STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Community Pride Ritzville LLC

Community Pride Ritzville LLC
PO Box 59
Saint John, WA 99171

RE: Community Pride Ritzville LLC License # 2631

Dear Administrator:

This letter addresses Compliance Determination(s) 78009 (Completion Date 05/21/2026) and 74629 (Completion Date 03/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/21/2026 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-2120, WAC 388-78A-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-1, WAC 388-78A-2130-2

The Department staff who did the on-site verification:
Patricia Eddy, Community Licensor

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 follow-up on 03/19/2026 of:
Community Pride Ritzville LLC
406 S Cascade St
Ritzville, WA 99169

This document references the following SOD dated: 03/26/2026

The following sample was selected for review during the unannounced on-site visit: 4 of 14 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Patricia Eddy, Community Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2831	Compliance Determination #:74629
Plan of Correction	Community Pride Ritzville LLC	Completion Date
Page 2 of 6	Licensee: Community Pride Ritzville LLC	03/26/2026

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 — 04/06/2026 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.

Sandra Davis — Administrator (or Representative) — 4/15/2026 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 observation, interview and record review, the facility failed to monitor, evaluate, and take appropriate action for 1 of 4 residents (Resident 4) who experienced difficulty breathing. This failure resulted in delayed medical treatment, contributed to ongoing respiratory distress, and placed the resident at risk for worsening lung symptoms and a decreased quality of life.

Findings included...

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-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 observation, interview and record review, the facility failed to monitor, evaluate, and take appropriate action for 1 of 4 residents (Resident 4) who experienced difficulty breathing. This failure resulted in delayed medical treatment, contributed to ongoing respiratory distress, and placed the resident at risk for worsening lung symptoms and a decreased quality of life.

Findings included…

Review of Resident 4's Negotiated Service Agreement (NSA), dated 02/08/2026, showed the resident was admitted to the facility on [redacted]/2026 and was diagnosed with [redacted] and [redacted]. Further review showed that the resident required oxygen use at two liters per minute.

Review of Resident 4's facility assessment, dated [redacted]/2026, showed that the resident required assistance with setting up appointments.

Review of Resident 4's March 2026 Medication Administration Records (MARs) showed that the resident had an order for oxygen two liters per minute that documented, "oxygen for comfort during the day and while sleeping". Review of the MARs showed that the resident's oxygen saturation (level) was checked at 7:00 AM and 7:00 PM daily. Further review of the MAR showed no documentation of the resident's oxygen saturation measurements.

Review of Resident 4's Medical Visit Summary, dated 02/11/2026, showed the resident had a chest x-ray that documented, "noted right lung consolidation [fluid in the lung] , seems like recurrence from 12/2025 pneumonia infection," and that the resident was to have a follow up in three weeks for shortness of breath and pneumonia. Further review showed the resident was prescribed antibiotics for pneumonia.

Review of a fax cover sheet sent to the facility by Resident 4's health care provider, dated 02/25/2026 Further review showed that the provider provided orders to "schedule appointment with PCP [Primary Care Physician] for oxygen refill."

Observation on 03/19/2026 at 1:55 PM, showed Resident 4 experienced rapid breathing with wheezing and paused for breath every one to two words when speaking with the department licensor. Observation showed the resident's nasal cannula for oxygen (flexible tube with two prongs used to deliver supplemental oxygen) laid on their bed and that the oxygen concentrator (a medical device that delivers oxygen) was not on. In an interview at that time, the resident stated that they were out of breath and had been for a few days.

In an interview on 03/19/2026 at 2:25 PM, Staff A, General Manager, stated that health care provider's ordered follow-up appointments had not been scheduled by the facility or attended by Resident 4.

