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

08/01/2025

KINDRED CARE SERVICES PLLC
VALLEY ROAD RESIDENTIAL CARE
3072 Valley Road NE
Moses Lake, WA 98837

RE: VALLEY ROAD RESIDENTIAL CARE # 751743

Dear Provider:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 63773 (Completion Date 08/01/2025) and 61902 (Completion Date 07/02/2025).

The Department completed a follow-up inspection of your Adult Family Home on 08/01/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10510 Resident rights Basic rights. The adult family home must ensure that each resident:

(1) Receives appropriate necessary services, as identified in the assessment and negotiated care plan;

(2) Is treated with courtesy, dignity, and respect;

(4) Has the opportunity to exercise control over life decisions, such as making the resident's own choices about daily life, participation in services or activities, care, and privacy;

(8) Has the freedom to have and use their personal belongings to the extent possible.

The Department staff who did the On Site verification:
Brittney Shull, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,
Michelle Ann Garbrough

Michelle Yarbrough, Adult Family Home Field Manager
Region 1, Unit C
Residential Care Services

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 Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 06/02/2025 and 06/30/2025 of:

VALLEY ROAD RESIDENTIAL CARE
3072 Valley Road NE
Moses Lake, WA 98837

This document references the following complaint number(s): 184872, 178215

The following sample was selected for review during the unannounced on-site visit: 4 of 6 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Brittney Shull, Community Complaint Investigator
Tamera Lapierre, Community Complaint Investigator

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

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.

Michelle Ann Garbrough
Residential Care Services

07/15/2025
Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative)

07/23/25
Date

WAC 388-76-10510 Resident rights Basic rights. The adult family home must ensure that each resident:

(1) Receives appropriate necessary services, as identified in the assessment and negotiated care plan;

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(8) Has the freedom to have and use their personal belongings to the extent possible.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure that each resident received appropriate behavioral interventions as identified in their negotiated care plan, was treated with dignity, was able to exercise control over their daily life decisions and had the freedom to use their personal belongings for 1 of 4 residents (Resident 1). This failure resulted in a violation of Resident 1's resident rights.

Findings included...

Record review of Resident 1's admission assessment, dated 03/26/2025, showed that Resident 1 had diagnoses of [redacted] and [redacted] Resident 1's admission assessment showed that they were no longer safe to be alone at home due to an increased need for supervised smoking and for assistance with Activities of Daily Living (ADL's).

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 Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative) | Date

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This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure that each resident received appropriate behavioral interventions as identified in their negotiated care plan, was treated with dignity, was able to exercise control over their daily life decisions and had the freedom to use their personal belongings for 1 of 4 residents (Resident 1). This failure resulted in a violation of Resident 1's resident rights.

Findings included…

Record review of Resident 1's admission assessment, dated 03/26/2025, showed that Resident 1 had diagnoses of [redacted] and [redacted]. Resident 1's admission assessment showed that they were no longer safe to be alone at home due to an increased need for supervised smoking and for assistance with Activities of Daily Living (ADL's).

Record review on 05/29/2025 of Resident 1's Negotiated Care Plan (NCP), dated 03/26/2025, showed that Resident 1 was a smoker and that staff were required to monitor the Resident 1 for safety while smoking.

Observation on 05/27/2025 at 1:35 PM showed Resident 1 paced around the AFH and continuously asked Staff B, Caregiver for a cigarette. Staff B's told Resident 1's it wasn't time for a cigarette yet.

Interview with Resident 1 on 05/27/2025 at 1:35 PM at the AFH, Resident 1 stated they wanted to smoke and couldn't get a cigarette from anyone. During the interview Resident 1 continuously asked for a cigarette. Resident 1 stated they did not understand why they could not have a cigarette when requested.
During an interview on 05/27/2025 at 2:15 PM Staff A, Provider, stated Resident 1 continuously asked staff for cigarettes. Staff A stated that they placed Resident 1 on a two-hour smoking schedule due to their repetitive requests for a cigarette after just having had one.

