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

Rose Adult Family Home LLC

Rose Adult Family Home LLC
3728 Sunset Way
Longview, WA 98632

RE: Rose Adult Family Home LLC License # 757941

Dear Provider:

This letter addresses Compliance Determination(s) 66263 (Completion Date 10/22/2025) and 58833 (Completion Date 08/04/2025).

The Department completed a follow-up inspection of your Adult Family Home on 10/22/2025 and found that you have corrected the violations listed in the Complaint report dated 08/04/2025. Your home is back in compliance as of 08/26/2025 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 388-76-10670-2, WAC 388-76-10400-1, WAC 388-76-10400-2, WAC 388-76-10400-3, WAC 388-76-10400-3-a, WAC 388-76-10400-3-b, WAC 388-76-10400-3-c, WAC 388-76-10485-1, WAC 388-76-10750-1, WAC 388-76-10750-3, WAC 388-76-10750-5-l, WAC 388-76-10655-1, WAC 388-76-10595-5, WAC 388-76-10595-5-a, WAC 388-76-10595-5-b, WAC 388-76-10595-6, WAC 388-76-10430-1, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d, WAC 388-76-10225-2-d, WAC 388-76-10225-2-e, WAC 388-76-10195-1, WAC 388-76-10020-1, WAC 388-76-10255-1, WAC 388-76-10255-2, WAC 388-76-10255-3

The Department staff who did the on-site verification:
Jennifer LeMaster, Community Nurse Field Manager

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

Sincerely,

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 04/30/2025 of:

Rose Adult Family Home LLC
3728 Sunset Way
Longview, WA 98632

This document references the following complaint number(s): 176037, 181316

The following sample was selected for review during the unannounced on-site visit: 4 of 4 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.

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

WAC 388-76-10670 Prevention of abuse. The adult family home must:

(2) Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the adult family home (AFH) failed to ensure staff prevented neglect for 1 of 4 residents (Resident 2 [R2]). This failure resulted in R2 having unmet care needs and not receiving hospice medications as ordered for 15 days after they were admitted to hospice services.

Findings included…

Review of department records showed the AFH opened for operation on 03/11/2025 after a change of ownership (CHOW).

On 04/30/2025 at 1:08 PM, review of resident record titled “Adult Family Home Disclosure of Services”, undated, showed "6. PERSONAL HYGIENE: If needed, the home may provide assistance with personal hygiene as follows: When deemed appropriate by the provider, the adult family home may provide the following: Assistance with oral care; Assistance with shaving and hair styling; Assistance with showers at least twice weekly or as client is able; Bed bath if client is unable to use shower; Application of deodorant lotions, and make up; Assistance with nail care, toenail trimming."

Review of R2’s record on site and available at the AFH, titled “Long Term Care Optional Assessment & Care Planning Tool” (undated), showed diagnoses that included

[redacted] and [redacted]. Record showed R2's decision making was severely impaired, they were oriented to person only, and had limited vision/visually impaired which required glasses to be worn during the day. Caregiver instructions for neurological care included providing a homelike, therapeutic environment: clocks/calendars visible, adequate light, consistent routine, safety checks, appropriate sensory stimulation, and when possible, using familiar objects from home, or objects with sentimental value, family pictures etc.

Review of R2's record titled "Adult Family Home Resident Negotiated Care Plan", dated 12/28/2023, showed R2 moved into the AFH on [redacted]/2023. Record showed R2 was visually impaired, required glasses while awake, and caregivers were to keep glasses clean and in working order. Caregiver instructions for neurological care included providing a homelike, therapeutic environment: clocks/calendars visible, adequate light, consistent routine, safety checks, appropriate sensory stimulation, and when possible, using familiar objects from home, or objects with sentimental value, family pictures etc. R2 had unsteady gait, history of falls, was a fall risk, and required a four wheeled walker and a wheelchair. R2's fall prevention plan included sensor alarms, floor (pressure pad) and fall mat. R2 required assistance with positioning and caregivers should monitor to make sure repositioning occurred every two hours during the day and night. R2 required hands-on assistance for hair care and required extensive assistance with bathing, preferred 2-3 showers per week, or more if requested. R2 required assistance with foot care and toenail trimming and caregiver instructions included filing R2's toenails every 2 weeks.