Observation on 03/19/2026 at 2:45 PM with Staff A and Staff B, Assistant Manager, showed Resident 4 continued to rapidly breath, wheeze and paused for breath every one to two words. Observation showed the resident's nasal cannula for oxygen still laid on their bed and that the oxygen concentrator was still not on. In an interview at that time, the resident again stated that they were out of breath. Observation showed Staff

A and Staff B did not address the resident's abnormal breathing until the department licensor showed concern for the resident's wellbeing. At the department's prompting, Staff A assessed Resident 4 and put the nasal cannula on and turned on the oxygen concentrator.

In an interview on 03/19/2026 at 4:40 PM, Staff A stated they would call for paramedics to evaluate the resident.

Review of Resident 4's Medical Visit Summary following the call for paramedics, dated 03/19/2026, showed that the resident had short, shallow, and rapid breathing. Review showed the resident had crackles and rhonchi (rattling) in their lungs and elevate cardiac enzymes (proteins released into the bloodstream, indicating heart muscle damage that may result in difficulty breathing.)

Review of Resident 4's undated medical record showed no documented communication to the resident's health care provider regarding the shortness of breath, monitoring of the shortness of breath or implementation of any interventions to address the shortness of breath, prior to the department expressing concerns about the resident's wellbeing. Review showed no documentation of the resident's oxygen saturation.

This is an uncorrected deficiency previously cited on 02/19/2026.

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date) 5|10|2026 .

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

Sandra Davis — Administrator (or Representative)

4|15|2026 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

A and Staff B did not address the resident's abnormal breathing until the department licensor showed concern for the resident's wellbeing. At the department's prompting, Staff A assessed Resident 4 and put the nasal cannula on and turned on the oxygen concentrator.

In an interview on 03/19/2026 at 4:40 PM, Staff A stated they would call for paramedics to evaluate the resident.

Review of Resident 4's Medical Visit Summary following the call for paramedics, dated 03/19/2026, showed that the resident had short, shallow, and rapid breathing. Review showed the resident had crackles and rhonchi (rattling) in their lungs and elevate cardiac enzymes (proteins released into the bloodstream, indicating heart muscle damage that may result in difficulty breathing.)

Review of Resident 4's undated medical record showed no documented communication to the resident's health care provider regarding the shortness of breath, monitoring of the shortness of breath or implementation of any interventions to address the shortness of breath, prior to the department expressing concerns about the resident's wellbeing. Review showed no documentation of the resident's oxygen saturation.

This is an uncorrected deficiency previously cited on 02/19/2026.

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, Community Pride Ritzville LLC 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-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on observation and record review, the facility failed to update negotiated service agreements to accurately reflect care needs for 1 of 4 residents (Residents 4). This failure resulted in a lack of interventions for wound prevention to include repositioning and monitoring for Resident 4 and placed the resident at risk for wounds and health complications.

Findings included…

Review of Resident 4's Department of Social and Health Services (DSHS)/Home and Community Services (HCS) assessment, dated 01/06/2026, showed that the resident was diagnosed with [redacted] and [redacted]. Further review showed that the resident had a pressure injury and required a turning and repositioning program that included staff to cue them to reposition (change positions to prevent prolonged pressure on areas of the body) the resident and to monitor pressure points daily.

Review of Resident 4's facility assessment, dated [redacted]/2026 (the day of admission), showed that the resident had a pressure wound (localized damage to the skin and underlying soft tissue that typically occurs over bony parts of the body where the skin is squeezed between bond and an external surface like a bed or wheelchair [pressure points]).

Observation on 03/19/2026 at 1:55 PM showed the Resident 4 laid in bed. In an interview at that time, the resident stated their position was not changed often.

On 03/19/2026 at 2:45 PM Resident 4 laid in the same position as observed previously.

Review of Resident 4's Negotiated Service Agreement (NSA), dated 02/08/2026, showed no documented interventions to cue the resident to reposition, a turning and repositioning program, or to monitor pressure points daily.

This is an uncorrected deficiency previously cited on 02/19/2026.

Statement of Deficiencies	License #: 2631	Compliance Determination #74529
Plan of Correction	Community Pride Ritzville LLC	Completion Date
Page 6 of 6	Licensee: Community Pride Ritzville LLC	03/26/2026

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date) 5/10/2026 .

