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

Caring Places Management, LLC
Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

RE: Easthaven Villa License # 2144

Dear Administrator:

This letter addresses Compliance Determination(s) 63760 (Completion Date 08/06/2025) and 59558 (Completion Date 05/27/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/06/2025 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-2660-1, WAC 388-78A-2660-2, WAC 388-78A-2660-3, WAC 388-78A-2660-4, WAC 388-78A-2630-1, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Easthaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2144
Compliance Determination #: 59558
Intake ID: 177466
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 05/14/2025 through 05/27/2025
Complainant Contact Date(s):

Allegation(s):

Restraints/Seclusion - General: Facility report of a resident allegation of abuse from staff, including physically restraining the resident.

Investigation Methods:

Sample:
Total residents: 69
Resident sample size: 5
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
Residents

Record Reviews:
State reporting log
Incident investigation
Facility policies
Personnel files
Care plan
Progress Notes
Time sheets
Alert charting

Investigation Summary:

Restraints/Seclusion - General: Facility suspended employee pending investigation. Facility investigated incident and obtained witness statements that showed resident was physically restrained by staff during care. Failed Practice Identified.
Incident not reported timely to the Complaint Resolution Unit. Failed practice identified.

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

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 05/14/2025 and 05/27/2025 of:

Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

This document references the following complaint number(s): 177466, 178449

The following sample was selected for review during the unannounced on-site visit: 5 of 69 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support 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
Residential Care Services

06/06/2025
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.

Mary McNeely
Administrator (or Representative)

6/9/2025
Date

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

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff did not restrain a resident for 1 of 1 resident (Resident 1, [R1]) reviewed. This failure resulted in R1 being restrained, receiving a skin tear, experiencing fear and distress and a decreased quality of life.

WAC 388-78A-2020 Definitions. "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult, which have the following meanings... "Restraint" means any method or device used to prevent or limit free body movement..."

RCW 70.129.120 Restraints-Physical or chemical. "The resident has the right to be free from physical restraint or chemical restraint. This section does not require or prohibit facility staff from reviewing the judgment of the resident's physician in prescribing

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

06/06/2025
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)

Date

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RCW 70.129.120 Restraints-Physical or chemical. "The resident has the right to be free from physical restraint or chemical restraint. This section does not require or prohibit facility staff from reviewing the judgment of the resident's physician in prescribing

psychopharmacologic medications."

Review of a facility policy titled, "Abuse, Neglect and Exploitation," undated, showed, "This Community will not tolerate verbal, physical, mental or sexual abuse, including involuntary seclusion of any Resident by any staff member, other Resident or visitor to the Community. An injury of unknown cause will be investigated as potential abuse. Under the section, titled, "Procedures," showed:
1) Mandatory Reporting:
a) Any staff member who observes discoloration or other damage to the skin of unknown cause (including bruising, swelling, redness, or scratch marks) will proceed with reporting and investigation as if an incident of abuse has occurred unless such abuse can be immediately ruled out by conversation with the resident (if capable of cognitive response) or immediate interviews of other cognitive witnesses.
b) Any staff member who has a reasonable cause to believe that an incident of abuse, abandonment, neglect, or financial exploitation of a vulnerable adult has occurred will notify the following departments immediately:
In Oregon- Department of Human Services (DHS) Adult Protective Services & Elder Abuse Hotline: 1 -800 -232-3020
In Washington- Department of Social and Health Services (DSHS) Hotline: 1-800-562-6078 -OR- Online (Washington Only)
The staff member should also report the incident immediately to someone within community management.
c) Any staff member who has reason to suspect an incident of sexual or physical assault has occurred will report to the hotline 1-800-562-6078 and to the local law enforcement emergency services number as soon as the Resident is protected from further harm.
d) If the incident involves licensed professionals, a report should also be made to professional licensing within the Department of Health.
e) All staff members will receive training on abuse, neglect, and exploitation as well as the mandatory reporting requirements during orientation and periodically throughout the year. A statement of understanding will be placed in the employee file.
f) Any staff member who is suspected of abuse, neglect or exploitation will not have access to any Resident until the Facility investigates the incident and takes action to assume the safety of the Residents.

Record review of R1's face sheet, undated, showed that R1 was admitted to the facility on [redacted]/2022.

Review of Department Records showed that a report was received on 04/30/2025 at 4:41PM notifying the Department that a caregiver observed an incident on 04/28/2025 where a resident became combative when staff were performing care, and the Medication Technician (Med Tech) grabbed R1 from behind. The med tech held R1's arms downs. R1 tried to push the Med tech off of them. After the incident, R1 was seen with a small skin tear on the top of their hand that appeared to be sustained from when the Med Tech grabbed them.