Review of R2's record titled "Nurse Delegation Nursing Visit", dated 03/24/2025, showed the Provider received initial nurse delegation training on 03/24/2025 to provide services for R2. Record showed R2's assessment of HEENT (head, eyes, ears, nose, throat) showed R2 was not wearing their glasses for vision at the time of the nurse delegation visit.

Review of R2's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/24/2025, showed relevant diagnoses that included [redacted], and [redacted] and showed R2 received hospice care. R2 had a known history or was currently being treated for depression and anxiety. R2 had short-term and long-term memory issues and their decision making was severely impaired. Caregiver instructions for R2's cognitive deficits included to provide a homelike, therapeutic environment: clocks/calendars visible, adequate light, consistent routine, safety checks, appropriate sensory stimulation, and when possible, use familiar objects from home or objects with sentimental value, family pictures etc. R2 was visually impaired and required to wear glasses during the day. Caregivers were to keep glasses clean and in working order. R2 had unsteady gait, history of falls in the last two years, risk for falls and non-compliant with safety instructions. Safety devices and tools included call light/button, mat alarm, and pad alarm. R2 was incontinent, R2 required extensive assistance with personal hygiene and bathing, and preferred 2-3 showers per week, or more if requested.

On 04/30/2025 at 11:37 AM observation showed R2's room smelled strongly of urine. Observation showed multiple incontinence briefs in the bedroom garbage can.

On 04/30/2025 at 12:20 PM, Provider stated the urine smell throughout the house was coming from R2's room. The Provider stated they take the garbage soiled with urine and feces and store it in the laundry room.

On 04/30/2025 at 11:47 AM, observation showed R2's hair was greasy and unwashed.

On 04/30/2025 at 11:52 AM, observation showed R2's toenails were dark and very long, both big toenails appeared yellow and black around the nail beds.

On 04/30/2025 at 11:08 AM, observation showed R2 did not have any visual aids (glasses) on while they were lying on their back while awake in bed. Observation showed R2's walls were empty/bare with no photos, clocks, calendars, or decorations.

On 06/12/2025 at 3:16 PM, CC3 stated they had sometimes walked into R2's room when visiting and it smelled like urine. CC3 stated that R2 did not get out of bed, all they have to do is stare at a wall, and R2 "didn't have an existence outside of that bedroom space".

On 04/29/2025 at 3:20 PM, Collateral Contact 1 (CC1), former facility staff member, stated as soon as R2 became [redacted] they discussed with Provider they need to have a turning schedule, but Provider believed the bubble mat (mattress overlay for pressure offloading) was enough to prevent R2 from getting bed sores. CC1 stated they had been using green wedge pillows for repositioning R2, but when Provider worked, they did not use them.

<Resident 2 Hospice>
On 04/30/2025 at 1:06 PM, review of R2's record titled "Private Pay Admission Agreement", showed the AFH worked with Home Health and Hospice as ordered by The Resident's primary physician.

Review of R2's record titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 06/03/2025, showed R2 was admitted onto hospice services on 05/16/2025 and Provider was present for the hospice admission.

On 06/12/2025 at 11:12 AM, Provider stated their nurse delegator updated the residents' orders when the orders were received by the AFH. Provider stated that when R2 was placed on hospice, the orders were faxed to the AFH, but the hospice staff did not notify them of the faxes. The Provider stated the faxes were sent after the hospice

staff came to the home. Provider stated they were unsure about what day R2 started hospice services and stated the hospice staff did not give them adequate instructions about R2's medications. Provider stated they were confused on the process for getting R2's medications refilled due to hospice services being involved. Provider stated there were no changes to R2's care or medication orders after starting hospice services and stated they received the orders via fax and printed them.