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

Sandra Davis
Administrator (or Representative)

4/15/2026
Date

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, Community Pride Ritzville LLC 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Community Pride Ritzville LLC
Provider Type: Assisted Living Facility
License/Cert.#: 2631
Intake ID: 210626
Compliance Determination #: 72353
Region/Unit #: RCS Region 1 / Unit B
Investigator: Veronica Jackson
Investigation Date(s): 02/05/2026 through 02/19/2026
Complainant Contact Date(s):

Allegation(s):
Change in facility administrator and ownership percentage not reported to the department.

Investigation Methods:

Sample:
Total residents: 13
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents well groomed.
Staff caring for resident's needs
Adequate staff to meet resident needs
Utility's (electricity/water) in use.
Resident care supplies adequate
Laundry services performed as scheduled
Infection control practices with no concerns
Food supplies and service with no concerns
Activity's completed per regulations
Environmental tour completed facility and grounds were clean and organized.
Valid assisted living facility license posted
Coordination of healthcare services

Interviews:
Administrator/Owner on record with department
General Manager
Assistant Manager
Residents
Hospice provider
HCS assessor
Caregiving staff

Record Reviews:
Facility policy's
Disclosure of Services
Current assisted living facility license on record with department
Resident records
Staff records

Investigation Summary:

Interviews with current managers, staff and administrator on file showed that change of ownership or administrator had not occurred. No failed practice identified.

Conclusion / Action:

- ☐ 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
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2631	Compliance Determination #72353
Plan of Correction	Community Pride Ritzville LLC	Completion Date
Page 1 of 13	Licensee: Community Pride Ritzville LLC	02/19/2026

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 the unannounced on-site full inspection and complaint investigation on 02/05/2026 and 02/10/2026 of:
Community Pride Ritzville LLC
406 S Cascade St
Ritzville, WA 99169

This document references the following complaint numbers: 210626.

The following sample was selected for review during the unannounced on-site visit: 4 of 13 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Veronica Jackson, Assisted Living Facility Licensor

From:
DSHS, Home and Community Living 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 — 02/26/2026 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.

Sandra Davis — Administrator (or Representative) — 03/06/2026 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 observation, interview and record review, the facility failed to monitor, evaluate, and take appropriate action for 1 of 4 Residents (Resident 4) who had a wound. This failure resulted in Resident 4's wound worsening and a lack of communication to the physician, and placed the resident at increased risk for pain, infection and worsening health conditions.

Findings included...

<Resident 4>

Review of Resident 4's Department of Social and Health Services (DSHS)/Home and Community (HCS) assessment, dated 01/06/2026, showed that the resident had a pressure injury (localized damage to the skin and underlying soft tissue) with instructions to clean with saline (a solution used in wound care), apply betadine (antiseptic solution), and to provide wound care with a dressing that was specially designed to be changed every three days and as needed. The assessment showed that the resident needed to be turned and repositioned to avoid constant pressure to the wound.

Review of Resident 4's facility assessment, dated [redacted] 2026, showed the resident was admitted to the facility on [redacted]/2026 and that the resident had diagnoses of [redacted] and [redacted]. Further review showed that the resident had a dime size wound to their upper back and required clean dressing changes.

Review of Resident 4's Negotiated Service Agreement (NSA), dated 02/08/2026, showed that the resident would let staff know when they needed to move or reposition, and that the resident needed extensive assistance from staff with skin care and all bed mobility and transfers. Further review showed that the resident had a wound on their back, required nurse delegated (under the direction and supervision of a registered nurse) dressing changes from staff and that wound care would be completed according to nurse instructions. The assessment showed that staff would report any wound concerns to management promptly.

Review of Resident 4's January 2026 and February 2026 Medication Administration Records (MARs) showed that the resident had an order for wound care that documented, "wound to back-change dressing every three days." Further review of the MARs showed that they lacked instructions for cleaning and monitoring the wound.

