STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Olympic Holdings - Riverview, LLC
Riverview Manor
555 E Goodlander Rd
Selah, WA 98942

RE: Riverview Manor License # 2701

Dear Administrator:

This letter addresses Compliance Determination(s) 68566 (Completion Date 11/18/2025) and 64783 (Completion Date 09/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/18/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-b, WAC 388-78A-2240

The Department staff who did the on-site verification:
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2701
Compliance Determination #: 64783
Intake ID: 191776
Investigator: Anna Cairns
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 08/27/2025 through 09/24/2025
Complainant Contact Date(s):

Allegation(s):
Staff at the facility were incorrectly documenting that medication had been administered when the medication was not available or administered to the named resident.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 4 Closed records sample size: 1
Observations:	Medication cart Medication room Staff to resident interactions
Interviews:	Administrator Registered Nurse Resident representatives Staff Resident
Record Reviews:	Characteristic roster Facility medication policies Resident records (face sheet, care plan, medication administration record, progress notes, physician orders) Incident investigation Staff schedule Staff list

Investigation Summary:
Observation, interview, and record review showed that staff were documenting that medications were being administered to residents that were not available at the facility. Failed practice identified. WAC 388-78A-2210 (1)(b). Previously cited on 01/29/2025.

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: Riverview Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2701
Compliance Determination #: 64783
Intake ID: 190850
Investigator: Anna Cairns
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 08/27/2025 through 09/24/2025
Complainant Contact Date(s): 08/27/2025, 09/19/2025

Allegation(s):

1. Residents at the facility are not getting their medications or medication refills.
2. The facility administrator was notified of medications not available for residents by staff multiple times and the administrator did not address the concern.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 4 Closed records sample size: 1
Observations:	Medication cart Medication room Staff to resident interactions
Interviews:	Administrator Registered Nurse Staff Resident representatives Resident
Record Reviews:	Characteristic roster Facility medication policies Resident records (face sheet, care plan, medication administration record, progress notes, physician orders) Incident investigation Staff schedule Staff list

Investigation Summary:

1. Observation, interview, and record review showed that residents were not getting their medications as prescribed and that medications were not available to residents. Failed practice identified. WAC 388-78A-2210 (1)(b) and WAC 388-78A-2240. Previously cited on 01/29/2025.
2. The facility administrator was notified of medications that were not available to residents at the facility. The administrator had an investigation completed, did a medication cart audit, and retrained staff. No failed practice identified.

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: Riverview Manor
Provider Type: Assisted Living Facility
License/Cert.#: 2701
Compliance Determination #: 64783
Intake ID: 192370
Investigator: Anna Cairns
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 08/27/2025 through 09/24/2025
Complainant Contact Date(s): 08/27/2025, 09/19/2025

Allegation(s):

1. The named resident was neglected by staff at the facility.
2. Multiple residents are missing medications or had been out of their medications.
3. Staff had brought concerns of residents without medications and missing medication to the facility administrator and their concerns were not addressed.

Investigation Methods:

Sample:
Total residents: 58
Resident sample size: 4
Closed records sample size: 1

Observations:
Medication cart
Medication room
Staff to resident interactions

Interviews:
Administrator
Registered Nurse
Staff
Resident representatives
Resident

Record Reviews:
Characteristic roster
Facility medication policies
Resident records (face sheet, care plan, medication administration record, progress notes, physician orders)
Incident investigation
Staff schedule
Staff list

Investigation Summary:

1. Observation and interview showed that residents and resident representatives had no concerns with neglect or care at the facility. No failed practice identified.
2. Observation, record review, and interview showed that multiple residents did not have medications available to them and were not given as prescribed. Failed practice identified. WAC 388-78A-2210 (1)(b) and WAC 388-78A-2240. Previously cited on 01/29/2025.
3. Interview showed that the facility administrator was notified of residents being

out of their medications. The facility administrator did an investigation, staff re-training on medication and ordering, and did a medication cart audit. The administrator and facility nurse had their records reviewed at the their last full inspection and had the required qualifications and credentials. No failed practice identified.

