26/2024 at 2:11 PM for Staff C, Memory Care Director, stated that an allegation of abuse was reported to them at 7:00 PM on 7/11/2024 and that they notified Staff A of this allegation. Staff C also stated that Staff A informed them that Staff D was to continue to work for their shift that night and that an investigation would be done in the morning.

Record review of MAR (Medication Administration Records) for Resident 1 dated for the month of July showed Staff D completing task “elevate lower extremities” during the night shift of 7/11/2024 and 7/12/2024.

Record review of records labeled Charting Notes for Resident 1 dated between the dates of 7/9/2024 and 7/15/2024 showed Staff D completing shift documentation at 5:23 AM on 7/11/2024 and 6:05 AM on 7/12/2024.

Record review of records labeled Charting Notes for Resident 2 dated between the dates of 7/11/2024 and 7/12/2024 showed Staff D completing shift documentation at 5:28 AM on 7/11/2024 and 6:19 AM on 7/12/2024.

Record review of record labeled “Statement of Accounts 7/11/24-7/12/24” written by Staff B, showed Staff B notified Staff A that Staff D had committed abuse if the allegation was accurate because “It is still abuse by slapping the hand of an ADULT dementia”(sic). In that same statement, Staff A responds “I’m not going to suspend him but I’m going to do an investigation. We can talk more about it tomorrow.”

During an interview on 07/26/2024 at 12:57 PM with Staff A, Staff A stated that they had been given direction but ultimately made a decision and that the wrong decision was made.

During an interview on 7/26/2024 at 1:40 PM with Staff A, Staff A stated that they had not called law enforcement.

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, PARK VISTA 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