STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

10/15/2025

Puyallup Memory Care LLC
Deer Ridge Memory Care Community
3901 5th St SE
Puyallup, WA 98374

RE: Deer Ridge Memory Care Community # 2578

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 64813 (Completion Date 10/15/2025) and 55940 (Completion Date 06/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/15/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(6) Level of personal care needs;

The Department staff who did the On Site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Deer Ridge Memory Care Community
Provider Type: Assisted Living Facility
License/Cert.#: 2578
Intake ID: 162464
Compliance Determination #: 55940
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 03/06/2025 through 06/18/2025
Complainant Contact Date(s):

Allegation(s):
1. Unexpected death

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Resident Representatives Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the discharged records of the named resident Staff records Staff progress notes Incident log / reports Facility Abuse-Neglect abuse policy

Investigation Summary:
1. Per record review and interviews with staff, the ALF failed to conduct a pre-admission assessment prior to resident moving in. Failed facility practice identified. See Statement of Deficiency dated 06/10/2025.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Deer Ridge Memory Care Community
Provider Type: Assisted Living Facility
License/Cert.#: 2578
Intake ID: 166940
Compliance Determination #: 55940
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 03/06/2025 through 06/18/2025
Complainant Contact Date(s):

Allegation(s):
1. Staff to resident incident

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Staff Collateral contacts
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the discharged records of the named resident Staff records Staff progress notes Incident log / reports Facility Abuse-Neglect abuse policy

Investigation Summary:
1. Per record review and interviews with collateral contacts and staff, the facility failed to investigate and implement interventions when there was an allegation of resident abuse. Failed facility practice identified. See Statement of Deficiency dated 06/10/2025 .

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Deer Ridge Memory Care Community
Provider Type: Assisted Living Facility
License/Cert.#: 2578
Intake ID: 175622
Compliance Determination #: 55940
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 03/06/2025 through 06/18/2025
Complainant Contact Date(s): 06/11/2025

Allegation(s):
1. Staff to resident abuse

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Resident representatives X 3 attempts Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the discharged records of the named resident Staff records Staff progress notes Incident log / reports Facility Abuse-Neglect abuse policy

Investigation Summary:
1.Per record review and interviews with resident representative, collateral contacts and staff, the facility failed to investigate and implement interventions when there was an allegation of staff abusing resident. Failed facility practice identified. See Statement of Deficiency dated 06/10/2025 .

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
PO Box 99250, Lakewood, WA 98496

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 03/06/2025 of:

Deer Ridge Memory Care Community
3901 5th St SE
Puyallup, WA 98374

This document references the following complaint number(s): 162464, 166940, 175622

The following sample was selected for review during the unannounced on-site visit: 4 of 42 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on records review and interviews, the Assisted Living Facility (ALF) failed to conduct investigations to determine the circumstances of the accidents and incidents, implement interventions to prevent recurrence, and to protect residents for 5 of 5 sampled residents (Residents 1, 2, 3, 4, & 5 [R1, 2, 3, 4, & 5]). These failures resulted in these residents being placed at risk from continued accidents and incidents without measures to prevent future incidents.

Findings included…

Review of the ALF's "Abuse, Neglect, and Exploitation policy," dated 12/01/2024, it stated, "Upon the notice of reported, observed, suspected… form of abuse… a thorough investigation will be conducted…."

<Resident 1>
Record review of R1's "Face Sheet" with a print date of 03/07/2025 showed that R1 was

admitted to the ALF on [redacted]/2024 with diagnoses to include [redacted]. An assessment dated 10/25/2024 and negotiated service agreement dated 05/05/2025 did not show that R1 had any behaviors or a history of making accusations. There was no temporary service plan provided to review.

Review of the "Resident Incident and Accident Investigation" report for R1 dated 02/11/2025 showed that on 02/11/2025 R1 reported to their spouse that they had been raped the previous night, and the spouse informed facility staff. Review of the incident report did not include findings to rule out abuse, interventions to protect the residents, or changes to the care plan.

During an interview on 03/06/2025 at 10:07am, Collateral Contact 1 (CC1), Anonymous Staff Member, stated that they were aware of R1's allegation of rape. CC1 noted that R1 had provided a name of the alleged perpetrator; however, while no male staff member by that name worked at the facility, there was a resident with the same name. When asked whether the named resident could have possibly entered R1's room, CC1 stated they did not know. When asked about interventions in place to prevent residents from entering others' rooms, CC1 reported being unaware of any measures implemented after the allegation was made.

