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

04/21/2026

Centralia Point Operating Company LLC
Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

RE: Centralia Point Assisted Living and Memory Care # 2609

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 76259 (Completion Date 04/21/2026) and 72078 (Completion Date 03/11/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/21/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

The Department staff who did the On Site verification:
Maria Salas, ALF 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: Centralia Point Assisted Living and Memory Care
License/Cert.#: 2609
Compliance Determination #: 72078
Investigator: Clinton Fridley
Investigation Date(s): 01/28/2026 through 03/11/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 208663
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Concerns of neglect and lack of care.
2. Concerns of pressure wound related to lack of care.
3. Concerns of showers not being provided.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members
Record Reviews:	Medical records State reporting log Incident investigation Facility policies Staff patterns

Investigation Summary:

1. Based on record review and interview the facility failed to monitor resident's changing needs and take appropriate actions. Failed practice identified.
2. Based on record review and interview that facility failed to notify resident representative of worsening skin issue. Failed practice identified.
3. Based on record review, observation and interview the facility had a system in place for tracking showers. No failed practice identified.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2609	Compliance Determination # 72078
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 1 of 8	Licensee: Centralia Point Operating Company LLC	03/11/2026

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 01/28/2026 of:

Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

This document references the following complaint number(s): 208663

The following sample was selected for review during the unannounced on-site visit: 3 of 52 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF Complaint Investigator

From:
DSHS, Home and Community Living 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

03/16/2026
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.

Dawnielle Sweeney
Administrator (or Representative)

3/16/26
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to take appropriate actions after an identified skin impairment for 1 of 3 residents (Resident 1 (R1)). This failure resulted in R1's not being evaluated by a health care provider for skin breakdown and placed R1 at risk for worsening skin breakdown, pain, and decreased quality of life.

Findings included...

Record review of facility records showed the facility admitted R1 on [redacted]2025 for a two to three weeks for a respite stay while resident's wife underwent surgery. R1 had a history of dementia (a loss of cognitive function thinking, remembering, and reasoning).

Record review of facility document titled "Master Assessment/ Pre-Admission Assessment," dated 12/19/2025, documented that R1 was able to transfer (move from one location to another) independently but required reminders. R1 was oriented to self and had judgement and memory impairments that required moderate staff supervision but did not require wellness checks. R1 suffered from stress incontinence (lack of voluntary control) of urine and required one person assist for toileting. R1 was able to walk freely with a walker. R1 had a history of psoriasis (skin disease that causes a rash) and no evidence of wound care needed.

Record review of facility document titled "Service Plan," dated 12/26/2025 and updated 01/07/2026, showed R1 needed reminders for transfers but was able to stand independently, judgement and memory were poor and required moderate supervision. R1 required physical assistance of one staff member for toileting and stress incontinence care. Service plan does not any address skin concerns.

Record review of progress notes dated 01/02/2026 at 01:10 pm, showed that staff documented R1 had "sores and scratches" on the buttocks area.

Record review of facility document titled "Current Skin Issue Log," dated for January 2026, revealed that each entry tracked a skin condition for the whole month, with columns for weekly updates (week one, week two, week three and week four), treatments per standing order, treatment by home health, date resolved, resolved by initials. An entry, dated 01/04/2026, for R1 showed a skin issue of redness was located on the tailbone and week one note stated barrier cream. Week two note documented "small open area" and "clean & dressing). Week three note documented that R1 had discharged. There was no documentation in the other columns indicating treatments.

Record review of progress notes dated 01/04/2026 at 1:25 pm, showed that staff noted R1 had redness to their tailbone and applied cream. No mention of notifications to family or medical provider.

Record review of progress notes dated 01/05/2026 at 9:01 pm, showed that R1 "appears" to have a pressure sore to the tailbone area. R1 was unsteady and shaky when standing and required a two-person assist when using the restroom. Blood noted to be draining from right elbow area.

Record review of progress notes dated 01/06/2026 at 3:40 pm, showed that R1 has bruising to left side above the hip, bruising to the back on the spine and a red area near the tailbone.

