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

07/03/2025

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 # 1810

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 61432 (Completion Date 07/03/2025) and 57277 (Completion Date 04/09/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/03/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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;

(b) Maintain the assisted living facility free of safety hazards; and

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, Allied Health Field Manager

Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 57277
Investigator: Nikolas Jennings
Investigation Date(s): 04/02/2025 through 04/09/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 172685
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) Quality of care- Residents being neglected.
2) Death- Resident had fallen prior to death and was not reported or investigated.
3) Administration/personnel- Insufficient staff
4) Infection control- Biohazardous material being disposed of inappropriately.
5) Pharmaceutical services- Medications being administered inappropriately.

Investigation Methods:

Sample:	Total residents: Resident sample size: 7 Closed records sample size: 1
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents
Record Reviews:	Medical records Facility policies Staff patterns Shower schedules Incident reports

Investigation Summary:

1) Quality of care- Residents being neglected. Regarding showers, one resident has well documented history of refusing showers even with multiple attempts, and in interview admitted that she frequently didn't want one when asked. Interview with

residents and family revealed that care staff is in their rooms quickly after usage of call lights. Based on interview and record review, there is insufficient evidence to support failed practice.

2) Death- Resident had fallen prior to death and was not reported or investigated. Facility was aware of fall, and fall was investigated appropriately and documented. At time of fall, it was ruled as non injury so EMS was not notified. Based off interview and record review, there is insufficient evidence to support failed practice.

3) Administration/personnel- Insufficient staff. During a night shift on 03/06/2025, only two staff were available in the entire building, meaning two person assists were impossible to do while also attending other resident needs. Failed practice identified.

4) Infection control- Biohazardous material being disposed of inappropriately and failure to investigate potential infection. Observed a urinal half full in one residents' room, however when asked resident stated they would take care of it themselves. Staff interviewed stated that protocol was to dispose of urine in the toilet then clean the urinal and dispose of water in the toilet. One resident alleged to have blood in their urine, but none was observed. Staff reported that they had not seen blood in urine for "a while" and that it had not been reported recently. Based on interview and record review, there is insufficient evidence to support failed practice.

5) Pharmaceutical services- Medications being administered inappropriately. Facility is currently out on multiple concerns related to medications being administered improperly and allegation is included in previous citations. Failed practice cited in previous investigations.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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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 04/02/2025 of:

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

This document references the following complaint number(s): 172685

The following sample was selected for review during the unannounced on-site visit: 7 of 0 current residents and 1 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 D
PO Box 99250
Lakewood, WA 98496

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.

Cory Cisneros for Manfay Chan
Residential Care Services

04/15/2025
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)

4/30/25
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;

(b) Maintain the assisted living facility free of safety hazards; and

This requirement was not met as evidenced by:
Based on interview and record review, the facility failed to have sufficient staff in the building on 1 of 31 days in March. This failure led to all residents being placed at risk of unmet care needs and potential safety hazards.

Findings included...

In an interview on 04/02/2025 at 2:45PM with Staff A, Memory Care Director, stated that she wasn't sure if it was policy or not, but there was always required to be three staff members in the building during the night. Further stated that if there was not at least three staff members, one of the managers would need to come in to assist.

In an interview on 04/09/2025 at 3:33PM with Staff B, Assistant Executive Director, stated when asked about staffing during the night said, "At minimum three [staff members], but there should be on a normal schedule four." When asked why that was the case, Staff B stated, "In case there needs to be a two person assist, there is still one person to answer call lights in emergencies."

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-2450 Staff.

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

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This requirement was not met as evidenced by:

Based off interview and record review, the facility failed to have sufficient staff in the building on 1 of 31 days in March. This failure led to all residents being placed at risk of unmet care needs and potential safety hazards.

Findings included…

In an interview on 04/02/2025 at 2:45PM with Staff A, Memory Care Director, stated that she wasn't sure if it was policy or not, but there was always required to be three staff members in the building during the night. Further stated that if there was not at least three staff members, one of the managers would need to come in to assist.

In an interview on 04/09/2025 at 3:33PM with Staff B, Assistant Executive Director, stated when asked about staffing during the night said, "At minimum three [staff members], but there should be on a normal schedule four." When asked why that was the case, Staff B stated, "In case there needs to be a two person assist, there is still one person to answer call lights in emergencies."

Record review of staff schedule dated March 2025, showed on 03/08/2025 during the

night shift there was only one caregiver, and one medication technician in the entire building.

In an interview with Staff C, Executive Director, when asked about that date, Staff C stated, "I came in early on 03/08/2025. Around 4:00AM. But I can't exactly remember what time." When asked about who was there prior, stated it was only the two staff members on the schedule.

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) 5/24/25 .

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

Administrator (or Representative) Date 4/30/25

night shift there was only one caregiver, and one medication technician in the entire building.

In an interview with Staff C, Executive Director, when asked about that date, Staff C stated, “I came in early on 03/08/2025. Around 4:00AM. But I can’t exactly remember what time.” When asked about who was there prior, stated it was only the two staff members on the schedule.

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