Record review of a witness statement provided by Staff D, dated 04/28/2025, showed Staff D and Staff E went to R1's room to get them changed. Staff D and Staff E needed

additional help and Staff C was paged to assist. R1 was resistive and Staff C held R1 tighter and tugged on R1's hand/arm. Staff D stated that they saw Staff C grabbing R1 aggressively and appeared to be irritated/bothered by the situation. Staff D finished care with R1. Staff C, Staff D and Staff E reapproached R1 later in the day to provide care again to R1. Staff E was trying to take R1's clothing down to change R1's brief. Staff C began hugging R1 from behind. Staff [redacted] back was against the wall while restraining R1. R1 looked very angry, scared, and anxious because the way Staff C was restraining them. We completed care and while walking out, staff noticed bruises and Staff C stated they had already been there. R1 was seen shortly after with an open sore on their arm.

In an interview on 05/14/2025 at 11:14AM, Staff D stated R1 was crying and was really scared and was more aggressively fighting because they didn't want to be held.

Record review of a witness statement provided by Staff E, dated 04/28/2025, showed staff D and Staff E were trying to change R1 when R1 became aggressive. Staff D called for Staff C to assist. Staff C arrived and held R1's hand and arm. Staff finished care with R1. Staff C seemed annoyed and irritated with the situation. Staff C, Staff D, and Staff E reapproached later that day to change R1 after lunch. R1 became aggressive towards staff again. Staff C grabbed both of R1's hands while standing behind R1 and was holding R1 against their body. Staff C was holding R1 very rough and aggressive. As staff exited the room, bruising was noticed on R1's hands/wrists. Staff D brought the bruising to Staff C's attention and staff C stated the bruises had been there. Short time after the incident another staff member noticed a skin tear on R1.

Record review of the incident investigation, dated 4/28/2025, section titled "Analysis and Conclusion," showed, Staff C, Staff D and Staff E were assisting to change R1's clothes/brief. R1 became aggressive. Staff C stood behind R1 and hugged them from behind holding down R1's arms in a restraining manner. Staff reported that R1 was attempting to push Staff C off of them which likely caused the skin tear. While it does not seem that Staff C intentionally tried to harm R1, it is suspected abuse due to the restrictive way they held R1 with cares.

Record review of R1's progress notes, dated, 04/28/2025, showed Resident had a nickel sized skin tear on their left wrist. No active discharge but area is open.

In an interview on 05/14/2025 at 12:15PM, Staff B, stated Staff D and Staff E approached them and informed them that R1 sustained a skin tear caused by Staff C. Staff B stated Staff D and Staff E told them that Staff C had gone behind R1, wrapped their arms around R1 to restrain their arms and lifted them off the floor while fixing R1's pants.

In an interview on 05/14/2025 at 1:33PM, Staff F, Medication Technician, was asked what they would do if they witnessed a staff member holding a resident's arms so care could be provided, they stated they would report it to management and state because

physically holding someone is abuse.

In an interview on 05/14/2025 at 11:02AM, Staff G, Caregiver, was asked what the process was when they are changing a residents brief or clothes and they become combative, they stated they retry later and if they kept refusing then they would report to the med tech. Staff G stated if the med tech couldn't perform care then they would call the family of the resident for help. Staff G was asked if they would ever hold down a resident if they were being combative, they stated," no, never, that is a restraint."

In an interview on 05/14/2025 at 2:57PM, Staff A was asked if Staff C holding down the arms of R1 a restraint, they stated yes. Staff A was asked if physically restraining someone is abuse, they stated yes.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 7/11/25

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

Mary McNay — Administrator (or Representative)

6/9/25 — 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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff immediately reported alleged abuse to the department's Complaint Resolution Unit for 1 of 1 resident (Residents 1 [R1]) reviewed for incident reporting. This failure placed 69 of 69 residents at risk of unreported abuse and prevented the department and law

physically holding someone is abuse.

In an interview on 05/14/2025 at 11:02AM, Staff G, Caregiver, was asked what the process was when they are changing a residents brief or clothes and they become combative, they stated they retry later and if they kept refusing then they would report to the med tech. Staff G stated if the med tech couldn't perform care then they would call the family of the resident for help. Staff G was asked if they would ever hold down a resident if they were being combative, they stated," no, never, that is a restraint."

In an interview on 05/14/2025 at 2:57PM, Staff A was asked if Staff C holding down the arms of R1 a restraint, they stated yes. Staff A was asked if physically restraining someone is abuse, they stated yes.

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enforcement from evaluating facility systems in a timely manner.

Review of a facility policy titled, "Abuse, Neglect and Exploitation," undated, showed, "This Community will not tolerate verbal, physical, mental or sexual abuse, including involuntary seclusion of any Resident by any staff member, other Resident or visitor to the Community. An injury of unknown cause will be investigated as potential abuse. Under the section, titled, "Procedures," showed:
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Record review of R1's progress notes, dated, 04/28/2025, showed Resident had a nickel sized skin tear on their left wrist. No active discharge but area was open.

