STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

11/17/2025

Pine Ridge OpCo LLC
Pine Ridge Alzheimer's Special Care Center
12009 E Mission Ave
Spokane Valley, WA 99206

RE: Pine Ridge Alzheimer's Special Care Center # 2513

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 68777 (Completion Date 11/17/2025) and 65667 (Completion Date 10/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/17/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

The Department staff who did the On Site verification:
Sandra Fast, Community Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Pine Ridge Alzheimer's Special Care Center
License/Cert.#: 2513
Compliance Determination #: 65667
Investigator: Sandra Fast
Provider Type: Assisted Living Facility
Intake ID: 191324
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 09/16/2025 through 10/01/2025
Complainant Contact Date(s): 09/04/2025, 10/07/2025

Allegation(s):

1. A resident's call light and phone calls were allegedly ignored by nursing staff.
2. The facility allegedly almost never had resident supplies (gloves, briefs, wipes and soaps).
3. The facility allegedly did not document resident or staff incidents.
4. Alleged insufficient nursing staff for resident cares.
5. Resident cares and services not being done or documented.
6. Wheelchairs/footrests allegedly used as a restraining device/s.
7. Schedules allegedly not posted or updated.
8. Staff documents not asked for/kept up to date.
9. Alleged lack of qualified leadership in building.
10. The facility allegedly did not use agency staff to supplement the schedules.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Therapy staff
Record Reviews:	Medical records Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:

1. Resident were observed with call pendants that were in working order. All caregivers interviewed stated that they had not heard about residents' call lights/calls being ignored by staff. All residents observed with a call pendent had no complaints of their calls not being answered by staff. All staff observed were rounding on residents and assisting them as needed. No failed facility practice was identified.

2. The leadership staff further stated that back up gloves were available in the facility's supply closet. The resident closets and bathrooms observed and had no gloves available. The facility's supply closet was observed and had no gloves available. Sampled staff interviewed stated no glove availability in resident rooms and the supply closet. Failed facility practice was identified according to Washington Administrative Code (WAC) 388-78a-2610(2)(c)(ii)

3. Documents reviewed showed that investigations were conducted by the facility for safety issues or injuries that arose regarding sampled residents. All staff interviewed stated that resident related issues were reported to the Medication Technicians or to the Health Services Coordinator who investigated the concerns. The facility kept a log of all residents' incidents and investigations. All Staff interviewed further stated no concerns regarding suspecting or witnessing unsafe resident transfers while on duty. Staff interviewed stated that the facility encouraged staff to file a claim with the Department of Labor and Industries (L&I) if an injury was sustained while on duty. A referral was made to the Department of L&I for concerns that were not regulated by Residential Care Services. No failed facility practice was identified.

4. All sampled nursing staff interviewed expressed no concerns regarding staffing. The sampled nursing staff further stated that they were able to complete all the tasks that they were assigned during their shift. All sampled residents were well groomed, in fresh clothing, had no lingering odors and showed no signs of distress. A referral was made to the Department of L&I for concerns not regulated by Residential Care Services. No failed facility practice was identified.

5. All sampled physical therapy staff interviewed stated that they found the residents to be "as they should be," and had no concerns regarding cares and grooming. The facility had a documentation system to ensure that residents' care tasks were completed when they were scheduled and aligned with the residents' negotiated service agreements. The sampled staff stated that when a resident refused any cares the documentation system flagged the task for review. The staff further stated that the next shift was notified verbally regarding any refusal so they could follow up on tasks that the previous shift was unable to complete. All residents observed were calm, well-groomed and in fresh clothing. Observation showed no odors detected in the facility. All resident representatives interviewed expressed no resident care concerns. No failed facility practice was identified.

The facility had physical therapy (PT) and occupational therapy (OT) staff in house every Monday through Friday. The PT staff stated that the residents' physical functioning and safety needs were addressed by them and that all residents who had footrests on their wheelchairs had been assessed or were being assessed for a need for them by the PT professionals. The PT staff stated that they had not observed use of footrests that were not recommended by them. All residents observed with footrests showed no signs of distress. Review of sampled residents' records showed documentation of need for footrests reflected in their care plans. No failed facility practice was identified.

7. All sampled nursing staff interviewed stated no concerns about the schedule not being available or updated. All sampled staff further stated no concerns regarding the number of nursing staff on a shift. Records reviewed showed that the nursing staff schedule was updated with nursing staff who were present on each shift. A sampled nursing staff indicated that the schedule was posted in a spot that could be easily accessed by all nursing care staff. No failed facility practice was identified.

