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

Park View Villas, LLC
Park View Villas
2020 A St Se Ste 101
Auburn, WA 98002

RE: Park View Villas License # 2332

Dear Administrator:

This letter addresses Compliance Determination(s) 73471 (Completion Date 02/23/2026) and 71755 (Completion Date 01/20/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/23/2026 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-2130-1-c

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: Park View Villas
Provider Type: Assisted Living Facility
License/Cert.#: 2332
Compliance Determination #: 71755
Intake ID: 205994
Investigator: Phan Pham
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 01/20/2026 through 01/20/2026
Complainant Contact Date(s):

Allegation(s):
Quality of care - Named resident fell and sustained a hip fracture.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 2 Closed records sample size: 2
Observations:	Residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	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 fall with fracture/injury, quality of care and treatments were reviewed. The assistant living facility failed to ensure interventions to prevent repeated falls were in placed in a timely manner for one sampled resident. 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

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 01/20/2026 of:

Park View Villas
1430 Park View Lane
Port Angeles, WA 98363

This document references the following complaint number(s): 205994, 207015

The following sample was selected for review during the unannounced on-site visit: 2 of 40 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, 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 RN
Residential Care Services

01/23/2026
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)

1/27/26
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assistant living facility failed to ensure interventions to prevent repeated falls were in placed in a timely manner for 1 of 4 (Resident 1) sampled residents reviewed. This failure resulted in the resident having additional falls and sustained head injuries that required hospital visits which placed the resident at the likelihood for harm and services not being met.

Findings included...

Review of Resident 1's face sheet showed the resident admitted to the facility on [redacted]/2025 and no medical diagnoses were documented in the resident's record. Review of Resident 1's negotiated service agreement (NSA), dated 12/18/2025, documented the resident was a fall risk, dependent on staff members for assistance with their activities of daily living, transfers, and toileting. The resident was able to make their needs known. The NSA did not specify how often the resident was to be assisted with toileting.

On 01/20/2026 at 4:11 PM, the resident was observed sitting in a chair in their room,

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-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assistant living facility failed to ensure interventions to prevent repeated falls were in placed in a timely manner for 1 of 4 (Resident 1) sampled residents reviewed. This failure resulted in the resident having additional falls and sustained head injuries that required hospital visits which placed the resident at the likelihood for harm and services not being met.

Findings included...

Review of Resident 1‘s face sheet showed the resident admitted to the facility on [redacted]/2025 and no medical diagnoses were documented in the resident’s record. Review of Resident 1’s negotiated service agreement (NSA), dated 12/18/2025, documented the resident was a fall risk, dependent on staff members for assistance with their activities of daily living, transfers, and toileting. The resident was able to make their needs known. The NSA did not specify how often the resident was to be assisted with toileting.

On 01/20/2026 at 4:11 PM, the resident was observed sitting in a chair in their room,

neatly groomed and dressed. Resident 1 stated they had lost balance momentarily and fell. The resident said staff had checked them twice at night and once or twice during the day. The resident stated they needed staff assistance to go to the bathroom.

Review of an unusual occurrence and investigation report dated 12/25/2025 at 7:50 PM, documented the resident stood up, lost their footing and landed on their bottom. The resident had discomfort with their buttocks.

An unusual occurrence and investigation report dated 12/31/2025 at 6:20 PM, documented the resident was walking toward their bed when they fell. The resident said their right shoulder hurt and was not able to recall what happened. The resident's mobility status had changed.

An unusual occurrence and investigation report dated 01/01/2026 at 5:15 AM, documented the resident was found sitting against their bed. The resident said they had gotten up, walked, then hit the floor. A fax to the resident's provider documented the resident had a fall sometime very early on 01/01/2026 and was discovered at 5:15 AM. Staff found a gash on the back of the resident's head. The resident was transported to the hospital.

Review of the hospital record dated 01/01/2026, Resident 1 was seen at the hospital for a fall and diagnosed with [redacted].

An unusual occurrence and investigation report dated 01/01/2026 at 6:02 PM, documented that the resident had fallen in the bathroom and hit their head on the bathroom door. The resident was transported to the hospital for evaluation. Staff documented the resident had weakness/fatigue and changed in their mobility status. A fax to the resident's provider dated 01/01/2026 staff documented the resident had three falls in less than 24 hours.

