STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Pacwest Kennewick, LLC
Parkview Estates
7820 W 6th Ave
Kennewick, WA 99336

RE: Parkview Estates License # 2025

Dear Administrator:

This letter addresses Compliance Determination(s) 71485 (Completion Date 01/15/2026) and 63830 (Completion Date 12/17/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/15/2026 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-2630-1-a, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

The Department staff who did the on-site verification:
Krista Connelly, Community Nurse Consultant

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Parkview Estates
Provider Type: Assisted Living Facility
License/Cert.#: 2025
Compliance Determination #: 63830
Intake ID: 189841
Investigator: Krista Connelly
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 08/08/2025 through 12/17/2025
Complainant Contact Date(s): 08/07/2025

Allegation(s):

1. The Identified Resident alleged they were handled roughly by two unidentified staff and sustained an injury.

Investigation Methods:

Sample:	Total residents: 120 Resident sample size: 2 Closed records sample size: 2
Observations:	Identified resident Residents Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

Observation showed the Identified Resident had four small circular bruises along their forearm. During an interview the Identified Resident stated they were sustained when two staff pulled on their hands and arms to get them out of bed. Interviews with the Identified Resident's representative showed the facility had not identified and reported the injury and the allegation that the injuries were sustained by staff. Staff interviews showed the facility licensed nurse was aware of the bruising and the allegation that the staff handled the Identified Resident roughly. The facility licensed staff stated they had not started an investigation into how the bruising occurred and had not made a call to the Department's Complaint Resolution Unit. Failed practice identified in WAC 388-78A-2630 and WAC 388-78A-2371.

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

1200 Alder Street, Union Gap, WA 98903

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 08/08/2025 of:

Parkview Estates
7820 W 6th Ave
Kennewick, WA 99336

This document references the following complaint number(s): 189841, 190899

The following sample was selected for review during the unannounced on-site visit: 2 of 120 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Krista Connelly, Community Nurse Consultant

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

Statement of Deficiencies	License #: 2025	Compliance Determination # 63830
Plan of Correction	Parkview Estates	Completion Date
Page 2 of 5	Licensee: Pacwest Kennewick, LLC	12/17/2025

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

Laura Williams-Davis
Residential Care Services

12/24/2025
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.

Sonya Y. Arnold
Administrator (or Representative)

12.29.2025
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interviews and record review, the assisted living facility (ALF) failed to ensure a report was made to the Complaint Resolution Unit (CRU) when residents alleged abuse by facility staff for 1 of 2 residents (Resident 1). This failure placed residents at risk of abuse or neglect.

Findings included...

Record review of the facility's policy titled, "Abuse/Neglect/Misappropriation," dated 05/2024, showed any allegations of or suspected abuse must be reported immediately to a supervisor and/or the Executive Director. The policy showed all facility employees were mandated reporters and they must immediately report abuse to the Washington Abuse Hotline with reasonable cause to believe an incident is abuse, neglect or substantial injuries of unknown source.

Review of Resident 1's care plan, dated 03/25/2025, showed the resident required physical assistance for bathing, toileting and moving from their bed or wheelchair.

Observation on 08/08/2025 at 1:00 PM, showed Resident 1 had bruising on their right

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Review of Resident 1's care plan, dated 03/25/2025, showed the resident required physical assistance for bathing, toileting and moving from their bed or wheelchair.

Observation on 08/08/2025 at 1:00 PM, showed Resident 1 had bruising on their right

forearm and hand.

In an interview on 08/08/2025 at 1:14 PM, Resident 1 stated two care staff pulled too tightly on their right arm and hand trying to get them up from bed a couple days ago. Resident 1 stated the staff held on too tightly to their right wrist and the next day their right hand and arm were black and blue.

During an interview on 08/08/2025 at 1:30 PM, Staff B, medication aide, reported the facility practice was to make a report to the Department of Social and Health Services (DSHS) Abuse Hotline [CRU] whenever they saw or suspected abuse or neglect. Staff B stated whenever they saw a resident with any kind of injury or skin issue, the facility practice was to report it to Staff A, Licensed Nurse/Wellness Director. Staff B reported it was the facility nurse that assessed any bruising, injuries, skin issues and investigated any allegations of abuse.

