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

GRANDVIEW EPIC ADULT FAMILY HOME LLC

GRANDVIEW EPIC ADULT FAMILY HOME LLC
11003 114th Ave SW
Tacoma, WA 98498

RE: GRANDVIEW EPIC ADULT FAMILY HOME LLC License # 757799

Dear Provider:

This letter addresses Compliance Determination(s) 72669 (Completion Date 02/11/2026) and 65117 (Completion Date 10/13/2025).

The Department completed a follow-up inspection of your Adult Family Home on 02/11/2026 and found that you have corrected the violations listed in the Complaint report dated 10/13/2025. Your home is back in compliance as of 10/25/2025 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 388-76-10470, WAC 388-76-10470-2, WAC 388-76-10400, WAC 388-76-10400-3, WAC 388-76-10400-3-b

The Department staff who did the on-site verification:
Jonel Tuckett, AFH Complaint Investigator

If you have any questions, please contact me at (360)664-8421.

Sincerely,

Jennifer LeMaster

Jennifer LeMaster, Community Nurse Field Manager
Region 3, Unit F
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
6639 Capitol Blvd SW, Floor 1, Tumwater, WA 98501

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 09/04/2025 of:

GRANDVIEW EPIC ADULT FAMILY HOME LLC
11003 114th Ave SW
Tacoma, WA 98498

This document references the following complaint number(s): 192024

The following sample was selected for review during the unannounced on-site visit: 1 of 3 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Hannah Carmichael, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit G
6639 Capitol Blvd SW, Floor 1
Tumwater, WA 98501

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.

Jennifer LeMaster
Residential Care Services

10/17/2025
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)

10/23/25
Date

WAC 388-76-10470 Medication Timing Special directions.

(2) The home must ensure all directions given by the practitioner are followed when assisting or giving each resident medication. This includes but is not limited to:

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure all directions given by the practitioner were followed when giving medication to 1 of 3 residents (Resident 1 [R1]). This failure resulted in R1 receiving medications outside of their ordered parameters and placed R1 at risk for harm.

Findings included...

Review of R1's record titled "Assessment", dated 08/18/2025, showed diagnoses of [redacted]. Record showed R1's medications must be administered by staff and R1 had limitations that included being unable to read/see labels and unaware of dosages.

Review of R1's record titled "AFH Resident Negotiated Care Plan (NCP)", dated 08/22/2025, showed that R1 moved into the AFH on [redacted]/2025. Record showed R1 required more than one kind of medication assistance and had limitations which included being unable to read/see labels and unaware of medication dosages. Record showed caregiver instructions to give R1 oral medications as prescribed.

Review of R1's record titled "Nurse Delegation", dated 04/28/2025, showed R1 required nurse delegation for routine medication, PRN (as needed) medication, and topical medication administration.

Review of R1's record titled "Physician's Order", dated 09/2025, showed orders to check blood pressure and heart rate twice daily with breakfast and dinner. Record also showed

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

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Provider (or Representative) | Date

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Based on interview and record review, the Adult Family Home (AFH) failed to ensure all directions given by the practitioner were followed when giving medication to 1 of 3 residents (Resident 1 [R1]). This failure resulted in R1 receiving medications outside of their ordered parameters and placed R1 at risk for harm.

Findings included…

Review of R1's record titled "Assessment", dated 08/19/2025, showed diagnoses of [redacted]. Record showed R1's medications must be administered by staff and R1 had limitations that included being unable to read/see labels and unaware of dosages.

Review of R1's record titled "AFH Resident Negotiated Care Plan (NCP)", dated 08/22/2025, showed that R1 moved into the AFH on [redacted]/2025. Record showed R1 required more than one kind of medication assistance and had limitations which included being unable to read/see labels and unaware of medication dosages. Record showed caregiver instructions to give R1 oral medications as prescribed.

Review of R1's record titled "Nurse Delegation", dated 04/25/2025, showed R1 required nurse delegation for routine medication, PRN (as needed) medication, and topical medication administration.

Review of R1's record titled "Physician's Order", dated 09/2025, showed orders to check blood pressure and heart rate twice daily with breakfast and dinner. Record also showed

an order for Metoprolol Tartrate (medication used to treat heart conditions and works by slowing the heart rate and relaxing blood vessels), 25 mg (milligram) tablet, take one tablet by mouth twice daily with breakfast and dinner. Order start date was 07/24/2025. Order showed specific instructions/parameters to hold this medication for systolic blood pressure (SBP, the top number of a blood pressure reading that shows the force of blood against the artery walls when the heart beats) less than or equal to 110 or heart rate (HR) less than or equal to 60 beats per minute.