On 06/12/2025 at 3:16 PM Collateral Contact 3 (CC3), hospice staff, stated hospice services for R2 started on 05/18/2025. CC3 stated they visited a handful of times between 05/20/2025 - 05/30/2025 and stated the AFH's orders had not been updated during that time, the medication administration record (MAR) was not updated to reflect the hospice medication list, and after instructing the Provider on how to make the needed changes, they were still not updated by 5/30/2025. CC3 stated the Provider was present when the initial hospice assessment was done and they "cannot blame it on the fax machine". CC3 stated the Provider did not have the correct orders from the hospice care plan, they did not have the correct medications, they did not know how to open the fax application or how to open their messages, and stated it was clear the Provider did not know how to use the fax system. CC3 stated the Provider called Collateral Contact 4 (CC4) AFH Nurse Delegator (ND) with CC3 present, and CC4 said to the Provider and to CC3 that they did not know R2 was on hospice, CC4 hadn't received any hospice information from the Provider, CC4 was the one who fixed all medication orders for the AFH, and CC4 stated it was the Provider's job to call and notify them. CC3 stated they told the Provider at three hospice visits in a row, that they needed to pick up R2's hospice medications from the pharmacy and stated they had even received a call from the pharmacy triage nurse asking what was going on with the medications not being picked up. CC3 stated during their visits from 05/20/2025-05/30/2025, the medications onsite were incorrect, they did not have the newly prescribed acetaminophen (Tylenol) (medication used to treat fever and pain) 500 mg (milligrams) present, the MAR contained medications that had been discontinued and did not contain the newly prescribed haloperidol (medication used to help manage certain severe mental and neurological conditions), lorazepam (used to treat anxiety disorders and helps calm the nervous system), or Senna (natural laxative used to treat constipation), and morphine (used to relieve pain).

On 06/17/2025 at 12:50 PM, Collateral Contact 4 (CC4), registered nurse delegator, stated they received a phone call from Provider and CC3 on 05/30/2025 and CC3 asked why R2's hospice medications were not being given. CC4 stated they did not know R2 was on hospice until this phone call and Provider stated on the call that they thought the hospice orders were automatically being sent to CC4. CC4 stated that CC3 sent them the updated hospice orders and the MAR was updated for Provider on 05/31/2025. CC4 stated they were the one who always updated the orders on the MAR for Provider.

On 06/18/2025 at 10:52 AM Provider stated they were present for the initial hospice assessment at the AFH. Provider stated R2 was supposed to be started on hospice on 05/16/2025, but they didn't open or see the faxes from hospice, they didn't know what medications or what R2 was supposed to be taking, and stated there were no changes to the medications except a medication the Provider pronounced that was not understood by department staff. When department staff requested clarification, the

Provider again stated a medication name that was not recognizable to department staff. Department staff then asked for clarification if the Provider meant “acetaminophen”, the Provider stated they did. Provider stated CC3 did not tell them to notify CC4 and stated, “I did not know I was supposed to notify this”. Provider stated CC3 asked who updated the orders in the computer, they responded that CC4 does, then stated they called CC4 in front of CC3 and CC4 said they did not know about the hospice services. Provider stated, “I did not know I was supposed to notify the nurse delegator” and stated CC4 was notified about a week after R2 started hospice services. Provider stated if the AFH gets new orders for medications, they notify CC4 and CC4 makes those changes. Provider stated it was 10-12 days after R2 was admitted on hospice when CC4 updated the hospice orders on Syncwise (electronic MAR).

On 06/18/2025 at 3:00 PM, Provider stated they did not know when R2’s hospice orders were supposed to start and stated CC3 did not tell them they were supposed to start the orders when R2 was admitted on hospice. Provider stated, “they don’t tell me that the orders were supposed to start when hospice started”. The Provider stated they understood that R2’s orders were not updated until 15 days after they were admitted on hospice and stated “we didn’t need to start the medications”. Provider stated they understood what their responsibilities were as the provider, then stated “for some reason, I need to know what my responsibility is for R2 and for hospice”

On 06/18/2025 at 7:10 PM, CC4 wrote in an email to department staff that R2 was admitted on hospice on 05/18/2025, they were contacted by R2’s hospice staff on 05/30/2025 but the medication orders were not updated, and they received R2’s new hospice orders from hospice staff on 05/31/2025.

