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

Cascade Living Group - Shelton, LLC
Alpine Way Retirement Apartments
900 W Alpine Way
Shelton, WA 98584

RE: Alpine Way Retirement Apartments License # 2141

Dear Administrator:

This letter addresses Compliance Determination(s) 66860 (Completion Date 10/08/2025) and 64415 (Completion Date 08/20/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/08/2025 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Alpine Way Retirement Apartments
License/Cert.#: 2141
Compliance Determination #: 64415
Investigator: Paul Aube
Investigation Date(s): 08/20/2025 through 08/20/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 191095
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Facility report of resident allegations of sexual abuse.

Investigation Methods:

Sample:	Total residents: 87 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Management
Record Reviews:	Facility policies Progress Notes Negotiated Service Agreements Temporary Service Plans

Investigation Summary:
Quality of Care/Treatment: Facility failed to conduct follow facility policy, and conduct investigation into incident once they became aware of incident. Failed Practice Identified.

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 08/20/2025 of:

Alpine Way Retirement Apartments
900 W Alpine Way
Shelton, WA 98584

This document references the following complaint number(s): 191095

The following sample was selected for review during the unannounced on-site visit: 2 of 87 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2141	Compliance Determination # 64415
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 2 of 4	Licensee: Cascade Living Group - Shelton, LLC	08/20/2025

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.

Clinton Fridley
Residential Care Services

09/03/2025
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)

9/10/2025
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;

This requirement was not met as evidenced by:

Based on record review and interview, the memory care facility failed to investigate, and document investigative actions/findings after becoming aware of an allegation of potential sexual abuse involving 2 of 2 residents reviewed, (Resident 1 [R1] and Resident 2 [R2]). This failure placed R1 at risk for ongoing sexual abuse.

Findings Included...

Review of the facility policy titled, "Abuse & Neglect" last reviewed on 09/2017, stated, "All alleged/suspected abandonment, abuse or neglect is investigated by the executive director or designee." Under "Definitions and Examples" it stated, "SEXUAL ABUSE is any form of non-consensual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment." Under "Procedure" it stated, "The associate initiates an Alleged Abuse Investigation Summary documenting the facts of the alleged incident and forwards it to the nurse on duty for resident assessment, completion of investigation and preventative measures... The executive director or designee determines the type of incident and:
- Immediately investigates the alleged/suspected abuse using the following guidelines:
- Conducts an interview with the wellness director or other manager.
- Conducts all interviews individually and in a private place.

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-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;

This requirement was not met as evidenced by:

Based on record review and interview, the memory care facility failed to investigate, and document investigative actions/findings after becoming aware of an allegation of potential sexual abuse involving 2 of 2 residents reviewed, (Resident 1 [R1] and Resident 2 [R2]). This failure placed R1 at risk for ongoing sexual abuse.

Findings Included…

Review of the facility policy titled, “Abuse & Neglect” last reviewed on 09/2017, stated, “All alleged/suspected abandonment, abuse or neglect is investigated by the executive director or designee.” Under “Definitions and Examples” it stated, “SEXUAL ABUSE is any form of non-consensual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment.” Under “Procedure” it stated, “The associate initiates an Alleged Abuse Investigation Summary documenting the facts of the alleged incident and forwards it to the nurse on duty for resident assessment, completion of investigation and preventative measures… The executive director or designee determines the type of incident and:
• Immediately investigates the alleged/suspected abuse using the following guidelines:
• Conducts an interview with the wellness director or other manager.
• Conducts all interviews individually and in a private place.

• Interviews the individual alleging the abuse, the resident, and other associates who were on duty at the time of the alleged/suspected abuse.
• Expands interviews as indicated to identify others who were potentially affected by the alleged event.
• Documents the interviews and maintains confidentiality of the information at all times."

Review of R1's face sheet showed that R1 was admitted to the facility on [redacted]/2025.

Review of R1's progress notes, dated 08/16/2025 at 4:35PM, documented "[R1] asked staff member, 'What do I do if my [spouse/R2] demands sex and I do not want to?'… Staff member reported this to nurse, which prompted the need to file a state report. State report filed…"

During an interview with Staff A, the Executive Director, and Staff B, on 08/20/2025 at 9:51AM, Staff A and Staff B were asked to discuss the outcome/progress of the investigation into the allegations/concerns made by R1 against R2. Staff A stated that they were not aware of the allegations. Staff B stated that they were aware of the statements made by R1 and stated that R1 was placed on alert monitoring by the facility. At this time, Staff A and Staff B were requested to provide incident reports, and all documents that were part of the investigation.

On 08/20/2025 at10:23AM, Staff A stated that they were unable to locate any incident reports for this incident, for both R1 and R2.

During an interview with Staff B on 08/20/2025 at 10:45AM, Staff B was asked if it was part of the facility process to complete Incident Reports for allegations of abuse made by any resident. Staff B stated, "Yes, we usually do an incident report. There should be incident reports for both residents, and a behavioral incident report for the [aggressor], and a Temporary Service Plan for both residents. We also have a binder at the desk; the state reports that are time sensitive go straight to the ED and [they go] through that every day." Staff B was asked if it was a normal part of the investigation process to interview residents and staff. Staff B confirmed that interviews with staff and residents were a normal part of the investigation. Staff B was asked if there was any investigation into this incident conducted by the facility, such as resident interviews, or staff interviews, etc. Staff B stated that they were unsure and would have to ask the nurse who filed the report. Staff B was asked if they were able to locate or provide any documentation of the investigation including resident interviews, staff interviews, a summary of investigation, or any other parts of the investigation into this incident. Staff B stated, "No, just the chart notes."

This is a recurring deficiency previously cited on 05/02/2024.

Statement of Deficiencies	License #: 2141	Compliance Determination # 64415
Plan of Correction	Alpine Way Retirement Apartments	Completion Date
Page 4 of 4	Licensee: Cascade Living Group - Shelton, LLC	08/20/2025

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, Alpine Way Retirement Apartments is or will be in compliance with this law and / or regulation on (Date) 10/2/2025 .

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

Administrator (or Representative) Trudy Hunter Date 9/10/25

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, Alpine Way Retirement Apartments 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