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
1200 Alder Street, Union Gap, WA 98903

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 08/27/2025 and 08/28/2025 of:

Riverview Manor
555 E Goodlander Rd
Selah, WA 98942

This document references the following complaint number(s): 191776, 190850, 192370

The following sample was selected for review during the unannounced on-site visit: 4 of 58 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

Statement of Deficiencies	License #: 2701	Compliance Determination # 64783
Plan of Correction	Riverview Manor	Completion Date
Page 2 of 10	Licensee: Olympic Holdings - Riverview, LLC	09/24/2025

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.

Laura Williams-Davis
Residential Care Services

10/02/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

10/2/2025
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement a safe medication system and that medication orders were followed as prescribed for 3 of 5 residents (Resident 1,3, and 4). These failures resulted in resident medication administration records not being accurate and residents not receiving their medications as prescribed.

Findings Included...

Review of the undated facility Policy, "Medication administration and documentation" showed that staff were to ensure that residents received their medications as ordered, that they were to not document a medication as given without administering it, and that if a medication was not available, that staff were to document it accurately.

In an interview on 08/27/2025 at 1:30 PM, Staff A, Administrator, acknowledged that they were aware that Resident 1 had been out of their blood pressure medication and had missed several doses. Staff A also acknowledged Resident 3 and Resident 4 did not have all their medications available to them. Additionally, Staff A acknowledged that staff had been signing that medication had been given that were not at the facility.

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-2210 Medication services.

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Findings Included…

Review of the undated facility Policy, “Medication administration and documentation” showed that staff were to ensure that residents received their medications as ordered, that they were to not document a medication as given without administering it, and that if a medication was not available, that staff were to document it accurately.

In an interview on 08/27/2025 at 1:30 PM, Staff A, Administrator, acknowledged that they were aware that Resident 1 had been out of their blood pressure medication and had missed several doses. Staff A also acknowledged Resident 3 and Resident 4 did not have all their medications available to them. Additionally, Staff A acknowledged that staff had been signing that medication had been given that were not at the facility.

<Resident 1>

Review of Resident 1's Negotiated Service Agreement (NSA), dated 03/31/2025, showed that the resident had diagnoses of [redacted] and [redacted]. Resident 1's NSA showed that they required staff to provide medication assistance with administration and with ordering their medication through the facility's preferred pharmacy.

Review of Resident 1's physician order, dated 07/17/2025, showed that the resident had been prescribed Donepezil (used to treat dementia) 5 milligrams (MG), every evening, starting 07/01/2025. Additionally, the physician order showed that Resident 1 required blood sugar checks twice a day.

Review of Resident 1's July 2025 MAR, showed that their Donepezil once daily medication, had been administered to them twice on 07/03/2025 through 07/06/2025. Additionally, Resident 1's MAR did not document their blood sugar monitoring from 07/01/2025 through 07/31/2025.

Review of Resident 1's hospital discharge summary, dated [redacted]2025, showed that a physician at the hospital had made additional changes to their medications, that included Ferrous Sulfate (used to treat iron deficiency) 325 MG to be taken every other day and Furosemide (used to treat excess fluid and high blood pressure) 20 mg (2 tablets once daily). Additionally, the physician ordered Resident 1 Isosorbide Denitrate (used to lower blood pressure) 20 mg for the resident to start [redacted]/2025.

Review of Resident 1's August 2025 MAR showed the following:

- Ferrous Sulfate 325 mg was given daily, not every other day from 08/01/2025 08/19/2025.
- Furosemide 20 mg medication was prescribed as 2 tablets once daily, the MAR showed that the medication was given 20 mg twice daily.
- The MAR did not show Resident 1's blood sugar had been monitored twice daily from 08/01/2025 through 08/13/2025.
- Isosorbide Dinitrate 20 mg three time daily, the MAR showed that the medication was not available starting 08/13/2025. Resident 1's MAR showed given by staff for 12 doses from 08/13/2025 through 08/18/2025.

Review of the facility investigation, dated 08/28/2025, showed that staff had charted that the Isosorbide Denitrate medication for Resident 1 was administered. However, the investigation showed that the medication was out of stock at the facility from 08/13/2025 through 08/19/2025 and that the resident had missed 20 doses of their medication. The investigation showed that documentation for Resident 1 was, "Inconsistent and incorrect."

<Resident 3>

Review of Resident 3's NSA, dated, 07/23/2025, showed that the resident had diagnoses of [redacted], and [redacted]. Resident 3's NSA showed that they required staff to provide medication assistance with administration and with ordering their medication through the facility's preferred pharmacy.