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, Rose Adult Family Home 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.

_____ _____

Provider (or Representative) Date

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

(1) The care and services identified in the negotiated care plan.

(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.

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

(a) Actively supports, maintains or improves each resident's quality of life;

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

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the adult family home (AFH) failed to ensure care and services were provided in a manner and in an environment that actively supported their safety and quality of life for 4 of 4 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], & Resident 4 [R4]). This failure resulted in unmet care needs for all residents, and placed all residents at risk for harm.

Findings included…

Review of department records showed the AFH opened for operation on 03/11/2025 after a change of ownership (CHOW).

On 04/30/2025 at 1:06 PM, review of resident record titled “Private Pay Admission Agreement”, dated 03/11/2025, showed "6. Assistance with personal care needs such as bathing, grooming dressing including: All personal care needs identified on the Long Term Assessment completed prior to admission will be provided. The Provider will work with The Resident, staff, and other health care providers to create a Negotiated Care Plan to ensure that all personal care needs are met."

On 04/30/2025 at 1:08 PM, review of resident record titled “Adult Family Home Disclosure of Services”, undated, showed "6. PERSONAL HYGIENE: If needed, the home may provide assistance with personal hygiene as follows: When deemed appropriate by the provider, the adult family home may provide the following: Assistance with oral care; Assistance with shaving and hair styling; Assistance with showers at least twice weekly or as client is able; Bed bath if client is unable to use shower; Application of deodorant lotions, and make up; Assistance with nail care, toenail trimming."

Response to Requests for Help
On 04/30/2025 at 11:52 AM, observation showed a call bell was sounding from the AFH kitchen area stating “number 5”.

On 04/30/2025 at 11:56 AM, observation showed “number 5” call bell was still going

off.

On 04/30/2025 at 11:57 AM, observation showed “number 3” call bell was now going off.

On 04/30/2025 at 12:01 PM, observation showed “number 3” call bell was still sounding. Provider turned off call bell at 12:02 PM as she was walking through the kitchen area without checking on residents or addressing the cause of the call bell.

On 04/30/2025 at 12:02 PM, Collateral Contact 2 (CC2), R3’s legal representative who was waiting in the living room while the provider did personal care for R3, stated that R4 was okay, CC2 checked on R4 because their call bell was going off.

On 04/30/2025 at 12:04 PM CC2 stated it was hard for one caregiver to provide care for six people and clean and wash the laundry and do everything else required in the home. CC2 stated they wished that staff would get R3 out of their wheelchair more to let them stretch out and stated R3 is in their wheelchair 24 hours per day, “but I know they’re busy here”. CC2 stated that R3 occasionally waited a long time to receive needed care when staff were really busy. CC2 stated they observed R3 wearing multiple incontinence briefs at a time and stated, “I don’t like that” and thought the staff did that to change R3 less often, stating “that does not work for me”. CC2 stated they recently observed R3 with a puddle of urine under their wheelchair and stated, “I don’t like to see that”.

Resident 1
Review of R1’s record titled “Long Term Care Optional Assessment & Care Planning Tool”, dated 10/10/2024, showed diagnoses including [redacted], and [redacted]. Record showed R1’s decision making was severely impaired and R1 required extensive assistance with bathing and preferred 2-3 showers per week, or more if requested. Record showed R1’s vision was limited, required to wear glasses while awake, and showed R1 wore glasses full time. Caregiver instructions for R1’s glasses stated R1 was visually impaired, glasses were worn during the day, caregivers were to keep glasses clean and in working order.

Review of R1’s record titled “Care Plan”, dated 10/03/2024, showed R1 moved into the AFH on [redacted]/2021. Record showed R1 was moderately impaired and poor with making decisions, required psychopharmacological medications including Risperidone (type of antipsychotic medication that treats mental health conditions), and required limited

assistance, twice a week, with bathing, but required full assistance with washing of hair.

On 04/30/2025 at 11:03 AM, observation showed R1's hair was greasy and in an unkept and matted ponytail.