An unusual occurrence and investigation report dated 01/02/2026 at 1:35 AM, documented the resident was found on the floor in their room. The resident went to toilet without assistance and fell while attempting to walk back to their bed. The resident sustained redness and bruised their forehead. The resident had just returned from the hospital. The resident had weakness/fatigue and changed in mental, health and mobility status.

Despite staff documented Resident 1 had a chang in their mobility status on 12/31/2025, Resident 1 had three additional falls occur on 01/01/2026 at 5:15 AM, 01/01/2026 at 6:02 PM, and 01/02/2026 at 1:35 AM, the interventions to prevent falls were not in placed until 01/02/2026.

In an interview on 01/20/2026 at 3:27 PM, Staff C, Caregiver, stated Resident 1 needed

assistance to transfers and escort to the bathroom and staff members were responsible for assisting the resident. Staff C said residents NSAs had interventions related to the care and services required. Staff C stated temporary service plans (TSP) were normally generated when a resident returned from a hospital visit. Staff C said staff members were to follow the NSA when assigned to assist residents.

In an interview on 01/20/2026 at 3:49 PM, Staff B, Resident Care Supervisor, said Resident 1 needed help with her activities of daily living, transfers and toileting. Staff B stated TSPs were initiated when residents had a health decline and/or needed more services and/or assistance. Staff B said any staff member was able to initiate a TSP and notify the ED that a TSP had been initiated. Staff B stated TSP should have been initiated immediately for Resident 1 after the fall on 12/31/2025. Staff B said staff members were verbally informed when a TSP had been initiated. Staff B stated staff members were responsible for reviewing and following the TSP when assigned to assist the resident. Staff B said they did not know why interventions to prevent additional falls for Resident 1 were not in placed until 01/02/2026.

In an interview on 01/20/2026 at 4:28 PM, Staff A, Executive Director, stated TSPs were initiated when residents had changed in condition and/or after an incident. Staff A said the TSPs had short-term interventions to prevent similar incidents from recurring and/or falls. Staff A stated any staff member was able to initiate a TSP and inform Staff A that a TSP had been initiated. Staff A said staff were verbally notified to review the TSPs that were placed in the communication book. Staff A stated they reviewed Resident 1 fall incident reports on 01/02/2026 and initiated the TSP. Staff A said Resident 1 did not have a fall since the TSP was initiated and may have prevented the resident from falling if the TSP was initiated earlier.

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, Park View Villas is or will be in compliance with this law and / or regulation on (Date) 2/5/26.

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

Administrator (or Representative)

1/27/26
Date

assistance to transfers and escort to the bathroom and staff members were responsible for assisting the resident. Staff C said residents NSAs had interventions related to the care and services required. Staff C stated temporary service plans (TSP) were normally generated when a resident returned from a hospital visit. Staff C said staff members were to follow the NSA when assigned to assist residents.

In an interview on 01/20/2026 at 3:49 PM, Staff B, Resident Care Supervisor, said Resident 1 needed help with her activities of daily living, transfers and toileting. Staff B stated TSPs were initiated when residents had a health decline and/or needed more services and/or assistance. Staff B said any staff member was able to initiate a TSP and notify the ED that a TSP had been initiated. Staff B stated TSP should have been initiated immediately for Resident 1 after the fall on 12/31/2025. Staff B said staff members were verbally informed when a TSP had been initiated. Staff B stated staff members were responsible for reviewing and following the TSP when assigned to assist the resident. Staff B said they did not know why interventions to prevent additional falls for Resident 1 were not in placed until 01/02/2026.

In an interview on 01/20/2026 at 4:28 PM, Staff A, Executive Director, stated TSPs were initiated when residents had changed in condition and/or after an incident. Staff A said the TSPs had short-term interventions to prevent similar incidents from recurring and/or falls. Staff A stated any staff member was able to initiate a TSP and inform Staff A that a TSP had been initiated. Staff A said staff were verbally notified to review the TSPs that were placed in the communication book. Staff A stated they reviewed Resident 1 fall incident reports on 01/02/2026 and initiated the TSP. Staff A said Resident 1 did not have a fall since the TSP was initiated and may have prevented the resident from falling if the TSP was initiated earlier.

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, Park View Villas 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