Review of Resident 4's Registered Nurse Delegation Instructions form, dated [redacted] 2026, showed the following steps to be completed every three days and as needed:

-Wash hands with warm water and soap. Apply gentle pressure if the wound is bleeding. Clean the wound with mild soap and running water. Dry the wound. Apply the dressing (type of dressing not indicated).

In an interview on 02/09/2026 at 11:30 AM, Resident 4 stated that they had been sleeping in their recliner chair as they were more comfortable sleeping there and that they sat in their chair most of the time. When asked if they had any sores anywhere the resident stated that they had one on their back that had been there for "quite a while."

In an interview on 02/09/11:40 AM, Staff D, Day Caregiver, confirmed that Resident 4 had been sleeping in their recliner chair and not their bed. Staff D stated that Resident 4 had a quarter-sized (wound dime sized at admit) open sore on their back and that the treatment was to apply a band aid every three days. Staff D stated that at times the band aid rubbed away from the wound or rolled up and became displaced.

Observations on 02/09/2026 at 11:30 AM, 12:15 PM and 2:35 PM, showed Resident 4 sat upright in their chair with a pillow directly in the middle of their back. During each observation the resident was noted to be in the same position.

Observation on 02/09/2026 at 2:35 PM with the assistance of Staff A, General Manager, of Resident 4's pressure wound, showed an open area on the resident's midback area with full thickness (wound that extends into fat tissues and can lead to exposing muscle, tendon, or bone) of skin layer loss and a quarter sized deep red center. The skin surrounding the sore was a very deep red/dark purple color (which typically indicates that additional pressure injury may be imminent if pressure to the injury is not relieved) and was baseball sized. Further observation showed a band aid was not covering the wound and was instead rolled up and out of place.

In an interview on 02/09/2026 at 3:50 PM, Staff A stated the when the resident was admitted, the facility nurse contacted the hospital the resident was admitted from and obtained treatment information from a hospital staff member. Staff A stated that at that time the nurse requested an order from the doctor for the current dressing change order. Staff A stated that they did not clean Resident 4's open wound or monitor it for infection daily because the order did not specify to do that. Staff A confirmed there were no documented records to show that the facility monitored, took periodic measurements, or documented descriptions of Resident 4's pressure wound since the resident admitted. Staff A further stated that home health was not monitoring the resident, the resident had not seen a doctor since admission and there had not been an appointment scheduled for the resident to see a doctor. When asked what pressure relieving measures were in place for the resident, Staff A stated that the resident used a pillow behind their back and that the resident was able to move the pillow side to side. Staff A stated that they were not aware that the resident was sleeping in their chair at night and believed the resident was sleeping in their bed every night.

Review of Resident 4's undated medical record showed no documented observations or measurements of the resident's wound. Further review showed no documented communication to the nurse delegator or the resident's health care provider regarding the wound's condition and increase in size (from dime sized to quarter sized).

In an interview on 02/10/2026 at 1:45 PM, Staff A stated that they had found out that Resident 4 had been sleeping in their chair some nights. Staff A confirmed that they were not aware of the previous treatment of the wound mentioned in the DSHS assessment and that the facility did not have a policy for monitoring residents with pressure wounds. Staff A further stated that after observing the Resident's wound condition, and discussion regarding concerns expressed about current wound treatment from the department licensor, they scheduled a next day appointment for the resident.

In an interview on 02/11/2026 at 1:30 PM, Collateral Contact 1 (CC1), DSHS/HCS Assessor, stated that based on the department's observation on 02/09/2026 and description of Resident 4's pressure sore, they were concerned about the continued treatment of a band aid that was ordered to be changed every three days.

Review of Resident 4's 02/11/2026 doctor's visit orders, showed orders to apply a Telfa dressing (non-adherent dressing used for chronic wounds) to the resident's pressure wound and to change daily until the resident was seen by a wound care specialist at their clinic.