During an interview on 03/06/2025 at 10:25am, Collateral Contact 2 (CC2), Anonymous Saff Member, stated that they had "never heard about R1's allegations of rape." When asked whether such reports should be communicated to staff to ensure resident welfare or implement necessary care plan adjustments, CC2 responded that they should be.

During an interview on 03/06/2025 at 10:35am, Staff B, Director of Residential Services was asked what the findings were from R1's allegation of rape investigation. Staff B stated that R1 had reported being raped by a male staff member the previous night and it was reported to staff by R1's spouse. When asked how abuse was ruled out, Staff B stated that no male staff member by the name R1 provided worked at the facility, "it sounds like she made it up." Staff B stated, "I didn't see any evidence of rape… if there was rape, her (R1) behavior would not remain the same." Staff B was asked about whether male staff or other facility personnel had been interviewed as part of the investigation. Staff B stated that no male staff member matching R1's description had been on duty the previous night and noted that the only individual with the name R1 mentioned was another resident who "is short, and not tall like she (R1) said." Staff B was asked if it was possible that the male resident could have entered R1's room, Staff B stated they did not think so. Staff B was not able to elaborate on how they came to that conclusion. When asked if there were any interventions put in place to protect R1 and other residents in the facility from possible abuse, Staff B stated, "none because she (R1) stated she made it up in a second interview."

<Resident 2>
Record review of R2 's "Face Sheet" with a print date of 06/02/2025 showed that R2 was admitted to the ALF on [redacted]/2022 with diagnoses to include [redacted].

A negotiated service agreement dated 05/05/2025 showed that R2 “grabbed others to walk with her…occasionally resistant to care” with no direction for staff on how to assist resident. There was temporary service plans provided to review.

Review of the department’s Secure Tracking and Reporting System’s (STARS) records showed that R2 was loudly scolded and hit on the hand by a staff member on two different occasions, 03/13/2025 or 03/23/2025 and 03/23/2025 or 03/30/2025. There were no investigations available into R2’s allegations of abuse by the staff members to review.

A record review of an email received from Staff A, Administrator, on 06/03/2025 at 12:26pm showed that Staff A was notified of the allegation of abuse of R2 by Staff D, Active Living Director, on 04/16/2025.

During an interview on 06/03/2025 at 2:40 pm, Collateral Contact 3 (CC3), R2’s Representative, was asked whether they had been notified or aware of an allegation of abuse involving R2 in April 2025. CC3 stated that they had not been informed of any incidents involving R2 from the facility.

During an interview on 06/03/2025 at 2:50pm, Staff C, Medication Technician, was asked about the alleged incident with R2. Staff C stated that “I don’t even know.” When asked if they did not remember an allegation of abuse against a resident, Staff C stated, “they said I took a bowl from her, and she said “ouch.” When asked to explain what happened and where the incident occurred, Staff C stated, "they didn’t tell me where it had happened.” Staff C was asked if they had been suspended after the incident, received coaching or some form of education on abuse/neglect prevention. Staff C stated “no, Administrator talked to me.”

During an interview on 06/03/2025 at 2:59 pm, Collateral Contact 4 (CC4), Anonymous Staff Member, stated that they were not aware of any allegations of resident abuse. CC4 stated that Staff C was “rough with residents, inpatient and verbally abusive.” CC4 stated that Staff C did not "like R2 because she (R2) grabbed everything" and that Staff C would find ways to swap assignments with other staff to avoid feeding R2. CC4 noted that both Staff A and Staff B were aware of concerns regarding Staff C’s behavior. When asked whether they had received any education or in-service training on abuse and neglect prevention, CC4 responded, "none."

During an interview on 06/03/2025 at 3:15 pm, Staff D, Active Living Director, stated that Staff E, Active Living Staff, had reported an allegation of resident abuse involving Staff C and R2. Staff D stated that they had notified Staff A of the allegation via email. When asked who was responsible for investigating the allegation, Staff D stated that Staff A “would take care of it.” Staff D stated that they followed up on the incident about a week later and was told by Staff A that “he (Staff A) took care of it.” Staff D stated that while they had not personally witnessed Staff C abusing residents, they described Staff C as “abrasive and disrespectful.” When asked whether they had

received any education or in-service training on abuse and neglect prevention following the incident, Staff D stated that they had not.