Review of Resident 3's physician order, dated 07/16/2025, showed that they were prescribed:

- -Carbidopa-Levodopa (used to treat symptoms of Parkinson's disease) 50-200 mg four times daily was ordered to start on 07/10/2025.
- Mirtazapine 15 mg (used to treat anxiety and depression) was ordered to start on 08/14/2025.
- Quetiapine 50 mg (used to treat neurocognitive disorder with Lewy bodies) was ordered to start 07/23/2025
- Rasagiline 1 mg (used to treat symptoms of Parkinson's disease), was ordered to start on 05/21/2025.
- Trazodone 100 mg (used to treat symptoms of Lewy bodies and for sleep), was ordered to start on 07/01/2025.

Review of Resident 3's August 2025 MAR showed the following:

- Carbidopa-Levodopa 50-200 mg was not available as of 08/14/2025.
- Mirtazapine 15 mg, was not available as of 08/14/2025.
- Quetiapine 50mg, showed a duplicate order, which showed that the medication was given twice on 08/20/2025 and 08/21/2025.
- Rasagiline 1mg, showed as not available starting 08/13/2025 through 08/16/2025, given 08/23/2025 and 08/24/2025, and then not available from 08/19/2025 through 08/22/2025.
- Trazodone 100 mg, showed as not available as of 08/10/2025.

Review of Resident 3's progress notes, dated 08/22/2025, showed that the resident had a duplicate order that needed to be removed of their Quetiapine 50 mg medication.

Review of the facility incident investigation, dated 08/28/2025, showed that Resident 3 had, "Inconsistent and incorrect," documentation in their record. The investigation showed that medication had been administered to Resident 3, when the medications were out of stock.

<Resident 4>

Review of Resident 4's NSA, revised on 07/22/2025, showed that the resident had diagnoses of [redacted], and [redacted]. Resident 4's NSA showed that they required staff to provide medication assistance with administration and ordering their medications through the facility's preferred pharmacy.

Review of Resident 4's physician orders, reviewed by the facility nurse on 08/27/2025 showed that they were prescribed:

- Buprenorphine Naloxone (used to treat pain) 2-0.5 mg once daily starting 06/12/2025.
- Desvenlafaxine (used to treat major depressive disorder), 25 mg once daily to start on 02/03/2025.
- Ezetimibe (used to treat high cholesterol) 10 mg once daily to start on 05/15/2025.
- Trintellix (an antidepressant used to treat major depressive disorder) 10 mg

Review of Resident 4's July 2025 MAR showed the following:

- Buprenorphine 2-05. MG, the MAR showed that Resident 4 had not been given their medication from 07/01/2025 through 07/06/2025.
- Trintellix 10 mg, the MAR showed that the resident was, "Absent from the home without meds", then showed that the medication was not available on 07/11/2025, administered on 07/13/2025, and that the medication was not available on 07/14/2025, and 07/15/2025.

Review of Resident 4's August 2025 MAR showed the following:

- Desvenlafaxine Succinate 25 mg, the MAR showed that the medication was not available starting 08/07/2025, then was signed by staff as administered on 08/10/2025, 08/12/2025, 08/18-08/19/2025, and then not available 08/19/2025 through 08/27/2025.
- Ezetimibe 10 mg, the MAR showed that the medication was not available and then was signed by staff as administered on 08/08/2025 through 08/27/2025.

In an interview on 09/10/2025 at 10:15 AM, Resident 4 stated that they had missed doses of their medication Trintellix from 07/04/2025 through 07/15/2025 and that they felt, "Sick," that they went through withdrawals, were tired, slept more, felt nauseous, and had a headache. . Additionally, Resident 4 stated that they were not out of the facility and that the dates that showed they were given the medication on the MAR, they were not. Resident 4 also stated they had missed doses of their Buprenorphine and had also not been given their Desvenlafaxine or Ezetimibe medication since 08/07/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Riverview Manor 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) 10/2/2025 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based observation, interview and record review, the facility failed to ensure that resident medications were obtained when staff were responsible to order medications for 4 of 5 residents (Residents 1, 3, 4 and 5). This failure resulted in residents not receiving their medications, and put them at risk of a decline in their chronic health conditions.

Findings Included...