8. During a licensing visit on 08/06/2025, the facility was cited for failed facility practice according to Washington Administrative Code (WAC) 388-78a-2474 – Training and home care aide certification requirements, which included subsections (2)(c)(4). During the licensing follow up visit on 09/25/2025 the facility was recited for the above mentioned WAC and subsections due to a missing valid credential for one additional staff, and missing dementia specialty trainings for two additional staff. Failed facility practice was identified and cited by the licensing staff.
9. Records reviewed showed that there was Medication Technician (MT) coverage at the facility on every shift. All sampled staff interviewed stated that MTs were notified when there was a resident concern. All sampled MTs stated that if there was a resident concern, they would notify the Health Services staff or the Executive Director during the weekdays and that emergency services would be notified to come and assess a resident if there was a concern for injury or illness after hours or on the weekends. No failed facility practice was identified.
10. Records reviewed showed agency staff were listed on the nursing staff schedule for almost all shifts and days of the week. All sampled staff interviewed stated no concerns regarding not having enough staff to care for the residents. All sampled staff observed were rounding on residents and assisting them with their needs. An agency staff was observed assisting residents with care related tasks. All residents observed were calm and showed no signs of distress. Sampled resident representatives stated no resident care concerns. No failed facility practice was identified

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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
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2513	Compliance Determination # 65667
Plan of Correction	Pine Ridge Alzheimer's Special Care Center	Completion Date
Page 1 of 4	Licensee: Pine Ridge OpCo LLC	10/01/2025

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 09/16/2025 of:

Pine Ridge Alzheimer's Special Care Center
12009 E Mission Ave
Spokane Valley, WA 99206

This document references the following complaint number(s): 191324, 192373, 192628

The following sample was selected for review during the unannounced on-site visit: 3 of 45 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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Page 2 of 4	Licensee: Pine Ridge OpCo LLC	10/01/2025

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.

J. Salquist
Residential Care Services

10/08/2025
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.

Becky Bearden
Administrator (or Representative)

10/12/25
Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observation and interviews, the facility failed to ensure personal protective equipment was readily available for use inside of the residents' rooms for 4 of 7 staff (Staff C, D, E and F). This failure placed residents and staff at risk for spread of infection.

Findings included...

Observation on 09/16/2025 at 10:21 AM, showed that resident unit number 27 had no gloves inside the closets or the bathroom.

Observation on 09/16/2025 at 10:27 AM, showed that resident unit number 23 had no gloves inside the closets or the bathroom.

Observation on 09/16/2025 at 10:39 AM, showed that resident unit number 19 had no gloves inside the closets or the bathroom.

Observation on 09/16/2025 at 11:44 AM, showed that the facility's supply closet had no supply of gloves.

In an interview on 10/01/2025 at 3:04 PM, Staff A, Executive Director, stated that gloves were to be located in each resident's room inside their closet or bathroom. Staff A further stated that they were unaware gloves were not being stocked in resident rooms.

In an interview on 10/01/2025 at 1:30 PM, Staff B, Health Services Coordinator, stated that gloves were to be located in each resident's closet or bathroom. Staff B further stated that supplies [including gloves] had been running out after a change in the supplier.

In an interview on 09/04/2025 at 1:14 PM, Collateral Contact 1, former Caregiver, stated that the facility never had sufficient supplies of gloves for the residents and that they had to "go searching" for gloves.

In an interview on 09/16/2025 at 10:10 AM, Staff C, Caregiver, stated that gloves were low most of the time and had frequently run out completely, since they started working at the facility on 04/29/2025. Staff C further stated that they frequently had to search for gloves in other places and that a few times they had provided cares to residents without gloves "in a pinch" because no gloves were readily available in residents' rooms. Staff C stated that night staff were to stock the residents' rooms with gloves but there were no gloves available in the storage closet with which to stock the rooms.

In an interview on 09/16/2025 at 12:53 PM, Staff F, Caregiver, stated that they normally had to retrieve gloves from places other than the residents' rooms where they were supposed to be located.

In an interview on 09/25/2025 at 11:50 AM, Staff D, Caregiver stated that there were rarely enough supplies in residents' rooms and that they would "borrow" gloves from their second job so that they could perform their duties. Staff D further stated that other caregivers who had a second job would also bring their own gloves obtained from their other job locations.

In an interview on 09/24/2025 at 12:36 PM, Staff G, Medication Technician (MT), stated that some staff members had brought up glove supply issues at the facility's all staff meetings in the past. Staff G further stated that staff had stopped bringing up the concern because the ones who had spoken up were labeled as "Nitpicky."

In an interview on 09/26/2025 at 2:39 PM, Staff E, MT, stated that there were often times when they did not have any gloves for their shift. Staff E further stated that they did not know the reason why the facility ran out of gloves so frequently.

Statement of Deficiencies	License #: 2513	Compliance Determination # 65667
Plan of Correction	Pine Ridge Alzheimer's Special Care Center	Completion Date
Page 4 of 4	Licensee: Pine Ridge OpCo LLC	10/01/2025

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, Pine Ridge Alzheimer's Special Care Center is or will be in compliance with this law and / or regulation on (Date) 10/31/25 .

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

Becky Bearden
Administrator (or Representative)

10/12/25
Date