During an interview on 06/03/2025 at 3:25 pm, Staff A was asked to explain the incident detailed in an email regarding allegations of R2 being abused by a staff member. Staff A responded, "Everything you have there." When asked about the findings of their investigation, Staff A stated that Staff C had "reached out too fast" and that the incident was not corroborated. When asked if there were any witnesses present, Staff A stated, “I am sure there were other people.” Staff A was asked what interventions had been implemented to prevent recurrence. Staff A stated, "No actions were taken because the allegation could not be confirmed." When asked if there was an investigation and if staff had received any in-service training or education on preventing resident abuse and neglect, Staff A responded, "I can put something together." There was no investigation or staff in-service reports received by the department as of the last day of data collection.

During an interview on 06/03/2025 at 3:56 pm, Staff E stated that Staff C had instructed R2 to release a clothing protector. When R2 held onto it tightly, Staff C grabbed the protector and "slapped R2’s arm." Staff E stated that R2 said “ouch” and Staff C proceed to yank the clothing protector from R2. Staff E stated they reported to Staff D, and that this was not the first concerning interaction between Staff C and R2. Staff E stated that about a week prior, Staff C had yanked another resident’s blanket from R2, causing her to “almost fall”. When asked whether any interventions were put in place or if staff received education on abuse and neglect prevention following the incident, Staff E stated that they were not aware of any and they had not received any in-service training.

In an interview on 06/05/2025 at 11:53am, Staff B stated that they were not aware of any allegations of abuse for R2. Staff B was asked if there was an investigation on file, Staff B stated that there was not. Staff B stated that all allegations of abuse or neglect should be investigated and reported to the department. When asked why this allegation was not investigated, Staff B stated that they were on vacation in April and that Staff A, the Administrator, would have been responsible for the investigations.

<Resident 3>
Record review of R3’s “Face Sheet” with a print date of 03/07/2025 showed that R3 was admitted to the facility on [redacted]/2022 with diagnoses to include [redacted] and [redacted]. Record review of a negotiated service plan dated 03/07/2025 did not show R3 being a fall risk. There was no temporary service plan available to review and there were no interventions in place to prevent further falls or how to manage cat litter dust to prevent falls.

Review of the “Resident Incident and Accident Investigation” reports for R3 dated 01/13/2025, 02/24/2025, 02/26/2025, and 02/27/2025 showed that R3 sustained falls on

01/13/2025, 02/24/2025, 02/26/2025 and 02/27/2025. The facility failed to document findings or made any necessary changes to the resident's care plan following the falls on 01/13/2025, 02/26/2025 and 02/27/2025.

During an Interview on 03/06/2025 at 10:07am, CC1 was asked if R3 had been a fall risk prior to the multiple falls. CC1 stated that R3 had not previously been identified as a fall risk. When asked what might have contributed to R3's multiple falls within a short period, CC1 was uncertain, noting that R3 had fallen while going to the bathroom and had also fallen out of bed. CC1 stated that, to their knowledge, no changes had been made to R3's care plan following the incidents.

During an interview on 03/06/2025 at 10:35am, Staff B was asked what the causes of R3's multiple falls were and what interventions had been implemented to prevent recurrence. Staff B stated that R3 had a cat, and the litter dust was responsible for the falls. Staff B stated they didn't have interventions in place as R3's family wanted the facility to take responsibility for the litter box. Staff B did not offer a response when asked how not implementing measures because the family wanted staff to take care of the litter box would ensure resident safety. When asked about the cause of R3's fall on 02/27/2025, Staff B stated that R3 had been sitting on the edge of the bed while having lunch and fallen. Staff B was asked why R3 had been left alone in that position, given that she had fallen the previous day and had documented increased weakness and poor balance. Staff B stated that R3 had "been ok." Staff B was not able to elaborate on what being "ok" meant.

<Resident 4>
Record review of R4's "Face Sheet" with a print date of 05/30/2025 showed that R4 was admitted to the ALF on [redacted]/2024 with diagnoses to include [redacted]. A negotiated service agreement dated 08/24/2024 showed that R4 was independent with transfers. An assessment dated 11/23/2024 showed that R4 sustained a hip fracture and needed a two-person assist with transfers. There was no updated negotiated service agreement after the hip fracture. The ALF's incident reports showed that R4 sustained falls on 01/18/2025, 01/29/2025, and 01/31/2025. There was no temporary care plans provided to review for interventions after the falls.

Review of the "Resident Incident and Accident Investigation" reports for R4 dated 01/18/2025, 01/29/2025, and 01/31/2025 showed that R4 sustained multiple falls on 01/18/2025, 01/29/2025, and 01/31/2025. There were no investigative findings determining the causes of the falls for 01/18/2025 and 01/29/2025.

