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

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 License # 2513

Dear Administrator:

This letter addresses Compliance Determination(s) 69748 (Completion Date 12/08/2025) and 66600 (Completion Date 10/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/08/2025 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-2140-1-a-iii

The Department staff who did the on-site verification:
Amy Wright, NCI Complain 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 #: 66600
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 194809
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/02/2025 through 10/10/2025
Complainant Contact Date(s): 09/24/2025, 10/13/2025

Allegation(s):

1. Resident falls.
2. Bruising of unknown origin.
3. Inadequate showers.
4. Missing clothes.
5. Medication not given at correct time.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 4 Closed records sample size: 0
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Reporter/Alleged Victim's Representative Executive Director Health Services Director Medication Technician Caregiver Resident Representative
Record Reviews:	*Disclosure of Services *Characteristic roster *Staff roster *Resident face sheets *Resident care plans *Resident assessments *Progress notes *Medication Management and Documentation Policy *Grievance Policy *Fall Policy

*Facility fee scale
*As-worked staff schedule
*Incident investigations
*Shower documentation
*Medication administration records

Investigation Summary:

1. Record review showed that the negotiated service agreements for residents who were assessed as being at risk for falls, and who had a history of falls, did not include interventions to prevent further falls. Failed facility practice identified and cited under WAC 388-78A-2140 Negotiated service agreement contents (1)(a)(iii).
2. The Alleged Victim's Representative was interviewed. They stated that the resident fell, though they had not initially noticed the resident's facial bruises. Record review showed that the facial bruises developed the day after the resident's fall. The Alleged Victim's Representative stated they verified that bruises could develop days after an injury occurred. The Alleged Victim's Representative stated they had no complaints about the resident's care. Staff were observed available to supervise resident safety. No failed facility practice.
3. Interview with the Alleged Victim's Representative showed that the facility had improved in providing the residents with routine shower assistance. Record review confirmed that the residents received routine showers with infrequent exceptions or refusals of care. Residents were observed and they appeared well kept. Staff were observed available to assist with resident care. No failed facility practice.
4. Interview with the Alleged Victim's Representative showed they never told facility management about the resident's missing clothes. Interview with facility management showed the facility had a process for labeling resident clothes and for keeping residents' laundry separated so it could be returned to the correct owner. Resident representatives were interviewed, and they denied concerns about missing items. Facility management was observed available to address missing item concerns. No failed facility practice.
5. Record review could not confirm that the Alleged Victim was given medication at the incorrect time. Interview with staff responsible for passing resident medications showed they felt confident in their ability to provide resident medications timely on a typical day. Resident representatives were interviewed, and no concerns were voiced about untimely medication administration. Facility management was observed available to address medication concerns. No failed facility practice.

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 10/02/2025 of:

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

This document references the following complaint number(s): 195327, 194809

The following sample was selected for review during the unannounced on-site visit: 4 of 46 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain 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

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 — 10/16/2025 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) — 10/22/25 Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in the negotiated service agreement, interventions to prevent falls for residents identified as being at risk for falls for 2 of 2 residents (Residents 1 and 2). This failed practice placed residents at risk of falls, pain, injury, hospital visits, and decreased quality of life.

Findings included...

<Resident 1>

Review of an incident report for Resident 1, dated 09/11/2025, showed that the resident had a fall on that day. The incident report showed that Resident 1's fall resulted in a lump above their left eye, an abrasion to their nose, and knee pain. Review of the incident report showed that after their fall, Resident 1 cried and stated, "Oh I hurt." Further review of the incident report showed that the resident was sent to the hospital for evaluation after their fall.

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

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Based on interview and record review, the facility failed to document in the negotiated service agreement, interventions to prevent falls for residents identified as being at risk for falls for 2 of 2 residents (Residents 1 and 2). This failed practice placed residents at risk of falls, pain, injury, hospital visits, and decreased quality of life.

Findings included…

<Resident 1>

Review of an incident report for Resident 1, dated 09/11/2025, showed that the resident had a fall on that day. The incident report showed that Resident 1's fall resulted in a lump above their left eye, an abrasion to their nose, and knee pain. Review of the incident report showed that after their fall, Resident 1 cried and stated, "Oh I hurt." Further review of the incident report showed that the resident was sent to the hospital for evaluation after their fall.

Review of an incident report for Resident 1, dated 09/16/2025, showed that the resident had a fall on that day. The incident report showed that after their fall, Resident 1 complained of breast and knee pain. The incident report showed that a bruise developed on Resident 1's left breast, redness developed on their right breast, and they had scrapes to both knees.

Review of a Falls Management Evaluation for Resident 1, dated 09/17/2025, showed that the resident had two falls within the last 90 days and that they were at average risk for falls.

In an interview on 10/02/2025 at 12:19, Staff A, Executive Director, stated that Resident 1 had two falls since 09/11/2025. Staff A stated that if a resident had a history of falls or a risk for falls, their care plan should reflect that and it should include interventions to prevent falls.

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 07/16/2025, showed there were no fall interventions listed for Resident 1.

<Resident 2>

Review of a Quarterly Assessment for Resident 2, dated 07/16/2025, showed that the resident was at a low risk for falls.

Review of an incident report for Resident 2, dated 09/28/2025, showed that the resident had a fall on that day. The incident report showed that the resident hit their face on the floor and received a skin tear to their elbow.

Review of an incident report for Resident 2, dated 10/01/2025, showed that the resident had a fall on that day at 1:15 AM. The incident report showed that after the resident's fall, they grimaced while trying to move or walk. The incident report showed that the resident was recently started on a new pain medication due to a previous fall with pain.

Review of an incident report for Resident 2, dated 10/01/2025, showed that the resident had a fall on that day at 1:47 PM.

In an interview on 10/10/2025 at 8:47 AM, Collateral Contact 1 (CC1), Resident Representative, stated that staff had been providing the resident with a lot of care due to a recent fall.

Review of an NSA for Resident 2, dated 07/16/2025, showed there were no fall

interventions listed for Resident 2.

This is a recurring citation previously cited on 08/06/2025.

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) ~~11/25/25~~ 11/24/25 BB

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

Becky Bearden
Administrator (or Representative)

10/22/25
Date

interventions listed for Resident 2.

This is a recurring citation previously cited on 08/06/2025.

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)_____ .

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

_____ _____

Administrator (or Representative) Date