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

11/03/2025

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) 68140 (Completion Date 11/03/2025) and 65138 (Completion Date 09/19/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/03/2025 and found no deficiencies.

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

WAC 388-78A-2371 Investigations. The assisted living facility must:

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

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,

Laurie Anderson

Laurie Anderson, Community 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 #: 65138
Investigator: Nikolas Jennings
Investigation Date(s): 09/04/2025 through 09/19/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 191833
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Quality of care- Resident hit their spouse.

Investigation Methods:

Sample:	Total residents: 53 Resident sample size: 2 Closed records sample size: 0
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Identified resident
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:
1) Quality of care- Resident hit their spouse. Record review showed that facility investigation was done appropriately. Investigation showed interventions were not placed to prevent reoccurrence. Interview with staff showed that interventions were not placed and should have been. Failed practice identified. Citation issued.

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 09/04/2025 of:

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

This document references the following complaint number(s): 191894, 191833

The following sample was selected for review during the unannounced on-site visit: 2 of 53 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.

Laurie Anderson
Residential Care Services

09/22/2025
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)

9/29/2025
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to protect 1 of 2 sampled residents (Resident 1) during and after completion of the facility's investigation of alleged abuse. This failure placed Resident 1 at continued risk for abuse.

Findings included...

Review of the facility's undated policy titled "Abuse, Neglect or Exploitation" showed staff were to "report the incident to your supervisor so a plan can be developed to protect the resident from further harm."

Review of the facility's undated policy titled "Medication Technician & QMAP Training", showed "The Community has established an alert charting system for special attention to, and documentation about, residents who require additional monitoring or intervention. Needs for increased attention could include but are not limited to the following: an occurrence/event, change in condition or medication, new move in, return from a hospital stay/ER visit, resident to resident altercation or other reason that affects a resident."

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

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(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

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Review of the facility's undated policy titled "Abuse, Neglect or Exploitation" showed staff were to "report the incident to your supervisor so a plan can be developed to protect the resident from further harm."

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Record review of facility investigation, dated 08/22/2025, showed that a staff member witnessed Resident 1 smack Resident 2's hand while they were walking to the dining room. In the documentation, the staff stated Resident 2 appeared "really scared".

Record review of Resident 1's progress notes, dated 07/29/2025 through 09/14/2025, showed no alert charting was started related to the facility's investigation.

Record review of Resident 2's progress notes, dated 06/14/2025 through 09/14/2025, showed no alert charting was started related to the facility's investigation.

In an interview on 09/04/2025 at 2:43 PM, Staff A, Assistant Executive Director, stated that there were currently no active interventions in place to avoid further harm to Resident 1.

In an interview on 09/04/2025 at 3:36 PM, Staff B, Executive Director, stated that after an incident of potential abuse, staff were expected to implement interventions to prevent further incidents. Staff B stated that no interventions were put in place to protect Resident 1. Staff B stated that following an incident, the expectation was for residents to be placed on alert monitoring. Staff B stated that neither Resident 1 nor Resident 2 were placed on alert monitoring.

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) 11/03/2025.

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

Administrator (or Representative) — Date: 9/29/2025

Record review of facility investigation, dated 08/22/2025, showed that a staff member witnessed Resident 1 smack Resident 2's hand while they were walking to the dining room. In the documentation, the staff stated Resident 2 appeared "really scared".

Record review of Resident 1's progress notes, dated 07/29/2025 through 09/14/2025, showed no alert charting was started related to the facility's investigation.

Record review of Resident 2's progress notes, dated 06/14/2025 through 09/14/2025, showed no alert charting was started related to the facility's investigation.

In an interview on 09/04/2025 at 2:43 PM, Staff A, Assistant Executive Director, stated that there were currently no active interventions in place to avoid further harm to Resident 1.

In an interview on 09/04/2025 at 3:38 PM, Staff B, Executive Director, stated that after an incident of potential abuse, staff were expected to implement interventions to prevent further incidents. Staff B stated that no interventions were put in place to protect Resident 1. Staff B stated that following an incident, the expectation was for residents to be placed on alert monitoring. Staff B stated that neither Resident 1 nor Resident 2 were placed on alert monitoring.

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

_____ _____

Administrator (or Representative) Date