In an interview on 06/18/2025 at 4:04pm, Staff B was asked what the causes of R4's (01/18/2025 & 01/29/2025) falls were. Staff B stated, "I don't know." When asked what their investigation found, Staff B stated that R4 used to walk, "maybe she tried to get up… I assume she tried to get up, I don't know. It's really hard to get what's on their mind; it's hard to guess what they are thinking." When asked how they would prevent falls from occurring if they didn't know the cause, Staff B stated that all residents who

were high fall risks had motion sensors. When asked if there were interventions put in place, Staff B stated, “I don’t remember.” Staff B stated that they kept R4 out of the room per family request.

<Resident 5>
Record review of R5’s “Face Sheet” with a print date of 03/07/2025 showed that R5 was admitted to the facility on [redacted]/2025 with diagnoses to include [redacted] and [redacted]. Progress notes showed that R5 sustained falls on [redacted]/2025, 01/08/2025 & 01/09/2025 and passed away on [redacted]/2025. There were no investigations into the cause of the falls or measures put in place to prevent recurrence. There was no temporary care plan available to review.

Review of the “Resident Incident and Accident Investigation” reports for R5 dated [redacted]/2025, 01/08/2025, and [redacted]20256, R5 sustained falls on [redacted]/52025, 01/08/2025 and [redacted]/2025. There were no interventions implemented to prevent recurrence.

During an interview on 03/06/2025 at 10:35am, Staff B was asked about the findings regarding R5’s multiple falls, their causes, and what interventions were implemented to prevent recurrence. Staff B stated that the facility had attempted to rehydrate R5 by providing fluids. When asked if the falls were investigated, Staff B stated that they were not and they “thought that he (R5) was tired from travelling.” When asked whether earlier intervention following the first fall could have prevented subsequent falls, Staff B stated, "Probably, but he (R5) was just too sick when he got here." Staff B was asked if there was a possibility that R5 had hit his head during the fall on 01/08/2025, given that a progress note dated 01/08/2025 documented, "Client has another fall this afternoon," with no further details or any investigation. Staff B stated that they did not know.

This is a recurring deficiency previously cited on 05/19/2023, 10/05/2022, and 09/09/2022.

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, Deer Ridge Memory Care Community 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

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(6) Level of personal care needs;

This requirement was not met as evidenced by:

Based on records review and interviews, the Assisted Living Facility (ALF) failed to conduct a pre-admission assessment for 1 of 5 sampled residents (Resident 5 [R5]). This failure resulted in this resident not receiving appropriate services and a decline in their health.

Findings included…

Review of R5's face sheet with a print date of 03/07/2025 showed that R5 was admitted to the facility on [redacted]/2025 with diagnoses to include [redacted]. The progress notes dated [redacted] 2025 showed that R5 needed 3-4 staff to assist with transfers and needed 1:1 feeding. Progress notes showed that R5 passed away on [redacted]/2025, three days after being admitted to the ALF.

Review of ALF and R5's chart records showed no preadmission assessment was on file. There was no preadmission assessment in R5's chart to review.

During an interview on 03/06/2025 at 10:35 am, Staff B, Director of Residential Services, was asked about the cause of R5's death and whether any factors may have contributed to his passing within days of arriving at the facility. Staff B stated that R5 was not well and had been admitted to the facility "prematurely." Staff B was asked to elaborate. Staff B stated that R5 was "very sick," and the facility could not manage his care. When asked if they had conducted an assessment before accepting R5 to determine if the facility could meet his needs, Staff B responded, "I didn't do an actual evaluation." When asked how the facility could have determined its ability to meet R5's needs without an assessment, Staff B stated that R5 "came from a far hospital." When asked when the ALF noticed that R5's care was unmanageable, Staff B stated that the day R5 arrived at the facility. Staff B stated R5 needed 3-4 staff for transfers, 1:1 assistance with feeding and a sitter to ensure his safety. Staff B was asked what actions the facility took upon recognizing R5's need for a higher level of care. Staff B stated, "I decided to keep him… I thought he would get better." When asked why they didn't send R5 back to the hospital for further evaluation and stabilization, Staff B stated that they believed "he was tired from traveling."

During an interview on 06/10/2025 at 3:44pm, Staff A, Administrator, stated that they were surprised that a preadmission assessment was not conducted.

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, Deer Ridge Memory Care Community 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