On 04/30/2025 at 9:17 AM, Collateral Contact 5 (CC5), R1's legal representative, stated ever since the new ownership took over, R1 started looking worse, their hair looked like it was ripped out with a brush and was matted at the roots.

On 04/30/2025 at 11:03 AM, observation showed R1 did not have any visual aids (glasses) on while they were sitting at the dining room table for lunch.

Resident 2

Review of R2's record on site and available at the AFH, titled "Long Term Care Optional Assessment & Care Planning Tool" (undated), showed diagnoses that included [redacted], and [redacted] Record showed R2's decision making was severely impaired, they were oriented to person only, and had limited vision/visually impaired which required glasses to be worn during the day. Caregiver instructions for neurological care included providing a homelike, therapeutic environment: clocks/calendars visible, adequate light, consistent routine, safety checks, appropriate sensory stimulation, and when possible, using familiar objects from home, or objects with sentimental value, family pictures etc.

Review of R2's record titled "Adult Family Home Resident Negotiated Care Plan", dated 12/28/2023, showed R2 moved into the AFH on [redacted]/2023. Record showed R2 was visually impaired, required glasses while awake, and caregivers were to keep glasses clean and in working order. Caregiver instructions for neurological care included providing a homelike, therapeutic environment: clocks/calendars visible, adequate light, consistent routine, safety checks, appropriate sensory stimulation, and when possible, using familiar objects from home, or objects with sentimental value, family pictures etc. R2 had unsteady gait, history of falls, was a fall risk, and required a four wheeled walker and a wheelchair. R2's fall prevention plan included sensor alarms, floor (pressure pad) and fall mat. R2 required assistance with positioning and caregivers should monitor to make sure repositioning occurred every two hours during the day and night. R2 required hands-on assistance for hair care and required extensive assistance with bathing, preferred 2-3 showers per week, or more if requested. R2 required assistance with foot care and toenail trimming and caregiver instructions included filing R2's toenails every 2 weeks.

Review of R2's record titled "Nurse Delegation Nursing Visit", dated 03/24/2025,

showed the Provider received initial nurse delegation training on 03/24/2025 to provide services for R2. Record showed R2's assessment of HEENT (head, eyes, ears, nose, throat) showed R2 was not wearing their glasses for vision at the time of the nurse delegation visit.

Review of R2's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/24/2025, showed relevant diagnoses that included [redacted], and [redacted] and showed R2 received hospice care. R2 had a known history or was currently being treated for depression and anxiety. R2 had short-term and long-term memory issues and their decision making was severely impaired. Caregiver instructions for R2's cognitive deficits included to provide a homelike, therapeutic environment: clocks/calendars visible, adequate light, consistent routine, safety checks, appropriate sensory stimulation, and when possible, use familiar objects from home or objects with sentimental value, family pictures etc. R2 was visually impaired and required to wear glasses during the day. Caregivers were to keep glasses clean and in working order. R2 had unsteady gait, history of falls in the last two years, risk for falls and non-compliant with safety instructions. Safety devices and tools included call light/button, mat alarm, and pad alarm. R2 was incontinent, R2 required extensive assistance with personal hygiene and bathing, and preferred 2-3 showers per week, or more if requested.

On 04/30/2025 at 11:37 AM observation showed R2's room smelled strongly of urine. Observation showed multiple incontinence briefs in the bedroom garbage can.

On 04/30/2025 at 12:20 PM, Provider stated the urine smell throughout the house was coming from R2's room. The Provider stated they take the garbage soiled with urine and feces and store it in the laundry room.

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On 04/29/2025 at 3:20 PM, Collateral Contact 1 (CC1), former facility staff member,

stated as soon as R2 became [redacted], they discussed with Provider they need to have a turning schedule, but Provider believed the [redacted] was enough to prevent R2 from getting bed sores. CC1 stated they had been using green [redacted] for repositioning R2, but when Provider worked, they did not use them.

<Resident 2 Hospice>
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Review of R2's record titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 06/03/2025, showed R2 was admitted onto hospice services on 05/16/2025 and Provider was present for the hospice admission.