Review of R1's record titled "Nurse Delegation: Instructions for Nursing Task", dated 08/07/2025, showed routine medication administration was a delegated task with instructions that the caregiver will show competency on how to administer medications to R1 properly and be knowledgeable of the nature of the medication. The list of medications included Metoprolol Tartrate 25 mg tablet, take one tablet by mouth twice daily with breakfast and dinner, hold medication for SBP less than or equal to 110 or HR less than or equal to 60 beats per minute. Record showed the method of verification that medications were being administered correctly was the medication administration record (MAR). The steps to performing medication administration included Step 1. The six right's, right medication, right patient, right dosage, right route, right time, right documentation. Before administering any medication, check. Check MAR three times prior to administering any medication; Step 3. Preparation, check each medication against doctor's order; and Step 10. Documentation, record each medication in R1's chart. Record if medication was refused. Record if patient's condition warranted omitting medication.

Review of R1's record titled "August 2025 MAR", dated 08/01/2025-08/31/2025, showed instructions to check blood pressure and heart rate twice daily with breakfast and dinner, start date [redacted]/2025. Record showed medication administration instructions for Metoprolol Tartrate, 25 mg tablet, take one tablet by mouth twice daily with breakfast and dinner with parameters to hold this medication if R1's SBP was less than or equal to 110 or R1's HR was less than or equal to 60 beats per minute. Record showed SBP and diastolic blood pressure (DBP, the bottom number of a blood pressure reading that shows the force when the heart rests between beats) were recorded every morning at 8 AM. SBP and HR were only recorded at 8 PM from 08/01/2025-08/04/2025 and were not documented after 08/04/2025. Record showed on 08/11/2025 R1's SBP was 108, on 08/15/2025 SBP was 103, on 08/16/2025 SBP was 105, and on 08/29/2025 SBP was 110. Record showed this medication was marked as given every day of August 2025 and not held per medication parameters.

In an interview on 09/03/2025 at 4:45 PM, Collateral Contact 1 (CC1), nurse not associated with the AFH, stated there were parameters for R1's Metoprolol that stated to not give the medication if R1's HR or SBP were under certain numbers and orders for twice-a-day vital signs for blood pressure (BP) and heart rate. CC1 stated AFH staff were only checking for BP in the mornings and not the evenings according to R1's August 2025 MAR. CC1 stated for R1's evening dose of Metoprolol, AFH staff didn't have the BP or HR recorded at all but were apparently giving the medication. CC1 stated that even though all the BP's and HR were recorded under the morning dose, there were two or three instances where either the HR or BP were under the parameter where it should've been held but was marked as given.

On 09/04/2025 at 11:09 AM, Provider stated they checked R1's vital signs "every morning, especially BP" and stated they offered to take R1's BP in the evening, but R1

would refuse pretty much every night. Provider denied that AFH staff documented R1's refusals for BP and HR monitoring in the evenings. Provider stated, "oh I'm not sure", when reviewing the Metoprolol that was marked as given that should've been held based on the medication parameters for BP and HR. Provider stated they were unsure if the medication was given or if this was a documentation error.

On 09/19/2025 at 12:10 PM, R1 stated that AFH staff checked their blood pressure and heart rate once a day

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, GRANDVIEW EPIC ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 10/25/25 .

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

Provider (or Representative) 10/23/24 Date

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

(3) The care and services in a manner and in an environment that:

(b) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the Adult Family Home (AFH) failed to ensure 1 of 3 residents (Resident 1 [R1]) received the care and services in a manner that actively supported the safety of R1. This failure placed R1 at risk for infection and harm when delegated tasks were not performed as instructed.

Findings included...

Review of R1's record titled "Assessment" dated 08/18/2025 showed diagnoses of [redacted], and [redacted]. Record showed R1 had recurring UTIs and a home health agency was indicated for indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine continuously) care and completed catheter changes. Record showed that R1 had ongoing UTI's due to a suprapubic catheter (a thin, flexible tube inserted directly into

would refuse pretty much every night. Provider denied that AFH staff documented R1's refusals for BP and HR monitoring in the evenings. Provider stated, "oh I'm not sure", when reviewing the Metoprolol that was marked as given that should've been held based on the medication parameters for BP and HR. Provider stated they were unsure if the medication was given or if this was a documentation error.

