STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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

RE: Deer Ridge Memory Care Community License # 2578

Dear Administrator:

This letter addresses Compliance Determination(s) 73968 (Completion Date 03/13/2026) and 69363 (Completion Date 01/07/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/13/2026 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

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

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: 200607
Compliance Determination #: 69363
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 12/01/2025 through 01/07/2026
Complainant Contact Date(s):

Allegation(s):
1. Resident to resident incident

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	General environment Residents in their rooms and common areas Staff-to-resident interactions Resident behaviors
Interviews:	Residents, including the named resident Staff Resident Representative
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff progress notes Incident log / reports

Investigation Summary:
1. Per observation, record review and interviews with collateral contacts and staff, the facility failed to investigate a resident-to-resident incident to determine the circumstances of the incident and implement interventions to prevent recurrence. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 01/07/2026. Citation issued.

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 12/01/2025 and 01/06/2026 of:

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

This document references the following complaint number(s): 200607

The following sample was selected for review during the unannounced on-site visit: 3 of 51 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.

Laurie Anderson — Residential Care Services

01/15/2026 — 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)

01/16/2026 — 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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to investigate a resident-to-resident incident for 3 of 3 sample residents (Resident 1, Resident 2, and Resident 3) to determine the circumstances of the incident and implement interventions to prevent recurrence. This failure placed all three residents at risk for continued harm and a decreased quality of life.

Findings included...

Observation on 12/01/2025 at 09:33 AM showed Resident 2 and Resident 3 in the dining room area. There were no staff members present.

Review of the facility records showed the facility maintained incident reports and facility investigation paperwork related to resident care and concerns. The records showed there was no investigation available for the resident-to-resident incident on 11/01/2025. There was no documentation in the records that showed the facility implemented any measures to prevent future altercations.

During an interview on 12/01/2025 at 10:00 AM, Collateral Contact 1 (CC1), stated that both Residents 1 and Resident 2 exhibited behaviors toward others. CC1 stated that they were unaware of any interventions in place to prevent recurrence of a similar incident.

During an interview on 12/01/2025 at 10:15 AM, Collateral Contact 2 (CC2), stated that Resident 1 exhibited aggressive behaviors toward other residents and staff. CC2 stated that they were unaware of what measures were in place to prevent Resident 1 from harming others.

During an interview on 12/01/2025 at 10:25 AM, Staff A, Administrator, stated that there was "no way of knowing what happened" regarding the incident between Resident 1, Resident 2, and Resident 3. Staff A stated that the Director of Residential Services was the staff responsible to complete an investigation. Staff A stated that the facility did not have a Director of Residential Services at the time of the incident.

During an interview on 01/05/2026 at 2:25 PM, Collateral Contact 3 (CC3) stated that they heard about the incident between Resident 1 and Resident 2. CC3 stated that they were not informed of the circumstances surrounding the incident. CC3 stated that they were unaware of any new changes to the residents' care plans following the event. CC3 stated that to prevent resident altercations, caregivers roam around the building.

During an interview on 01/05/2026 at 2:35 PM, Collateral Contact 4 (CC4) stated that both Residents 1 and Resident 2 had a history of aggressive behaviors and were previously involved in a physical altercation with other residents. CC4 stated that they were not aware of the incident between Resident 1, Resident 2, and Resident 3. CC4 stated that they were unaware of any recent or new changes to the residents' care plans after the recent incident.

During an interview on 01/05/2026 at 2:48 PM, Collateral Contact 5 (CC5) stated that any completed incident reports were forwarded to Staff A for investigation. CC5 stated that after Staff A or the Director of Residential Services completed an investigation, staff were notified of changes to the care plan based on the outcome of the investigation. CC5 stated they were unaware of changes to Residents 1, Resident 2, or Resident 3 care plans after the recent incident.

During an interview on 01/06/2026 at 3:21 PM, Collateral Contact 6 (CC6), stated that there were no residents in the facility with aggressive behaviors and that residents were pretty calm. CC6 stated that they were unaware of any incident involving Residents 1, Resident 2, and Resident 3. CC6 stated that they were unaware of any recent changes to Residents 1, Resident 2, and Resident 3 care plans after the recent incident.

During an interview on 01/06/2026 at 3:29 PM, Collateral Contact 7 (CC7), stated that

they heard about the incident between Resident 1, Resident 2, and Resident 3. CC7 stated that Resident 1 goes into outbursts and will hit or try to go after other residents. CC7 stated that Resident 2 was difficult to calm down. CC7 stated they were unaware of any changes made to Resident 1 or Resident 2's service plan after the recent incident. CC7 stated that they keep an eye on Resident 1 and move residents into another room to protect them.

During an interview on 01/06/2026 at 3:43 PM, Collateral Contact 8 (CC8) stated that both Residents 1 and 2 had mood swings. CC8 stated they were unaware of any measures implemented to prevent recurrence.

During an interview on 01/06/2026 at 3:58 PM, Collateral Contact 9 (CC9) stated that they were not aware of the incident between Residents 1, Resident 2, and Resident 3. CC9 stated that to prevent Resident 1 from becoming agitated, staff would fall into Resident 1's world, walk with them, and separate them from the crowd. CC9 stated that there were no new changes to Resident 1, Resident 2 or Resident 3 care plans.

During an interview on 01/07/2025 at 4:27 PM, Staff A stated that regional staff conducted the investigation and the facility did not have a copy of the investigation. Staff A stated that no actions were taken following the incident. Staff A stated that the facility typically relied on redirecting residents as a preventative measure.

This is a recurring deficiency previously cited on 06/18/2025 subsections (1)(2)(3)(4) and on 05/24/2024 subsections (1)(2)(3).

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) 02/21/2026 .

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

Administrator (or Representative) — Date: 01/16/2026