STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Caring Places Management, LLC
San Juan Villa
112 Castellano Way
Port Townsend, WA 98368

RE: San Juan Villa License # 2143

Dear Administrator:

This letter addresses Compliance Determination(s) 75193 (Completion Date 03/30/2026) and 72411 (Completion Date 02/03/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/30/2026 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-2660-1

The Department staff who did the on-site verification:
Phan Pham, Complaint Investigator

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

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: San Juan Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2143
Compliance Determination #: 72411
Intake ID: 210088
Investigator: Phan Pham
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 02/02/2026 through 02/03/2026
Complainant Contact Date(s):

Allegation(s):
Quality of care - Another resident allegedly was sleeping with the resident in the same bed.

Investigation Methods:

Sample:	Total residents: 32 Resident sample size: 4 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named residents, residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An on-site investigation was conducted, and the concerns related to abuse, quality of care and treatments were reviewed. The assisted living facility failed to report an incident to the resident's representative and physician in a timely manner. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

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

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HOME AND COMMUNITY LIVING ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 02/02/2026 of:

San Juan Villa
112 Castellano Way
Port Townsend, WA 98368

This document references the following complaint number(s): 210088, 210955, 211263

The following sample was selected for review during the unannounced on-site visit: 4 of 32 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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 RN
Residential Care Services

02/11/2026
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.

CSoule
Administrator (or Representative)

2-12-2026
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members notify and/or consulted with the resident's physician and representative in a timely manner in accordance with the Long-term care resident rights RCW 70.129.030(6)(a)(i)(ii) when the resident was found in a bed with another resident for 1 of 4 sampled residents (Resident 1) reviewed. This failure placed the resident at risk for abuse and services not being met.

Findings included...

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2025 with diagnoses including [redacted] and [redacted]. Review of Resident 1's undated negotiated service agreement (NSA) documented the resident was dependent on staff members for assistance with their activities of daily living. The resident had memory impairment and was able to communicate their needs.

On 02/2/2026 at 11:35 AM, Resident 1 was observed sitting in a chair in their room, neatly groomed and dressed. In an interview Resident 1 could not provide information related to the incident.

Review of an investigation report dated 01/22/2026 at 9:20 PM, documented Resident 1 was found in another resident's room. Resident 1 was sleeping in the same bed as the other resident and they were under covers. Resident 1 was wearing a shirt and in their underwear. The investigation report showed staff notified the resident's representative and physician on 01/25/2026 at 4:45 PM and 5:16 PM respectively.

In an interview on 02/02/2026 at 11:41 AM, Staff B, Caregiver, stated caregivers were responsible for immediately notifying incidents to the medication technician. Staff B said the medication technician was responsible for obtaining the evidence and notifying the resident's representative and physician.

In an interview on 02/02/2026 at 11:44 AM, Staff A, Resident Care Coordinator, said a caregiver found Resident 1 sleeping in another resident's bed and reported it to the medication technician. Staff A stated it was the medication technicians were trained to immediately notify the resident's representative and physician. Staff A said she notified the resident's representative and physician on 01/25/2026 when she became aware that they have not been notified.

In an interview at 11:55 AM, Staff C, Medication Technician, stated caregivers report incidents to the medication technicians and the medication technicians were responsible for initiating the investigation, gathering information and notifying the residents' representative and physician.

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, San Juan Villa is or will be in compliance with this law and / or regulation on (Date) 3-20-2026 .

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

Administrator (or Representative) — Date: 2-12-2026