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

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

RE: VALLEY ROAD RESIDENTIAL CARE License # 751743

Dear Provider:

This letter addresses Compliance Determination(s) 69471 (Completion Date 12/02/2025) and 66854 (Completion Date 10/15/2025).

The Department completed a follow-up inspection of your Adult Family Home on 12/02/2025 and found that you have corrected the violations listed in the Complaint report dated 10/15/2025. Your home is back in compliance as of 11/04/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10400-2

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 Yarbrough

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

Statement of Deficiencies	License #: 751743	Compliance Determination # 66854
Plan of Correction	VALLEY ROAD RESIDENTIAL CARE	Completion Date
Page 1 of 4	Licensee: KINDRED CARE SERVICES PLLC	10/15/2025

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 10/08/2025 of:

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

This document references the following complaint number(s): 196371, 196002

The following sample was selected for review during the unannounced on-site visit: 3 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Brittney Shull, 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

Statement of Deficiencies	License #: 751743	Compliance Determination # 66854
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Page 2 of 4	Licensee: KINDRED CARE SERVICES PLLC	10/15/2025

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.

Michelle Ann Yarbrough
Residential Care Services

10/21/2025
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)

11/04/25
Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

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 necessary [redacted] care and services for 1 of 1 residents (Resident 1). This failure placed Resident 1 at risk for health deterioration.

Findings included...

Review of Resident 1's Department Assessment, dated 10/29/2024, showed Resident 1:
-Required nurse delegation for continuous [redacted] therapy.
-Made poor decisions regarding their health, refused their BiPAP machine (a non-invasive ventilation therapy used to assist in breathing), not understand the consequences that resulted in feeling poor and hypoxic (low oxygen levels).
-Required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
-Facility staff would adjust flow rate and assist with [redacted] use once nurse delegation was in place.
-The AFH was responsible for the task of [redacted] therapy.

Review of Resident 1's Negotiated Care Plan, dated 11/10/2024 showed Resident 1 used [redacted] and staff were to assist with positioning [redacted] during transfers and mobility. Resident 1 was unaware of consequences, impulsive, easily agitated, and

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

10/21/2025
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)

Date

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Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure that each resident received necessary [redacted] care and services for 1 of 1 residents (Resident 1). This failure placed Resident 1 at risk for health deterioration.

Findings included...

Review of Resident 1's Department Assessment, dated 10/29/2024, showed Resident 1:
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-Made poor decisions regarding their health, refused their BiPAP machine (a non-invasive ventilation therapy used to assist in breathing), not understand the consequences that resulted in feeling poor and hypoxic (low oxygen levels).
-Required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
-Facility staff would adjust flow rate and assist with [redacted] use once nurse delegation was in place.
-The AFH was responsible for the task of [redacted] therapy.

Review of Resident 1's Negotiated Care Plan, dated 11/10/2024 showed Resident 1 used [redacted] and staff were to assist with positioning [redacted] during transfers and mobility, Resident 1 was unaware of consequences, impulsive, easily agitated, and

resistive with care. It showed that staff should identify and avoid triggers, reassure, comfort and redirect as needed, and rule out basic needs. The NCP did not show:
-Which parties were responsible for which duties of [redacted] care, including [redacted] supply, set up, or use monitoring.
-What to do if Resident 1 refused to follow the physician ordered [redacted] treatment.
-What signs or symptoms to monitor for respiratory problems related to improper or inadequate [redacted] use.
-How to trouble shoot [redacted] flow problems.
-How to manage use of portable [redacted] when Resident 1 was away from the home.

Review of Resident 1's Nurse Delegation Instructions dated 08/14/2025 showed that Resident 1 required 6L (liters) continuous [redacted] and 7 to 9L for shortness of breath. It showed that staff should:
-Turn the [redacted] to the ordered setting.
-Assist with [redacted] for delivery.
-Call 911 for breathing difficulty or unresponsiveness.
-Call Resident 1's provider for an inability to redirect mood/behavior.

Review of Resident 1's Physician Orders dated 09/02/2025 showed that Resident 1 required continuous [redacted] at 6L via [redacted] and 7 to 9L continuous [redacted] via [redacted] for shortness of breath.

On 10/08/2025 at 11:22am, Staff A, Provider, stated that Resident 1 only had a small [redacted], 2.9L [redacted], with capacity of 425L of [redacted] for outings. Staff A stated the AFH staff had realized it was not enough [redacted], and Resident 1 would decrease the [redacted] flow to make the [redacted] last during the outing. Staff A stated Resident 1 refused to use the new portable [redacted] and left on an outing that morning with the small [redacted]. Staff A stated that staff should check the [redacted] to make sure it is working, the [redacted] is connected, and there is enough [redacted] supply when Resident 1 leaves the facility. Staff A stated that if Resident 1 did not receive enough [redacted], their lips would turn blue. Staff A stated that at Resident 1's last clinic appointment, the clinic staff noticed Resident 1 did not have enough [redacted] and had run out of [redacted]. Staff A stated they were sitting with Resident 1 at the clinic and did not pay attention to their face.

In an observation on 10/08/2025 at 11:39am, Staff A answered the phone then directed Staff B, Caregiver, to pick up Resident 1 from the Emergency Room as Resident 1 had fallen while the resident was at the store. Staff B left the AFH and did not bring the portable [redacted] or an additional [redacted] of [redacted].

Review of the Hospital "After Visit Summary," dated 10/08/2025, showed that Resident 1 was evaluated for weakness and treated for Chronic Hypoxic Respiratory Failure.

In an observation on 10/08/2025 at 12:34pm Resident 1 returned to the facility with Staff B. Resident 1 was breathing heavily and quickly through their mouth, their respirations (breaths) were audible, and Resident 1's lips were blue. Resident 1's [redacted] was not turned on and the gauge showed [redacted] was still present in the [redacted].

On 10/08/2025 at 12:34pm, Staff B stated that when they picked up Resident 1 from the

Emergency Room, Resident 1 was seated in a wheelchair in the waiting room with [redacted] in their nose. Staff B stated they did not check the [redacted] to ensure it was turned on.

On 10/08/2025 at 12:45pm, Resident 1 stated that they should be on 6L of [redacted] at home. Resident 1 stated they turn their [redacted] down to 3L on outings to make sure it will not run out, as their [redacted] empties within 1 hour at 6L flow.

On 10/09/2025 at 4:44pm, Collateral Contact 1 (CC1), Healthcare Provider, stated that on 09/26/2025, Staff A had taken Resident 1 to an appointment. CC1 stated that Staff A was seated next to Resident 1 and was using their cell phone. CC1 stated that Resident 1 was slumped over, blue in the lips, and Staff A had not noticed. CC1 stated that they told Staff A that Resident 1 did not have [redacted] and Staff A replied that the [redacted] was on and had been on since they left the facility 10 to 15 minutes prior. CC1 stated that Resident 1 had a difficult time standing and they had to use a wheelchair to get Resident 1 back to the exam room. CC1 stated that no [redacted] was flowing from the [redacted], and Resident 1's [redacted] saturation was 66% (normal level 95-100%). CC1 stated that Resident 1 had been brought to an appointment by another caregiver on 08/29/2025 and Resident 1 had a similar incident in which Resident 1 was unstable, agitated, their [redacted] saturations were in the 60s, and the caregiver walked away from Resident 1 stating that they were directed by Resident 1 to go away from them.

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) 11/04/2025

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

Provider (or Representative) 11/04/2025 Date

Emergency Room, Resident 1 was seated in a wheelchair in the waiting room with [redacted] in their nose. Staff B stated they did not check the [redacted] to ensure it was turned on.

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