Review of undated, facility policy, "Unavailable Medications" showed that "The facility was to provide medications to residents in a timeframe and in a manner that promotes health and welfare".

<Resident 1>

Review of Resident 1's Negotiated Service Agreement (NSA), dated 03/31/2025, showed that the resident had diagnoses of [redacted] and [redacted] Resident 1's NSA showed that they required staff to provide medication assistance with administration and with ordering their medication through the facility's preferred pharmacy.

Review of Resident 1's hospital discharge summary, dated [redacted]2025, showed that the medication Isosorbide Dinitrate 20 mg (used to treat symptoms of heart failure and lower blood pressure) was prescribed and was to start on [redacted]/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Riverview Manor 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-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based observation, interview and record review, the facility failed to ensure that resident medications were obtained when staff were responsible to order medications for 4 of 5 residents (Residents 1, 3, 4 and 5). This failure resulted in residents not receiving their medications, and put them at risk of a decline in their chronic health conditions.

Findings Included…

Review of undated, facility policy, “Unavailable Medications” showed that “The facility was to provide medications to residents in a timeframe and in a manner that promotes health and welfare”.

<Resident 1>

Review of Resident 1’s Negotiated Service Agreement (NSA), dated 03/31/2025, showed that the resident had diagnoses of [redacted] and [redacted]. Resident 1’s NSA showed that they required staff to provide medication assistance with administration and with ordering their medication through the facility’s preferred pharmacy.

Review of Resident 1’s hospital discharge summary, dated [redacted]/2025, showed that the medication Isosorbide Dinitrate 20 mg (used to treat symptoms of heart failure and lower blood pressure) was prescribed and was to start on [redacted]/2025.

Review of Resident 1's MAR, dated August 2025, showed that between 08/13/2025 and 08/19/2025, the resident's Isosorbide Denitrate, three times daily medication was not available at the facility.

Review of the facility incident investigation, dated 08/28/2025, showed that Resident 1' s isosorbide denitrate medication was out of stock from 08/13/2025 through 08/19/2025. Additionally, the investigation showed that Resident 1 missed a total of 20 doses of their medication.

In an interview on 08/27/2025 at 1:30 PM, Staff A, Administrator, stated that Resident 1 had missed multiple doses of their blood pressure medication.

<Resident 3>

Review of Resident 3's NSA, dated 07/23/2025, showed that the resident had diagnoses of [redacted], and [redacted]. Resident 3's NSA showed that they required staff to provide medication assistance with administration and with ordering their medication through the facility's preferred pharmacy.

Review of Resident 3's physician order, dated 07/16/2025, showed that that were prescribed:

- Carbidopa-levodopa) 50-200 milligrams (mg), four times daily (used to treat symptoms of Parkinson's disease) was ordered to start on 05/21/2025.
- Mirtazapine 15 mg (used to treat anxiety and depression) was ordered to start on 08/14/2025.
- Quetiapine 50 mg (used to treat neurocognitive disorder with Lewy bodies) was ordered to start 07/23/2025
- Rasagiline 1 mg (used to treat symptoms of Parkinson's disease), was ordered to start on 05/21/2025.
- Trazodone 100 mg (used to treat symptoms of Lewy bodies and for sleep), was ordered to start on 08/14/2025.

Review of Resident 3's August 2025 MAR showed the following:

- Carbidopa-levodopa 50-200 mg was to be given four times daily. Resident 3's MAR showed that the medication was documented as not available, beginning 08/05/2025 through 08/17/2025.
- Mirtazapine 15 mg to be given at bedtime, the MAR showed as not available starting on 08/14/2025 and did not show as given until 08/20/2025.

- Quetiapine 50 mg, the MAR showed that the medication was not available starting on 08/14/2025 and was not given until 08/26/2025.
- Rasagiline 1mg, the MAR showed that the medication was not available starting on 08/13/2025 through 08/22/2025.
- Trazadone 100 mg, the MAR showed that the medication had been started on 07/23/2025 and the medication was not available starting 08/10/2025 through 08/19/2025.

Review of Resident 3's progress note, dated 08/14/2025, showed that, "The resident is running out of all medications."

Review of the facility incident investigation, dated 08/28/2025, showed that Resident 3' s medications were not available from 08/14/2025 to 08/22/2025 and that the facility staff continued to contact the pharmacy for medications on 08/22/2025.