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date) 03/06/2026

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

Sandra Davis — Administrator (or Representative)

03/06/2026 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to develop or update negotiated service agreements to accurately reflect care needs for 2 of 4 residents (Residents 4 and 3). This failure resulted in a lack of interventions for positioning, weight monitoring, and food and drink intake for Resident 4, a lack of interventions for transfer/mobility needs and toileting for Resident 3, and placed the residents at risk of health complications and a decreased quality of life.

Findings included...

<Resident 4>

-Positioning with Pressure Wound

Review of Resident 4's Department of Social and Health Services (DSHS)/Home and Community Services (HCS) assessment, dated 01/06/2026, showed that the resident had diagnoses of [redacted] and [redacted]. Further review showed that the resident had a pressure injury and required a turning and repositioning program that included staff to cue them to reposition in bed, and to monitor pressure points daily.

Review of Resident 4's facility assessment, dated [redacted]2026, (the day of admission) showed that the resident's pressure wound was the size of a dime.

Review of Resident 4's Negotiated Service Agreement (NSA), dated 02/08/2026, showed that the resident had a pressure wound on their back, the resident would let staff know when they needed to move or reposition and needed extensive assistance from staff with skin care and all bed mobility and transfers. Review of the NSA showed no documented interventions to cue the resident to reposition, a turning and repositioning program, or to monitor pressure points daily.

Observation on 02/09/2026 at 11:30 AM, 12:15 PM, and 2:35 PM, showed Resident 4 sat upright in their chair and in the same position each observation.

In an interview on 02/09/2026 at 11:30 AM, Resident 4 stated that they had been sleeping in their recliner chair as they were more comfortable sleeping there and that they sat in their chair most of the time. When asked if they had any sores anywhere the resident stated that they had one on their back that had been there for "quite a while."

In an interview on 02/10/2026 at 12:45 PM, Staff A, General Manager, stated that Resident 4 repositioned themselves with a pillow behind their back and that they were not aware that the DSHS assessment stated that the resident required staff to cue the resident to turn them in order to relieve pressure to the wound or to assist the resident

with repositioning if needed. Staff A further stated they were not aware that the resident's wound had worsened.

In an interview on 02/09/11:40 AM, Staff D, Day Caregiver, confirmed that Resident 4 had been sleeping in their recliner chair and not their bed. Staff D stated that Resident 4 had a quarter sized open sore on their back and for positioning, the resident used a pillow behind their back.

Observation on 02/09/2026 at 2:35 PM with the assistance of Staff A, General Manager, of Resident 4's pressure wound showed it was quarter sized and had surrounding redness the size of a baseball.

Review of Resident 4's doctor's visit orders, dated 02/11/2026, showed that a doctor had assessed the pressure wound and ordered daily dressing changes and a referral to a wound care specialist.

-Weight Monitoring

Review of the facility's undated policy titled, "Health Promotion Services," showed that staff would provide weight monitoring for residents monthly and PRN (when necessary).

Review of Resident 4's DSHS/HCS assessment, dated 01/06/2026, showed that the resident had diagnoses of [redacted] and [redacted]. Review showed the resident was five foot eight inches tall, weighed 102 pounds and had recently lost weight.

In an interview on 02/09/2026 at 11:40 AM, Staff D, Day Caregiver, stated that they were not aware that per facility policy, residents were to be weighed monthly. Staff D stated they had never obtained Resident 4's weight.

In an interview on 02/09/2026 at 1:00 PM, Staff A stated that they could not obtain a weight on Resident 4 because the resident could not safely stand on the scale and that the facility did not have a scale to obtain the weights of residents in wheelchairs.

In an interview on 02/10/2026 at 12:45 PM, Staff A confirmed they were not aware that Resident 4 had a history of weight loss as stated on the DSHS assessment and did not have a policy for monitoring residents with a history of weight loss.