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_____ _____
Provider (or Representative) Date

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Findings included…

Review of R1's record titled "Assessment", dated 08/19/2025, showed diagnoses of [redacted] and [redacted]. Record showed R1 had recurring UTIs and a home health agency was indicated for indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine continuously) care and completed catheter changes. Record showed that R1 had ongoing UTI's due to a suprapubic catheter (a thin, flexible tube inserted directly into

the bladder through a small incision in the lower abdomen) which can cause delusions. R1 required extensive assistance with toileting and caregiver instructions included assisting with catheter use and care.

Review of R1's record titled "AFH Resident Negotiated Care Plan (NCP)", dated 08/22/2025, showed that R1 moved into the AFH on [redacted]/2025. Record showed that R1 was totally dependent on AFH staff for toileting needs and R1 had a catheter that required care by following the order as prescribed by R1's primary care doctor.

Review of R1's record titled "Nurse Delegation", dated 04/25/2025, showed R1 required nurse delegation for catheter flushing. Record showed R1 had a suprapubic catheter and had recurrent UTI's.

Review of R1's record titled "Nurse Delegation: Instructions for Nursing Task", dated 08/07/2025, showed catheter flushing was a delegated task with instructions for caregivers to follow doctor's orders/instructions and safely flush the catheter. Instructions stated to flush the catheter twice daily with 100-200 milliliters (ml) of sodium chloride 0.9% irrigation solution.

Review of R1's record titled "Catheter Flushing Instructions", undated, located in R1's nurse delegation binder, showed steps for "Flushing the Catheter":
1. Clean the catheter. Scrub the connection site between the catheter and drainage tubing with an alcohol pad, cleaning the area for 15 to 30 seconds before continuing.
6. Clean the catheter connection site and drainage tubing. Scrub both the catheter connection site and drainage tubing with an alcohol wipe for about 15 seconds.

In an interview on 09/03/2025 at 4:45 PM, Collateral Contact 1 (CC1), nurse not associated with the AFH, stated they witnessed an AFH staff member not using an alcohol wipe to sterilize the catheter end or tubing.

On 09/04/2025 at 10:55 AM, observation showed the bottle of sodium chloride 0.9% irrigation solution used for R1's catheter flushing, expiration date 11/01/2025, with instructions printed on the label that stated to use 100-200 mL to flush catheter twice daily.

On 09/04/2025 at 10:55 AM, Caregiver 1 (CG1), AFH staff, stated they flush R1's catheter twice daily, they used 50 mL of irrigation solution in the syringe, they would check to make sure the catheter was not clogged, and denied cleaning the catheter or syringe with alcohol wipes throughout their process of flushing the catheter. CG1 stated that a previous caregiver in the AFH showed them how to perform this task and that the nurse delegator "walked me through kind of."

On 09/04/2025 at 11:09 AM, Provider stated the AFH staff do the catheter flushing task for R1 per nurse delegation instructions and stated that R1 had a history of chronic UTI. Provider stated they flushed R1's catheter by using 50 mL of the sodium chloride 0.9% irrigation solution, then they opened up the catheter tubing and would put the syringe on the tubing connection and then flushed with 50 mL of irrigation solution. Provider denied that they used alcohol wipes to clean the catheter or the tubing. Provider stated they were to be following the nurse delegator's instructions for flushing R1's catheter.

On 10/06/2025 at 1:12 PM, Collateral Contact 2 (CC2), AFH nurse delegator, stated that

the AFH staff were to be following the nurse delegation instructions. CC2 stated that AFH staff were instructed to use alcohol wipes to sterilize the catheter and the tubing and that they should be following the catheter flushing instructions that were printed and placed in R1's nurse delegation binder.

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

Patrick Cattimy
Provider (or Representative)

10/21/25
Date

the AFH staff were to be following the nurse delegation instructions. CC2 stated that AFH staff were instructed to use alcohol wipes to sterilize the catheter and the tubing and that they should be following the catheter flushing instructions that were printed and placed in R1's nurse delegation binder.

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