In an interview on 08/08/2025 at 2:12 PM, Staff A stated on 08/06/2025, the facility was notified Resident 1 had small bruises on their right forearm. Staff A stated they looked at the bruises and Resident 1 reported their arm was pulled on by unidentified care staff. Staff A stated they had not reported the injury of unknown source to the DSHS abuse hotline [CRU].

As of 12/15/2025, no report to CRU had been completed by the facility.

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Statement of Deficiencies	License #: 2025	Compliance Determination # 63830
Plan of Correction	Parkview Estates	Completion Date
Page 4 of 5	Licensee: Pacwest Kennewick, LLC	12/17/2025

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, Parkview Estates is or will be in compliance with this law and / or regulation on (Date) 1.7.2026 .

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

Sonya Y. Arnold — Administrator (or Representative)

12.29.2025 — Date

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

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility (ALF) failed to investigate and document an allegation of abuse for 1 of 2 residents (Resident 1). This failure placed the resident at risk of abuse.

Findings included...

Record review of the facility's policy titled, "Abuse/Neglect/Misappropriation," dated 05/2014, revised 08/2018 showed all allegations of abuse, neglect, misappropriation of resident property, and injuries of unknown source were thoroughly investigated to determine what occurred and make necessary changes to the provision of care and services to prevent reoccurrences. The policy showed the investigation first phase of the investigation must be completed withing 24 hours of knowledge of the incident and should begin as soon as the is identified and the alleged victim protected.

Review of Resident 1's care plan, dated 03/25/2025, that showed the resident required one staff assistance for transfers in/out of bed and directed the staff to use a gait belt (a transfer belt made of strong fabric placed around the resident's waist for the caregivers support and to protect the resident from injury). The care plan stated Resident 1 could be resistant if staff attempt to get Resident 1 out of bed before 10:00 AM.

Plan/Attestation Statement

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Administrator (or Representative) Date

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Page 5 of 5	Licensee: Pacwest Kennewick, LLC	12/17/2025

Observation on 08/08/2025 at 1:00 PM, showed Resident 1 had discolored areas on their right forearm and hand. On top of the forearm there was a circular, light red colored area with a slightly purple tinge on the bottom of the area. Above this area, and close to Resident 1's right elbow, there were two circular areas that were light red colored, and they were surrounded by fading colors of yellow. These areas were smaller in size than the larger area one on top of their forearm. The skin on top of Resident 1's right hand was thin, sagging and had an oblong area of redness at the base of their middle finger.

In an interview on 08/08/2025 at 1:14 PM, Resident 1 stated two care staff wanted to get them up early for breakfast and started pulling on both hands and arms a couple of days ago. The resident further stated they told the staff to stop because it hurt, but the two staff were talking to each other and did not hear the request. Resident 1 stated the two caregivers did not use any type of transfer belt, pulling instead on both of their arms and hands. Resident 1 stated they held on too tightly to their right wrist and the next day their right and arm were black and blue.

In an interview on 08/08/2025 at 2:12 PM, Staff A, Licensed Nurse/Wellness Director, confirmed on 08/06/2025 a nurse from an outside agency noted the bruising on a visit note dated 08/06/2025. Staff A stated they looked at the bruises and Resident 1 stated their arm was pulled on by unidentified care staff. Staff A stated they had not initiated an investigation into how the bruising occurred and could not explain why.

Record review on 12/17/2025 showed there was no documentation or investigation related to the bruising after staff were made aware.

Plan/Attestation Statement

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Administrator (or Representative) Sonya Y. Arnold Date 12.29.2025

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In an interview on 08/08/2025 at 2:12 PM, Staff A, Licensed Nurse/Wellness Director, confirmed on 08/06/2025 a nurse from an outside agency noted the bruising on a visit note dated 08/06/2025. Staff A stated they looked at the bruises and Resident 1 stated their arm was pulled on by unidentified care staff. Staff A stated they had not initiated an investigation into how the bruising occurred and could not explain why.

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