In an interview on 02/11/2026 at 1:30 PM, Collateral Contact 1 (CC1), DSHS/HCS Assessor, who had completed the DSHS assessment on 01/06/2026, stated that they were concerned that Resident 4 had not had any weight monitoring based on the resident's history of weight loss and a recent diagnosis of [redacted].

Review of Resident 4's undated medical record showed no documentation of weight measurements for the resident since admit on [redacted]2026.

Review of Resident 4's NSA, dated 02/08/2026, showed no documentation of the need for the resident to be monitored for weight loss.

-Food and drink intake.

Review of Resident 4's DSHS/HCS assessment, dated 01/06/2026, showed that the resident had diagnoses of [redacted] and [redacted]. Review showed the resident had a swallowing problem and required a straw for liquids

Review of Resident 4's facility assessment, dated 01/22/2026, showed the resident had chewing/swallowing concerns due to missing and broken teeth.

Review of Resident 4's NSA, dated 02/08/2026, showed that the resident required assistance with meals including set up, queueing, and physical assistance as needed. The NSA showed no documentation of the resident's chewing/swallowing problems or their need to use a straw to drink liquids. Further review of the NSA showed no interventions were listed for monitoring meal intake due to the resident's difficulty with chewing and swallowing

Observation on 02/09/2026 at 12:15 PM, showed Resident 4, during lunch service, had only eaten a small custard dessert and two bites of the main meal. Further observation showed the resident had a small glass of water and a glass of orange-colored juice next to them without a straw.

In an interview on 02/10/2026 at 12:45 PM, Staff A confirmed that Resident 4 was not monitored for meal intake. Staff A stated they were not aware that Resident 4 had a history of weight loss. Staff A stated they would schedule the resident for a next day appointment with the health care provider.

In an interview on 02/11/2026 at 1:30 PM, Collateral Contact 1 (CC1), DSHS/HCS Assessor who had completed the DSHS assessment on 01/06/2026, stated that they were concerned that Resident 4 had not had any weight or intake monitoring based on the resident's history of weight loss and a recent diagnosis of [redacted].

Review of Resident 4's doctor's visit orders, dated 02/11/2026, showed the resident required calorie and fluid intake monitoring and two to three supplement shakes to be administered daily as needed.

<Resident 3>

Review of Resident 3's DSHS/HCS assessment, dated 10/29/2025, showed that the resident required extensive assistance from one staff for transfers and mobility needs.

Review of Resident 3's nursing care notes, dated 01/11/2026, showed that the resident complained of catheter (tube inserted into the bladder for urine elimination) pain. Review showed no interventions were implemented at that time.

Review of Resident 3's nursing care notes, dated 01/15/2026, showed that the resident had complained of not being taken to the bathroom and that staff explained to the resident it was due to having a catheter.

Review of Resident 3's nursing care notes, dated 01/28/2026, showed the resident was upset because they could not go to the bathroom. The notes showed that staff tried to calm them down and informed them that they had a catheter.

In an interview on 02/06/2026 at 12:00 PM, Resident 3 stated that facility staff would not assist them to the bathroom, so they had to eliminate their bowels into a brief while lying in bed. Resident 3 also stated that they were concerned about getting a kink in their catheter tubing as it happened frequently. The resident asked the department licensor to look to see the catheter was currently kinked. Observation at that time showed the resident's leg was laying on top of the catheter tubing. Observation showed facility staff straightened the tubing but did not reposition the tubing to lay above the resident's leg.

In an interview on 02/10/2026 at 12:45 PM, Staff A stated they were not aware that the NSA should include instructions and interventions for staff to utilize when providing care to a resident with a urinary catheter and mobility/elimination needs. Staff A further stated that they could not safely transfer or assist Resident 3 to the bathroom toilet as the resident required a Hoyer lift (mechanical transfer device) for transfers.

Review of Resident 3's NSA, last updated on 01/13/2026, showed that facility staff would ensure the resident got to the toilet safely. Review showed the resident required a catheter for urine elimination and a Hoyer lift for mobility and transfers. Review showed no instructions or interventions (to include monitoring for function and infection) were documented in the NSA for staff to utilize when providing care to a resident with a catheter. Further review showed no interventions for bowel elimination were documented.