Review of AFH Safety Plan for Resident 1 dated 06/04/2025, showed that the facility would offer Resident 1 preferred snacks such as Tootsie Rolls, chocolate, juice, or coffee as a technique to de-escalate Resident 1's frequent requests. The safety plan also showed that the AFH would ensure treatment of Resident 1 was respectful.

Review of AFH Observation Notes dated 06/08/2025, showed that Staff B documented that Collateral Contact 1 (CC1), Resident Representative, brought snacks for Resident 1.

Record review of Resident 1's updated Negotiated Care Plan on 06/30/2025, showed an update dated 06/15/2025 that Resident 1 perseverated on smoking and a physician order directed that they could have a cigarette every hour. The Negotiated Care Plan showed that staff should tell Resident 1 it was not time and redirect with a snack, or a ride with family when it had not been enough time to smoke. Review of the Negotiated Care Plan did not show any interventions of restricting dietary intake or preventing Resident 1 from assisting themselves to a snack.

An observation on 06/30/2025 at 1:57pm, showed that Resident 1 requested to have a cigarette. Staff B used a loud and intimidating tone to tell Resident 1 it was not time. Staff B asked Resident 1 in a nagging tone, "What time is it?" Resident 1 looked at the clock in the kitchen and stated they had a few minutes still. Staff B stated in front of Resident 1, "We are working on patience," and told Resident 1 to wait.

An observation on 06/30/2025 at 2:14pm, showed that Resident 1 entered the kitchen and requested a cigarette and was declined by Staff B. Resident 1 attempted to open the freezer door and asked if they could get into the freezer. Staff B replied to Resident 1 in a harsh, loud, and abrupt tone stating, "You are not allowed in the freezer or refrigerator. Can I get you water? I just offered." Resident 1 stated they wanted ice

cream. Staff B asked Resident 1, "When is snack time," repeated their name abruptly after they did not answer, then asked again in a nagging tone, "When is snack time?" Staff B told Resident 1 that the ice cream was not theirs, it was AFH's ice cream, and Resident 1 had to wait until it was snack time. Staff B again asked Resident 1 when they could get a snack a harsh tone. Resident 1 sounded confused and named off multiple times in a soft and timid voice, "Two? Four? Six?" Staff B shook their head no and replied again in the same harsh tone, "It's not time." Staff B did not tell Resident 1 when snack time was. Resident 1 requested water from Staff B in a quiet tone. Staff B stated, "It's plain water." Resident 1 refused the water. Resident 1 stated, "I like flavored water."

On 06/30/2025 at 1:50pm, Resident 1 stated that Staff B was "Mean sometimes" and would "Yell at them." Resident 1 elaborated that Staff B yelled at them when they forgot to use their cane.

On 06/30/2025 at 2:07pm, Resident 2 stated that they were not treated with respect by some of the caregivers in the facility. Resident 2 stated that Staff B was "Like a bulldog."

On 06/30/2025 at 2:00pm, Collateral Contact 1 (CC1), Resident Representative, stated that Staff B was "Not very nice." CC1 stated that they were instructed to bring snacks for Resident 1 and on one occasion, they had brought licorice and sweets for Resident 1. CC1 stated that Staff B grabbed the licorice and yelled that Resident 1 could not have it, telling CC1 it would "spoil Resident 1's dinner" and took it away from Resident 1. CC1 stated Staff B's tone shocked them and they had recalled hoping Staff B would state they were joking, and they did not. CC1 stated that Staff B told CC1 they would hide the licorice where only Staff B would know its location and did not put it in the pantry with the other snacks. CC1 stated that Staff B was "Mean," "Very strict," and "Scared CC1 when they yelled."

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, VALLEY ROAD RESIDENTIAL CARE is or will be in compliance with this law and / or regulation on (Date) 07/23/25.

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

Provider (or Representative) — Date 07/23/25

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

_____ _____

Provider (or Representative) Date