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On 06/12/2025 at 3:16 PM Collateral Contact 3 (CC3), hospice staff, stated hospice services for R2 started on 05/18/2025. CC3 stated they visited a handful of times between 05/20/2025 - 05/30/2025 and stated the AFH's orders had not been updated during that time, the medication administration record (MAR) was not updated to reflect the hospice medication list, and after instructing the Provider on how to make the needed changes, they were still not updated by 5/30/2025. CC3 stated the Provider was present when the initial hospice assessment was done and they "cannot blame it on the fax machine". CC3 stated the Provider did not have the correct orders from the hospice care plan, they did not have the correct medications, they did not know how to open the fax application or how to open their messages, and stated it was clear the Provider did not know how to use the fax system. CC3 stated the Provider called Collateral Contact 4 (CC4) AFH Nurse Delegator (ND) with CC3 present, and CC4 said to the Provider and to CC3 that they did not know R2 was on hospice, CC4 hadn't received any hospice information from the Provider, CC4 was the one who fixed all medication orders for the AFH, and CC4 stated it was the Provider's job to call and notify them. CC3 stated they told the Provider at three hospice visits in a row, that they needed to pick up R2's hospice medications from the pharmacy and stated they had even received a call from the pharmacy triage nurse asking what was going on with the medications not being picked up. CC3 stated during their visits from 05/20/2025-05/30/2025, the medications onsite were incorrect, they did not have the newly prescribed acetaminophen (Tylenol) (medication used to treat fever and pain) 500 mg (milligrams) present, the MAR

contained medications that had been discontinued and did not contain the newly prescribed haloperidol (medication used to help manage certain severe mental and neurological conditions), lorazepam (used to treat anxiety disorders and helps calm the nervous system), or Senna (natural laxative used to treat constipation), and morphine (used to relieve pain).

On 06/17/2025 at 12:50 PM, Collateral Contact 4 (CC4), registered nurse delegator, stated they received a phone call from Provider and CC3 on 05/30/2025 and CC3 asked why R2's hospice medications were not being given. CC4 stated they did not know R2 was on hospice until this phone call and Provider stated on the call that they thought the hospice orders were automatically being sent to CC4. CC4 stated that CC3 sent them the updated hospice orders and the MAR was updated for Provider on 05/31/2025. CC4 stated they were the one who always updated the orders on the MAR for Provider.

On 06/18/2025 at 10:52 AM Provider stated they were present for the initial hospice assessment at the AFH. Provider stated R2 was supposed to be started on hospice on 05/16/2025, but they didn't open or see the faxes from hospice, they didn't know what medications or what R2 was supposed to be taking, and stated there were no changes to the medications except a medication the Provider pronounced that was not understood by department staff. When department staff requested clarification, the Provider again stated a medication name that was not recognizable to department staff. Department staff then asked for clarification if the Provider meant "acetaminophen", the Provider stated they did. Provider stated CC3 did not tell them to notify CC4 and stated, "I did not know I was supposed to notify this". Provider stated CC3 asked who updated the orders in the computer, they responded that CC4 does, then stated they called CC4 in front of CC3 and CC4 said they did not know about the hospice services. Provider stated, "I did not know I was supposed to notify the nurse delegator" and stated CC4 was notified about a week after R2 started hospice services. Provider stated if the AFH gets new orders for medications, they notify CC4 and CC4 makes those changes. Provider stated it was 10-12 days after R2 was admitted on hospice when CC4 updated the hospice orders on Syncwise (electronic MAR).

On 06/18/2025 at 3:00 PM, Provider stated they did not know when R2's hospice orders were supposed to start and stated CC3 did not tell them they were supposed to start the orders when R2 was admitted on hospice. Provider stated, "they don't tell me that the orders were supposed to start when hospice started". The Provider stated they understood that R2's orders were not updated until 15 days after they were admitted on hospice and stated "we didn't need to start the medications". Provider stated they understood what their responsibilities were as the provider, then stated "for some reason, I need to know what my responsibility is for R2 and for hospice"

On 06/18/2025 at 7:10 PM, CC4 wrote in an email to department staff that R2 was admitted on hospice on 05/18/2025, they were contacted by R2's hospice staff on 05/30/2025 but the medication orders were not updated, and they received R2's new hospice orders from hospice staff on 05/31/2025.

