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

07/28/2025

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) 62989 (Completion Date 07/28/2025) and 59651 (Completion Date 05/21/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/28/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

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
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 59651
Investigator: Nikolas Jennings
Investigation Date(s): 05/16/2025 through 05/21/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 178797
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Quality of life- Resident medications missing.
2) Pharmaceutical services- Resident given incorrect dosage of medication.
3) Nursing service- improper nursing delegation.

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:
1) Quality of life- Resident medications missing. Medications were indeed missing for resident, however record review shows that facility and staff think that the medication was given to the resident incorrectly. No failed practice.

2) Pharmaceutical services- Resident given incorrect dosage of medication. Record review shows that medication technician was on their third day of working as a

medication technician. Interview reveals that on the third day of training, staff should be shadowing the new trainee to ensure that everything goes smoothly. Staff were not present and monitoring to ensure that there were no issues. Failed practice identified.

3) Nursing service- improper nursing delegation. Resident did not require nursing delegation to give medications. No failed practice.

Conclusion / Action:

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

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

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 05/16/2025 of:

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

This document references the following complaint number(s): 178797

The following sample was selected for review during the unannounced on-site visit: 3 of 0 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 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.

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) — June 9, 2025 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based off interview and record review, the facility failed to ensure that 1 of 1 staff (Staff A) had completed their training on managing resident medications. This failure led to 1 of 3 residents (Resident 1 [R1]) receiving an overdose of a medication causing hospitalization and potential for death.

Findings included...

Record review of the narcotic lot for R1, dated 05/03/2025, showed that oxycodone liquid (a medication given for severe pain) was given on multiple times a day on 05/07/2025, 05/08/2025, 05/09/2025, 05/10/2025, and 05/11/2025. In each of the doses given, the dose given was 0.5mL (milliliters). On 05/11/2025 at 6:00PM, the dose given shows as 20mL. The signature shows as Staff A, Medication Technician.

Record review of a written statement dated 05/11/2025 from Staff A, stated, "I [staff A], gave the incorrect amount of oxycodone (liquid) oral solution. I was supposed to give her [R1] 0.5mL in a syringe but misread instructions and gave her [R1] over 20mL."

Record review of a calendar labeled "May 2025" with the name Staff A on the top, showed First day as 05/04/2025 and caregiver training on the dates of 05/04/2025,

05/05/2025, and 05/06/2025. The calendar further showed medication aide training on 05/07/2025, 05/08/2025, and 05/11/2025.

In an interview on 05/19/2025 at 5:02PM with Staff C, Memory Care Director, stated they were under the impression that Staff A had worked their required training shifts already, and that that further training was not necessary.

In an interview on 05/19/2025 at 2:24PM with Staff B, Executive Director, stated their protocol is to have medication technicians train for three days, the first where they shadow the employee they are training with, the second where they work together with the person they are training with, and the third where they are shadowed by the person they are training with. Further stated that on the date of the incident, it was Staff A's third day of training on the [medication] cart and that on that day Staff A was to be training with Staff C.

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) July 5, 2025

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

Administrator (or Representative) — June 9, 2025 — Date