In an interview on 05/14/2025 at 10:42AM, Staff E, was asked what their process was when providing care to a resident and they become combative, they stated if the resident is saying no, we don't force them to do anything. Staff E stated they will try to reapproach or have someone else approach the resident. Staff E was asked if they would ever hold down a resident, they stated no. Staff E was asked if they have ever seen that and they stated they had. Staff E stated R1 got combative, and Staff C grabbed R1 from behind and wrapped their arms around R1 to hold her arms in place so they could finish putting on R1's brief. Staff E was asked if it was ok to hold down a resident to perform care, they stated no. Staff E was asked what they did. Staff E stated they reported it that day to Staff B and the med aid. Staff E was asked if R1 sustained any injuries, they stated R1 had a skin tear on their arm.

In an interview on 05/14/2025 at 1:33PM, Staff F, Medication Technician, was asked what they would do if they witnessed a staff member holding a resident's arms so care could be provided, they stated they would report it to management and state because physically holding someone is abuse.

In an interview on 05/14/2025 at 12:15PM, Staff B, Caregiver, was asked what the process was when a resident became combative when providing care, they stated they would wait and try again with a different caregiver. Staff B stated they would get the med tech to try or the Resident Care Coordinator. Staff B was asked if they would ever hold down a resident, they stated no, we are not allowed to restrain anyone. Staff B stated we are allowed to hold their hands gently, but they should never be grabbed from behind, that will scare them. Staff B was asked if they are aware of an incident like that happening, they stated they were. Staff B stated Staff D and Staff E approached them that day it happened and told them that R1 had a skin tear caused by Staff C. Staff B stated that Staff D and Staff E told them that Staff C had gone behind R1 and wrapped their arms around R1 to restrain their arms. Staff B stated they were told the day it happened but waited to the next day (04/29/2025) to report it to Staff A in person.

Record review of an email sent to the department, on 05/21/2025 at 1:25PM, Staff A stated, the incident occurred on 04/28/2025 and they were notified of the incident on 04/30/2025. Staff A stated Staff C did not work past 04/30/2025.

In an interview on 05/14/2025 at 1:50PM, Staff A stated Staff C completed abuse/neglect training and mandatory reporting training.

In an interview on 05/14/2025 at 11:02AM, Staff G, Caregiver, was asked what the process was when they are changing a residents brief or clothes and they become combative, they stated they retry later and if they kept refusing then they would report to the med tech. Staff G stated if the med tech couldn't perform care then they would call the family of the resident for help. Staff G was asked if they would ever hold down a resident if they were being combative, they stated, no never, that is a restraint. Staff G

was asked what they would do if they witnessed that, they stated they would let Administration, and the med tech know immediately. Staff G stated they could call the state hotline and do a report as well.

In an interview on 05/14/2025 at 9:47AM, Staff A, Executive Director, was asked what was expected of staff if they were to witness another staff member physically restraining a resident, they stated they were to report it to us. Staff A stated they expect their staff to mandatory report but 90% of the time the caregivers aren't comfortable doing so. Staff A was asked why staff didn't report it to management on the date of the incident, they stated they didn't know. Staff A was asked if the incident should have been reported on 04/28/2025, they stated yes immediately. Staff A was asked what the process was when staff report seeing another staff member restrain a resident, they stated they would take witness statements and send that person who is suspected of the abuse home. Staff A was asked if Staff C worked on 04/29/2025, they stated they didn't know.

Record review of time sheets for Staff C showed:
04/28/2025- 5:52AM- 2:23PM
04/29/2025- 6:03AM -2:14PM
04/30/2025- 6:02AM-2:02PM

In an interview on 05/14/2025 at 2:57PM, Staff A was asked if Staff C holding down the arms of R1 a restraint, they stated yes. Staff A was asked if physically restraining someone abuse, they stated yes. Staff A was asked how soon this incident should have been reported to the Complaint Resolution Unit, they stated it should have been reported within 24 hours, but as soon as possible. Staff A was asked if the facility policy states to report allegations of abuse, they stated yes. Staff A was asked if Staff C should have been taken off the schedule sooner, they stated yes.

This is a recurring deficiency previously cited on 08/05/2024 and 02/22/2023

Statement of Deficiencies	License # 2144	Compliance Determination # 53558
Plan of Correction	Easthaven Villa	Completion Date
Page 9 of 9	Licensee: Caring Places Management, LLC	05/27/2025

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 7/11/25.

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

Administrator (or Representative) — Date: 6/9/2025

Plan/Attestation Statement

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Administrator (or Representative) Date