Record review of progress notes dated 01/11/2026 at 4:10 am, showed that R1 was saying "ouch" whenever legs were being moved during care. R1 required three staff to transfer. Staff noted swelling to legs and elevated them in a recliner. R1 constantly tried to stand up and ask for help to get up.

R1's records as of 01/10/2026, showed no documentation that staff reported the skin issue to the family representative or health care provider.

In an interview on 01/28/2026 at 10:05 am, collateral Contact 1 (CC1) stated that R1 had walked in the facility on [redacted] 2025 with no real health concerns and in less than [redacted] days had become bedridden. Stated when R1 was dehydrated, had a pressure wound on the tailbone, and had a urinary tract infection when admitted to the hospital. CC1 stated that R1 was now receiving end-of-life (hospice) care, was bedridden and unable to get up.

In an interview on 02/03/2026 at 10:59 am, Staff B, Registered Nurse (RN), stated that the only assessment for R1 was the "Master Assessment/Pre-Admission Assessment" that was dated 12/19/2025. Staff B stated that there had not been any other assessments completed except for the preadmission assessment completed prior to R1 admitting to the facility.

In an interview on 02/09/2026 at 10:33 am CC1 stated that R1 had passed away.

This is a recurring citation previously cited on 05/30/2024.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) ~~4-30-2026~~ 4-5-26 DS

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

Dawnielle Sweeney — Administrator (or Representative)

3/16/26 — Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to report skin breakdown to resident representatives and health care provider for 1 of 3 residents (Resident 1 (R1)). This failure resulted in R1 not having a health care provider evaluate the skin breakdown and provide interventions and placed resident at risk for worsening skin breakdown, pain and a decreased quality of life.

Findings included...

Record review of facility records showed the facility admitted R1 on [redacted]2025 for a two to three weeks for a respite stay while resident's wife underwent surgery. R1 had a history of dementia (a loss of cognitive function thinking, remembering, and reasoning).

Record review of facility document titled "Master Assessment/ Pre-Admission Assessment," dated 12/19/2025, documented that R1 was able to transfer (move from one location to another) independently but required reminders. R1 was documented as being oriented to self and suffered judgement and memory impairments that required moderate supervision by staff but did not require wellness checks. Documented that R1 suffered from stress incontinence (lack of voluntary control) of urine and required one person to physically help him use the toilet. R1 was able to walk freely with a walker. The assessment document showed that R1 had a history of psoriasis (skin disease that causes a rash) and no evidence of wound care needed.

Record review of facility document titled "Service Plan," dated 12/26/2025 and updated 01/07/2026, showed R1 needed reminders for transfers but was able to stand independently, judgement and memory were poor and required moderate supervision. R1 required physical assistance of one staff member for toileting and stress incontinence care. Service plan does not address skin concerns.

Record review of facility records titled "Incident/ Accident log," dated 12/29/2025 through 01/28/2026, showed R1 had documented falls on 12/29/2025 at 7:50 pm, 01/01/2026 at 4:15 pm, 01/04/2026 at 11:24 am, 01/05/2026 at 9:20 am and 01/08/2026 at 7:19 pm.

Record review of progress notes dated 12/29/2025 at 8:18 pm, showed that R1 had

suffered an unwitnessed fall and staff documented that the facility nurse was notified and would notify the family tomorrow.

Record review of resident incident report, date of incident 12/29/2025 at 7:50 pm, completed by Staff C, Resident Care Manager, on 01/02/2026 at 7:43 am, showed that R1 had a non-injury fall and showed that no notifications were made to R1's family or physician.

Record review of progress notes dated 01/02/2026 at 1:10 pm, showed that R1 needed to be always monitored due to high fall risk and noncompliance of using wheelchair for mobility in the facility. R1 was unable to seat himself safely in a chair and required guidance from staff. R1 had "sores and scratches" on the buttocks area. No documentation that R1's family or medical provider was notified.

Record review of progress notes dated 01/04/2026 at 1:25 pm, showed that staff noted R1 had redness to their tailbone and applied cream. No mention of notifications to family or medical provider.

