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

Pioneer Street LLC
Ridgefield Living Center
104 Pioneer St
Ridgefield, WA 98642

RE: Ridgefield Living Center License # 2252

Dear Administrator:

This letter addresses Compliance Determination(s) 70847 (Completion Date 12/31/2025) and 70531 (Completion Date 12/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/31/2025 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-2650, WAC 388-78A-2650-1, WAC 388-78A-2650-2, WAC 388-78A-2650-3

The Department staff who did the off-site verification:
Clinton Fridley, Community Nurse Field Manager

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: Ridgefield Living Center
Provider Type: Assisted Living Facility

License/Cert.#: 2252
Intake ID: 206209
Compliance Determination #: 70531
Region/Unit #: RCS Region 3 / Unit E
Investigator: Clinton Fridley
Investigation Date(s): 12/22/2025 through 12/23/2025
Complainant Contact Date(s):

Allegation(s):

1. Physical Environment: furnace overheated due to failure of fan - caused melting of some wires and smoke.
2. Life Safety Code: evacuation of the facility due smoke discovered because of smell of burning wires.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 2 Closed records sample size: 0
Observations:	facility common areas
Interviews:	executive director assistant executive director caregiver medication technician residents
Record Reviews:	resident characteristics roster incident report

Investigation Summary:

1. Physical Environment: facility responded appropriately, furnace does not serve resident sleeping areas so no impact to residents, repairs underway, unable to substantiate failed practice.
2. Life Safety Code: facilities evacuation processes followed and no concerns with execution or planning in relation to the possible fire, facility failed to report to the department immediately, as required, 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 12/22/2025 of:

Ridgefield Living Center
104 Pioneer St
Ridgefield, WA 98642

This document references the following complaint number(s): 206209

The following sample was selected for review during the unannounced on-site visit: 2 of 33 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Clinton Fridley, Community Nurse Field Manager

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 #: 2252	Compliance Determination #70531
Plan of Correction	Ridgefield Living Center	Completion Date
Page 2 of 3	Licensee: Pioneer Street LLC	12/23/2026

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

12/23/2025
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.

Sophie Swindell
Administrator (or Representative)

12/31/2025
Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the assisted living facility;

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address, and

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility did not immediately report to the Department, as required, when staff evacuated the facility after discovering something burning and saw smoke for 1 of 1 assisted living facilities. This failure resulted in the Department not being aware residents were evacuated and placed them at risk for harm.

Findings included...

Record review of facility document titled, "RCL INCIDENT REPORT," undated, documented that on 12/11/2025 at 8:30 PM, in the "basement/boiler room", staff reported smelling burning and seeing smoke coming from neighboring boiler room, alerted other staff, called 911 and all three staff on duty evacuated the residents out of the building.

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-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the assisted living facility;

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility did not immediately report to the Department, as required, when staff evacuated the facility after discovering something burning and saw smoke for 1 of 1 assisted living facilities. This failure resulted in the Department not being aware residents were evacuated and placed them at risk for harm.

Findings included…

Record review of facility document titled, “RCL INCIDENT REPORT,” undated, documented that on 12/11/2025 at 6:30 PM, in the “basement/boiler room”, staff reported smelling burning and seeing smoke coming from neighboring boiler room, alerted other staff, called 911 and all three staff on duty evacuated the residents out of the building.

Statement of Deficiencies	License #: 2252	Compliance Determination #706531
Plan of Correction	Ridgefield Living Center	Completion Date
Page 3 of 3	Licensee: Pioneer Street LLC	12/23/2025

On 12/22/2025 at 3:31 PM, Staff B, Assistant Executive Director, stated that the facility had to evacuate residents on 12/11/2025 due to staff discovering the smell of something burning and seeing smoke. Staff B stated that normally they would notify the Department immediately via the complaint hotline.

On 12/22/2025 at 3:53 PM, Staff A, Executive Director, stated that normally they notify the Department right away but stated they forgot to report immediately. Staff A stated that once they remembered it wasn't reported, they notified the Department.

On 12/23/2025 at 2:05 PM, review of Department records showed that, on 12/22/2025 at 12:33 PM, the facility reported the 12/11/2025 incident.

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, Ridgefield Living Center is or will be in compliance with this law and / or regulation on (Date) 12/31/2025.

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

Leslie Saundell — Administrator (or Representative)

12/31/2025 — Date

On 12/22/2025 at 3:31 PM, Staff B, Assistant Executive Director, stated that the facility had to evacuate residents on 12/11/2025 due to staff discovering the smell of something burning and seeing smoke. Staff B stated that normally they would notify the Department immediately via the complaint hotline.

On 12/22/2025 at 3:55 PM, Staff A, Executive Director, stated that normally they notify the Department right away but stated they forgot to report immediately. Staff A stated that once they remembered it wasn't reported, they notified the Department.

On 12/23/2025 at 2:05 PM, review of Department records showed that, on 12/22/2025 at 12:33 PM. the facility reported the 12/11/2025 incident.

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, Ridgefield Living Center 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