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

02/27/2026

Caring Places Management, LLC
Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

RE: Westhaven Villa # 2152

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 73603 (Completion Date 02/27/2026) and 71155 (Completion Date 01/08/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/27/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

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 RN
Clinton Fridley, Community Nurse Field Manager

Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Westhaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2152
Compliance Determination #: 71155
Intake ID: 207918
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/08/2026 through 01/08/2026
Complainant Contact Date(s):

Allegation(s):
Death – General: Facility report of an unexpected resident death in the community.

Investigation Methods:

Sample:
Total residents: 28
Resident sample size: 3
Closed records sample size: 1

Observations:
Residents
Activities
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Management

Record Reviews:
Incident investigation
Facility policies
Medical records
Negotiated Service Plans
Temporary Service Plans
Progress Notes/Alert Charting
Staff training records

Investigation Summary:
Death – General: Facility failed to provide life saving measures per policy. 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 01/08/2026 of:

Westhaven Villa
1000 Anderson Dr
Aberdeen, WA 98520

This document references the following complaint number(s): 205332, 207918

The following sample was selected for review during the unannounced on-site visit: 3 of 28 current residents and 1 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 #: 2152	Compliance Determination # 71155
Plan of Correction	Westhaven Villa	Completion Date
Page 2 of 3	Licensee: Caring Places Management, LLC	01/08/2026

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

01/15/2026
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.

Administrator (or Representative)

1/22/26
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff followed their policy and training as it relates to actions staff must take when 1 of 1 residents (Resident 1 (R1)) was found unresponsive and not breathing. This failure resulted in staff not initiating cardiopulmonary resuscitation when a resident was found with no heartbeat.

Findings included...

Record review of an undated facility policy titled, "Cardiopulmonary Resuscitation (CPR) and End of Life," stated that when a resident is found not responsive or has no heartbeat that staff are to call 911, the nursing supervisor, or hospice (if the resident is on hospice care), to get emergency help and if the resident's Physician's Orders for Life Sustaining Treatment form (POLST) indicates "Yes CPR" or a POLST has not been provided, that they are to initiate CPR.

Record review of Department records showed that the facility made a notification to the Department of R1's unexpected death on [redacted]/2026.

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

01/15/2026
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.

Administrator (or Representative)

Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff followed their policy and training as it relates to actions staff must take when 1 of 1 residents (Resident 1 (R1)) was found unresponsive and not breathing. This failure resulted in staff not initiating cardiopulmonary resuscitation when a resident was found with no heartbeat.

Findings included...

Record review of an undated facility policy titled, “Cardiopulmonary Resuscitation (CPR) and End of Life,” stated that when a resident is found not responsive or has no heartbeat that staff are to call 911, the nursing supervisor, or hospice (if the resident is on hospice care), to get emergency help and if the resident's Physician’s Orders for Life Sustaining Treatment form (POLST) indicates "Yes CPR" or a POLST has not been provided, that they are to initiate CPR.

Record review of Department records showed that the facility made a notification to the Department of R1’s unexpected death on [redacted]/2026.

Statement of Deficiencies	License #: 2152	Compliance Determination # 71155
Plan of Correction	Westhaven Villa	Completion Date
Page 3 of 3	Licensee: Caring Places Management, LLC	01/08/2026

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

Record review of R1's POLST form, dated [redacted]/2025, stated in large bold letters, "NO POLST." Under this in smaller text it stated, "POA/Guardian has not provided a POLST form." In the center of the page in large bold letters it stated, "Resident Status is Full Code."

Record review of R1's progress notes, dated [redacted]/2026, stated, "Caregiver went in to do breakfast reminders around 7:15am and the lights were off. [R1's spouse, who lives in same apartment with resident] stated that they were doing a room tray. Caregiver exited the apartment [they] returned around 8:30 am with their room trays [and] turned on the lights and observed [R1] in [their] recliner next to [R1's spouse]. [R1] appeared pale in color and [their] feet were straight out in front of [them]. [Caregiver] touched [R1] and attempted to wake [them] but [they were] cold and [their] body was stiff. [Caregiver] exited apartment and radioed Med Aide who immediately called 911 then the RCC [Resident Care Coordinator]. RCC notified RN [Registered Nurse] and the covering administrator."

During an interview with Staff A, the Resident Care Coordinator, on 01/08/2026 at 1:15PM, when Staff A was asked what R1's Code Status was, Staff A stated that R1 was a Full Code. Staff A was asked if the facility staff checked if R1 had a pulse and initiated CPR after finding the R1 unresponsive. Staff A stated that they did not perform CPR and only called 911 and made notifications to administration. When asked why CPR was not initiated per facility policy Staff A stated that the situation was hectic, and due to the state R1 was found, the Medication Aide thought it was too late. When asked if it was within the Medication Aide's scope of practice to call time of death of a resident, Staff A stated it was not within their scope. When asked if CPR should have been initiated Staff A stated, "Legally, 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, Westhaven Villa is or will be in compliance with this law and / or regulation on (Date) 2/13/26 .

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

Administrator (or Representative) — Date: 1/22/26

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

Record review of R1's POLST form, dated [redacted]/2025, stated in large bold letters, "NO POLST." Under this in smaller text it stated, "POA/Guardian has not provided a POLST form." In the center of the page in large bold letters it stated, "Resident Status is Full Code."

Record review of R1's progress notes, dated [redacted]/2026, stated, "Caregiver went in to do breakfast reminders around 7:15am and the lights were off. [R1's spouse, who lives in same apartment with resident] stated that they were doing a room tray. Caregiver exited the apartment [they] returned around 8:30 am with their room trays [and] turned on the lights and observed [R1] in [their] recliner next to [R1's spouse]. [R1] appeared pale in color and [their] feet were straight out in front of [them]. [Caregiver] touched [R1] and attempted to wake [them] but [they were] cold and [their] body was stiff. [Caregiver] exited apartment and radioed Med Aide who immediately called 911 then the RCC [Resident Care Coordinator]. RCC notified RN [Registered Nurse] and the covering administrator."

During an interview with Staff A, the Resident Care Coordinator, on 01/08/2026 at 1:15PM, when Staff A was asked what R1's Code Status was, Staff A stated that R1 was a Full Code. Staff A was asked if the facility staff checked if R1 had a pulse and initiated CPR after finding the R1 unresponsive. Staff A stated that they did not perform CPR and only called 911 and made notifications to administration. When asked why CPR was not initiated per facility policy Staff A stated that the situation was hectic, and due to the state R1 was found, the Medication Aide thought it was too late. When asked if it was within the Medication Aide's scope of practice to call time of death of a resident, Staff A stated it was not within their scope. When asked if CPR should have been initiated Staff A stated, "Legally, 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, Westhaven Villa 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