Observation on 09/10/2024 at 11:30 AM of the medication cart at the facility showed that Resident 3's Quetiapine, Mirtazapine, and Carbidopa-levodopa medication were filled on 08/20/2025.

<Resident 4>

Review of Resident 4's NSA, dated 07/22/2025, showed that the resident had diagnoses of [redacted], and [redacted]. Resident 4's NSA showed that they required staff to provide medication assistance with administration and ordering their medications through the facility's preferred pharmacy. Additionally, Resident 4's NSA showed that they were independent with decisions about their care in the cognition section.

Review of Resident 4's physician orders, reviewed by the facility nurse on 08/27/2025, showed that they were prescribed:

- Buprenorphine naloxone 2-0.5 mg once daily to start on 02/25/2025.
- Desvenlafax (used to treat major depressive disorder), 25 mg once daily to start on 02/03/2025.
- Ezetimibe (used to treat high cholesterol) 10 mg once daily to start on 05/15/2025.
- Trintellix (an antidepressant used to treat major depressive disorder), 10 mg once daily to start on 07/16/2025.

Review of Resident 4's July 2025 MAR showed the following:

- Buprenorphine naloxone 2-0.5 mg (pain medication), Resident 4's MAR showed

that the medication start date was 07/01/2025. The MAR showed that the medication was not given until 07/07/2025.
- Trintellix 10 mg the MAR showed that the medication was not available starting on 07/11/2025, was signed as given by staff on 07/16/2025, and was not given until 07/26/2025.

Review of Resident 4's August 2025 MAR showed the following:

- Desvenlafaxine succinate the MAR showed that the medication was not available starting 08/07/2025 through 08/27/2025.
- Ezetimibe 10 mg, the MAR showed that the medication was not available starting on 08/07/2025.

Review of Resident 4's September 2025 MAR showed that their Losartan Potassium 100 mg medication was not available starting on 09/06/2025.

Observation on 09/10/2025 at 11:30 AM, showed that the medication cart at the facility had Resident 4's Buprenorphine that had been filled on 09/04/2025, their Desvenlafaxine succinate medication that had been filled on 08/27/2025, their Ezetimibe that had been filled on 09/03/2025, their Trintellix that had been filled on 09/03/2025, and their Losartan Potassium that had been filled on 09/09/2025.

In an interview on 09/10/2025 at 10:15 AM, Resident 4 stated that they had been taking the same medications for years and that they were not getting the refills on the medications. Resident 4 stated that they were having negative side effects of feeling sick, going through withdrawals that they had felt nauseous, tired, more anxious, and more agitated.

<Resident 5>

Review of Resident 5's NSA, revised on 07/28/2025, showed that the resident had diagnoses of [redacted], and [redacted]. Resident 5's NSA showed that they required staff to provide medication assistance with administration and with ordering their medication through the facility's preferred pharmacy.

Review of Resident 5's Physician orders reviewed by the facility nurse on 08/27/2025, showed that they were prescribed:

- Quetiapine 25 mg (noon dose), to start on 07/17/2025.
- Quetiapine 25 mg (evening dose), to start on 07/17/2025.

Review of Resident 5's August 2025 MAR showed the following:

- Quetiapine 25 mg noon dose, Resident 5's MAR showed a start date of 08/14/2025. The MAR showed that the medication was not given until 08/19/2025.
- Quetiapine 25 mg evening dose, the MAR showed a start date of 08/14/2025. The MAR showed that the medication was not given until 08/19/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Riverview Manor 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.

Melanie Whetstone 10-2-2025

Administrator (or Representative) Date

Review of Resident 5's August 2025 MAR showed the following:

- Quetiapine 25 mg noon dose, Resident 5's MAR showed a start date of 08/14/2025. The MAR showed that the medication was not given until 08/19/2025.
- Quetiapine 25 mg evening dose, the MAR showed a start date of 08/14/2025. The MAR showed that the medication was not given until 08/19/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Riverview Manor 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

Riverview Manor Memory Care Community

555 E Goodlander Rd, Selah, WA 98942
Phone: 509-834-3962 | Email: melanie@riverviewmanorselah.com

Plan of Correction (POC)
WAC 388-78A-2210 – Medication Services

Inspection Date:	09/24/2025
POC Due Date:	10/12/2025

Deficiency Summary

The Washington Department of Social and Health Services identified that Riverview Manor did not meet Assisted Living Facility licensing requirements under WAC 388-78A-2210. Three of five resident records reviewed contained medication administration errors, including missed or unavailable medications and inaccurate MAR documentation.

