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

03/17/2026

CHP Longview-Monticello Park WA Tenant Corp
Prestige Senior Living Monticello Park
605 Broadway St
Longview, WA 98632

RE: Prestige Senior Living Monticello Park # 2238

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 72953 (Completion Date 03/17/2026) and 70299 (Completion Date 01/21/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/17/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

The Department staff who did the On Site verification:
Jacob Ubl, ALF NCI CI

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

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 follow-up on 12/16/2025 and 01/21/2026 of:

Prestige Senior Living Monticello Park
605 Broadway St
Longview, WA 98632

This document references the following SOD dated: 01/21/2026

The following sample was selected for review during the unannounced on-site visit: 3 of 88 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

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

01/28/2026
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)

2/5/26
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the residents physician and representatives when the resident had an incident resulting in a change in condition, resulting in hospitalization, for 1 of 3 sampled residents (Resident 1). This failure resulted in the resident's physician and representatives not being notified.

Findings included...

Record review of an undated facility protocol titled, "Incident Checklist," showed that after a resident incident, staff were to notify the residents physician and representative(s).

Record review of an undated face sheet showed Resident 1 (R1) admitted to the facility

on [redacted]/2025.

Record review showed that R1 returned to the facility, after hospitalization for a fall, on [redacted]/2025 and there was documentation that R1's physician or representative had been notified of the incident.

The facility was unable to provide a record to show the date that R1's fall occurred and if R1's physician or representative was notified of the fall.

In an interview on 12/16/2025 at 1:02 PM, R1 reported that they had returned from the hospital on [redacted]/2025 after a fall at the facility on [redacted]/2025. R1 reported not knowing if the facility notified their representative or physician of the fall.

Record review of email received on 12/18/2025 at 4:48 PM, from Staff B, Health Services Director, showed Staff B stated that when R1 returned from the hospital on [redacted]/2025, R1's fall and hospitalization dates were not documented at the facility and there was no documentation to show if the appropriate parties were notified of R1's fall and hospitalization.

In an interview on 01/21/2026 at 1:27 PM, Staff A, Executive Director, reported that the facility failed to notify R1's physician and representatives of R1's fall and hospitalization on [redacted]/2025. Staff A reported that this failure was unacceptable as their expectation was for staff to notify appropriate parties as soon as possible and document those notifications in an incident report. Staff A reported not knowing why facility staff failed to follow through as the facility had provided education on appropriate follow though, facility staff had demonstrated understanding and know better. Staff A reported the facility staff "must have just missed it" and that they were unable to explain why and how the failure occurred.

This is an uncorrected deficiency previously cited on 10/29/2025.

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, Prestige Senior Living Monticello Park is or will be in compliance with this law and / or regulation on (Date) 2/9/26 .

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

Administrator (or Representative) — Date: 2/5/26

Residential Care Services
Investigation Summary Report

Provider/Facility: Prestige Senior Living Monticello Park
License/Cert.#: 2238
Compliance Determination #: 67320
Investigator: Jacob Ubl
Investigation Date(s): 10/15/2025 through 10/29/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 197963
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Quality of Care/Treatment: Allegation that the facility did not respond to the Resident Alleged Victim's incident appropriately.

2. Physical Environment: Allegation that the facility call light malfunctioned when the Resident Alleged Victim activated it.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Residents Family members Maintenance staff
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:

1. Quality of Care/Treatment: Failed practice identified. The facility failed to notify appropriate parties after the Resident Alleged Victim's incident.

2. Physical Environment: The facility had trained caregivers to minimize and avoid a similar incident, investigated the incident, protected the residents, assessed the residents, updated resident's care plans, increased frequency of resident checks,

implemented interventions to decrease the risk of incident reoccurring, staff are aware of interventions, and an incident of similar nature did not reoccurred before the day of investigation. No 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 10/15/2025 and 10/29/2025 of:

Prestige Senior Living Monticello Park
605 Broadway St
Longview, WA 98632

This document references the following complaint number(s): 197963, 195408

The following sample was selected for review during the unannounced on-site visit: 3 of 88 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

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 RN
Residential Care Services

10/30/2025
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)

10/30/25
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the residents physician and representatives for 1 of 3 sampled residents (Resident 1) when the resident had an incident resulting in a change in condition. This failure resulted in the resident's physician and representatives not being able to make a decision about the resident's care and placed the resident at risk of unmet care needs and psychological harm.

Findings included...

Record review of an undated facility protocol titled, "Incident Checklist", showed that, after a resident incident, staff were to notify the residents physician and representatives.

Record review of an undated face sheet showed Resident 1 (R1) was admitted to the facility on [redacted]/2025 with a diagnosis of [redacted].

Record review showed that R1 had a fall incident, 08/03/2025, and R1's physician and representatives were not notified of the incident.

The facility was unable to provide a record to show that R1's physician and representatives were notified of R1's fall incident on 08/03/2025.

In an interview on 10/15/2025 at 12:41 PM, R1 reported that they had a fall in August and the facility failed to notify their representatives of the fall. R1 reported that they decided to move to another residence because they couldn't trust the facility after the failure. R1 reported that the failure caused them great stress and was upsetting.

In an interview on 10/16/2025 at 2:44 PM, Collateral Contact 1 (CC1), reported that the facility failed to notify R1's representatives of R1's fall incident on 08/03/2025. CC1 reported that the facility failure caused R1 a lot of stress, anxiety, and they were upset. CC1 reported that the facility failure caused R1 to feel the need to move to another residence as their trust in the facility was lost.

In an interview on 10/16/2025 at 4:11 PM, Collateral Contact 2 (CC2), reported that the facility failed to notify R1's representatives of R1's fall incident on 08/03/2025. CC2 reported that the facility failure caused R1 to feel disappointed and that the facility let them down. CC2 reported that the facility failure caused R1 to feel the need to move to another residence as R1 did not feel safe to remain at the facility. CC2 reported that the facility never gave them an adequate explanation for why the failure happened or how the facility intended to fix it, leaving them and R1 frustrated.

In an interview on 10/17/2025 at 2:04 PM, Staff B, heath services director, reported that the facility failed to notify R1's physician and representatives of R1's fall incident on 08/03/2025.

In an interview on 10/17/2025 at 2:04 PM, Staff C, residential care coordinator, reported that the facility failed to notify R1's physician and representatives of R1's fall incident on 08/03/2025.

In an interview on 10/29/2025 at 3:55 PM, Staff A, executive director, reported that the facility failed to notify R1's physician and representatives of R1's fall incident on 08/03/2025. Staff A reported that this failure was unacceptable as their expectation was for staff to notify appropriate parties as soon as possible and document those notifications in the incident report.

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, Prestige Senior Living Monticello Park is or will be in compliance with this law and / or regulation on (Date) 11/10/25 .

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

Administrator (or Representative)

10/30/25
Date