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date) 03/06/2026 .

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

Sandra Davis — Administrator (or Representative)

03/06/2026 — Date

WAC 388-78A-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report changes in physical condition to an external health care provider for 1 of 4 residents (Resident 1). This failure placed the resident at risk for health complications.

Review of Resident 1's DSHS/HCS assessment, dated 03/20/2025, showed that the resident had health indicators of edema (swelling due to excess fluid that often results in weight gain.). Further review showed that the resident required daily weights to be monitored and to notify the resident's external health care provider if weight gain in a 24-hour period was more than three pounds.

Review of Resident 1's December 2025, January 2026, and February 2026 MAR's, showed that the resident had an order for staff to obtain daily weights to be obtained and to notify the resident's external health care provider of weight gain of three pounds or more in a 24-hour period.

Review of Resident 1's weight log, dated January 2026, showed that the resident had a five-pound weight gain on 01/23/2026 and again on 01/30/2026. Further review showed that there were sections to document if a nurse/manager was notified or the primary care provider, and all sections were blank.

In an interview on 02/05/2026 at 3:35 PM, Staff B, Assistant Manager, confirmed that they had taken the resident's weight but had not noticed the five-pound weight gains on 01/23/2026 and 01/30/2026, and had not notified the doctor.

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date) 03/06/2026 .

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

Sandra Davis — Administrator (or Representative)

03/06/2026 — Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a Washington state name and date of birth background check was completed every two years for 1 of 5 sampled staff (Staff E). This failure placed residents at risk of receiving unsupervised care from staff that may have had a disqualifying crime listed on their background check.

Findings included...

Review of Staff B's, Activity Staff, personnel file showed a hire date of 12/14/2022. Further review showed that a Washington state name and date of birth background check was completed on 12/02/2021 and then again on 01/22/2024 (51 days after expiration)

In an interview on 02/09/2026 at 2:30 PM, Staff A, General Manager, stated that a background check was not completed in 2023 for Staff B.

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date) 03/06/2026 .

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

Sandra Davis — Administrator (or Representative)

03/06/2026 — Date

WAC 388-78A-2734 Liability insurance required Professional liability insurance coverage. The assisted living facility must have professional liability insurance or error and omissions insurance if the assisted living facility licensee has a professional license, or employs professionally licensed staff. The insurance must include:

(1) Coverage for losses caused by errors and omissions of the assisted living facility, its employees, and volunteers; and

(2) Minimum limits of:

(a) Each occurrence at one million dollars; and

(b) Aggregate at two million dollars.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide documentation of their current general and professional liability insurance policy. This absence of insurance placed residents at increased risk of uncompensated harm, disrupted continuity of care, and potential instability of operations should adverse events occur.

Findings included...

Requests to review a copy of the facility's general liability and professional liability insurance were made on 02/05/2026 and 02/06/2026.

Review of facility documents on 02/10/2026, the day the department licensor exited the full licensing visit, showed no documentation of general liability or profession liability.

Review of email requests sent on 02/12/2026 at 1:03 PM and 02/13/2026 at 10:41 AM from the department licensor to Staff B, Assistant Manager, showed requests were made for a copy of the facility's general and professional liability insurance.

Review of email response from Staff A, dated 02/13/2026 at 9:13 PM, showed that Staff A was still waiting for a response from the insurance company regarding the facility's general and professional liability insurance.

Review of email response dated 02/23/2026 at 12:54 PM, showed that Staff A, Manager had contacted the insurance company and anticipated a response that day with documentation of the facility's general liability insurance information.

In a phone interview on 02/19/2026 at 11:00 AM, Staff A, Manager, informed the department field manager that the facility's insurance policy had lapsed.

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date) 03/06/2026.

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

Sandra Davis — Administrator (or Representative)

03/06/2026 — Date