Record review of facility document titled "Current Skin Issue Log," dated for January 2026, revealed that each entry tracked a skin condition for the whole month, with columns for weekly updates (week one, week two, week three and week four), treatments per standing order, treatment by home health, date resolved, resolved by initials. An entry, dated 01/04/2026, for R1 showed a skin issue of redness was located on the tailbone and week one note stated barrier cream. Week two note documented "small open area" and "clean & dressing). Week three note documented that R1 had discharged. There was no documentation in the other columns indicating treatments.

Record review of progress notes dated 01/05/2026 at 2:05 am, showed that R1 had bruising to the left hip, had a staff assisted lowering to the floor due to R1 missing the bed where R1's elbow hit the bed frame and landed on their bottom, staff summoned emergency medical personnel to assist R1 off the floor.

Record review of progress notes dated 01/05/2026 at 9:01 pm, showed that R1 "appears" to have a pressure sore to the tailbone area. R1 was unsteady and shaky when standing and required a two-person assist when using the restroom. Blood noted to be draining from right elbow area.

Record review of progress notes dated 01/06/2026 at 3:40 pm, showed that R1 has bruising to left side above the hip, bruising to the back on the spine and a red area near the tailbone.

Record review of progress notes dated 01/07/2026 at 1:15 am, showed that R1 was found on the floor yelling for help, summoned assistance and got R1 off the floor and

back into bed.

Record review of progress notes dated 01/08/2026 at 4:33 am, showed that R1 was found sitting on the floor, against the wall by the toilet, staff unable to assist R1 up, called 911 for assistance, took two caregivers and two paramedics to assist R1 getting up off the floor.

Record review of resident incident report, date of incident 01/08/2026 at 7:19 pm, completed by Staff C on 01/09/2026 at 1:16 pm, showed that R1 had an assisted fall and the plan was to continue to monitor R1 and anticipate needs, assist as needed and keep using wheelchair. Incident report showed that notifications were not made to the family.

Record review of progress notes dated 01/09/2026 at 4:35 am, showed that R1 got about one hour of sleep, was trying to get up all shift, and is a two person transfer due to being unsteady while on their feet.

R1's records as of 01/10/2026, showed no documentation that staff reported the skin issue to the family representative or health care provider.

Record review of progress notes dated 01/11/2026 at 4:10 am, showed that R1 was saying "ouch" whenever legs are being moved during provided care, requires three staff to transfer R1. Staff noted swelling to legs and elevated them in a recliner, R1 constantly tried to stand up and ask for help to get up.

Record review of progress notes dated 01/11/2026 at 8:21 pm, showed that R1 was sent out to the hospital earlier in the shift but returned, after 20 minutes staff sent R1 back to hospital due to extreme swelling of the legs and staff could not transfer to toilet.

In an interview on 01/28/2026 at 10:05 am, Collateral Contact 1 (CC1) stated they had received a phone call from R1's primary provider voicing concerns for them to look at R1 for bruising because of multiple recent falls. CC1 stated that they called the facility asking if R1 had any bruising and was told no, then the facility changed their story stating R1 had missed the chair while sitting down which resulted in a bruise and scrape. CC1 stated that the facility reported that R1 had been having controlled falls when questioned about R1's falls. CC1 stated that the facility reported R1 would lower himself to the floor and then scoot across the room by himself. CC1 stated that R1 admitted to the facility on [redacted]/2025 walking and able to feed himself, to now being bedridden and receiving end-of-life services.

In an interview on 02/17/2026 at 12:45 pm, Collateral Contact 2 (CC2) stated that the facility contacted them twice about R1's falls during the time R1 was in the facility. CC2 stated that they were asked to bring a wheelchair for R1 to use during the second call

they received related to a fall that happened on 01/04/2026. CC2 stated that another family member delivered the wheelchair to facility on 01/05/2026 and the facility had notified the family member that R1 was falling at least once per shift and had fallen earlier that day. CC2 stated that the facility did not contact them about any open areas to R1 tailbone. CC2 stated that the facility did not notify them when the fire department had been contacted to assist R1 off the floor. CC2 stated that the facility never contacted them about R1's skin issues or changes besides the two times for a fall which included the request for a wheelchair. CC2 stated that R1 had been fully independent with the walker at the time of admission to the facility.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) ~~4-30-2026~~ 4-5-26 DS

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

Dawnielle Sweeney
Administrator (or Representative)

3/16/2026
Date