Immediate Corrective Action

All medication carts were audited for every resident on 09/25/2025 by the nursing team and Executive Director. Missing doses were identified and documented, primary care providers were notified, and pharmacy refill issues were corrected immediately. All medication technicians received retraining on: Proper MAR documentation and use of the Missing Medication Log; Required notifications (PCP, pharmacy, resident's family, RN, and Executive Director); and Refill timelines requiring prescription medications requested 7–10 days prior to depletion and OTC/VA medications at least 14 days prior due to refill processing times.

Ongoing Compliance Plan

Daily audits of random resident MARs will be completed by Tara Corbray – Health Care Coordinator, Melanie Pitt, RN, and Melanie Folkner-Burton, Executive Director, rotating responsibility to ensure accountability and consistency. Weekly summary reports of audit findings will be maintained for 90 days and reviewed during leadership and QA meetings. Quarterly med-pass observations and competency evaluations will be conducted for all med techs. Monthly pharmacy consultant reviews of MAR accuracy and refill timeliness will occur for three months. All results and corrective actions will be tracked through the Quality Assurance and Performance Improvement (QAPI) program to ensure sustained compliance.

Responsible Persons

Tara Corbray – Health Care Coordinator Melanie Pitt, RN – Registered Nurse Melanie Folkner-Burton – Executive Director

Attestation

Riverview Manor Memory Care Community attests that all cited deficiencies have been or will be corrected as outlined above and that systems are in place to ensure continued compliance with WAC 388-78A-2210. Documentation of all corrective actions and ongoing monitoring will be maintained on-site and made available to the Department upon request.

Signature: Melanie Folkner-Burton

Title: Executive Director

Date: 10/8/2025

Riverview Manor Memory Care Community

555 E Goodlander Rd, Selah, WA 98942
Phone: 509-834-3962 | Email: melanie@riverviewmanorselah.com

Plan of Correction (POC)
WAC 388-78A-2240 – Nonavailability of Medications

Inspection Date:	09/24/2025
POC Due Date:	10/12/2025

Deficiency Summary

The Department of Social and Health Services identified that Riverview Manor did not meet Assisted Living Facility licensing requirements under WAC 388-78A-2240. The facility, having assumed responsibility to obtain prescribed medications for residents, failed to secure medications in a correct and timely manner. This resulted in missed or delayed doses for multiple residents.

Immediate Corrective Action

Upon notification of the deficiency, all current medication orders and refill statuses for every resident were reviewed. The pharmacy was contacted to expedite delivery of any delayed or missing prescriptions. Missing medications were documented, and residents' primary care providers were notified. Medications in transit were tracked daily to prevent missed doses. All medication technicians were retrained on the procedure for monitoring stock, ordering ahead, using the Missing Medication Log, and escalation steps when a medication is not available. Refill timelines were reinforced: prescription medications must be ordered 7–10 days prior to depletion and OTC or VA medications at least 14 days prior.

Ongoing Compliance Plan

Medication inventory checks will be completed daily for each medication cart to ensure availability and proper stock levels. Refill requests will be submitted at least 7–10 days prior for prescriptions and 14 days prior for OTC or VA medications. The Missing Medication Log will be maintained and reviewed weekly by the Health Care Coordinator and RN. Daily audits of random resident MARs will be conducted for 30 days, then weekly for 90 days. A pharmacy audit will be requested within 90 days to ensure compliance and verify refill timeliness. Findings and corrective actions will be reviewed in monthly QA and leadership meetings.

Responsible Persons

Tara Corbray – Health Care Coordinator Melanie Pitt, RN – Registered Nurse Melanie Folkner-Burton – Executive Director

Attestation

Riverview Manor Memory Care Community attests that all cited deficiencies under WAC 388-78A-2240 have been or will be corrected as outlined above and that systems are in place to ensure continued compliance. Documentation of corrective work and ongoing monitoring will be maintained on-site and made available to the Department upon request.

Signature: 

Title: Executive Director

Date: 10/8/2025