Resident 3
Review of R3's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/12/2024, showed diagnoses including [redacted] and [redacted]. Record showed R3's decision-making was severely impaired, they had chronic pain treated by pain medications and repositioning, and cardiovascular issues causing edema (swelling). R2 had stress incontinence (leaking urine when pressure is put on the bladder), required briefs (disposable underwear) day and night, and caregiver instructions included checking R3 every 2 hours for incontinence and to wash, rinse, and dry soiled areas. R2 had unsteady gait, history of falls, was a fall risk, had impulsive behavior and required a wheelchair for mobility. R2 required assistance with positioning and caregiver instructions included to monitor making sure repositioning occurred every 2 hours during the day and night.

Review of R3's record titled "Routine Care Plan", dated 07/15/2024, showed R3 was dependent on caregivers for bathing, 2 times per week, body, foot, nail, and skin care. Record showed R3 would get "antsy" and try to lift out of their wheelchair and is sometimes uncomfortable and wanted to lay on the floor with blankets and pillows surrounding them so they could squirm around. R3 required extensive assistance with toileting, had bladder and bowel incontinence, and wore briefs (disposable underwear).

On 04/29/2025 at 3:20 PM, Collateral Contact 1 (CC1), former facility staff member, stated that R3 was [redacted] 24/7, the Provider did not use the foot rests on R3's wheelchair to keep their legs elevated, and R3's left leg was very swollen.

On 04/30/2025 at 11:08 AM observation showed R3 sitting in their wheelchair in the living room. R3's legs were hanging down in a dependent position (position where a part of the body, usually a limb, is lower than the rest of the body or the heart). Foot rests were on the wheelchair but were not being used.

On 04/30/2025 at 11:15 AM observation showed R3 sitting in their wheelchair in the living room. Their left leg was drooping and not in the foot rest and their right leg was pulled up to their chest with their knee bent.

On 04/30/2025 at 11:29 AM, observation showed Provider removed both foot rests from R3's wheelchair in the living room.

On 04/30/2025 at 11:35 AM, Provider stated they would not put the foot rests back on

R3's wheelchair until after lunch.

On 04/30/2025 at 12:03 PM, observation showed R3 sitting in their wheelchair in the living room. No foot rests were on the wheelchair. R3's left leg was hanging dependently and appeared swollen.

On 04/30/2025 at 12:04 PM Collateral Contact 2 (CC2), R3's legal representative, stated that R3 had swelling in their left leg and stated they would like to see it elevated a little more. CC2 stated that sometimes staff will place the leg on a tv tray to elevate it, but they would like to see R3's leg elevated more often.

On 04/30/2025 at 12:10 PM observation showed R3's legs were still hanging down in a dependent position and their left leg was very swollen in appearance.

On 04/30/2025 at 12:20 PM Provider stated they care for R3's leg edema (swelling) by elevating it. When department staff stated that R3's legs had been hanging down and there were no foot rests on their wheelchair, Provider stated that R3's legs were elevated.

On 04/29/2025 at 3:20 PM, Collateral Contact 1 (CC1), former facility staff member, stated when they would go to change R3's incontinence briefs during work shifts after Provider had been working multiple days in a row without help, R3 would typically be wearing two briefs with a pad inside and all three parts would be soaked through with urine.

Resident 4

Review of R4's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 09/30/2024, showed diagnoses including [redacted] and [redacted]. Record showed R4's decisions were poor, had poor vision, they were listed as a fall risk, had unsteady gait (the way someone walks), history of falls, impulsive behavior, and easily off balance. Safety strategies included a call button at bedside to call for assistance, door alarmed, frequent checks every 1-2 hours as needed to ensure safety, fall alarms, and a fall mat. Record showed R4 was required to wear disposable briefs day and night and required extensive assistance with bladder/bowel control.

Caregiver instructions for toileting showed staff cleaning of environment (floor, toilet, garbage can, handrails, bedding, sink).

Review of R4's record titled "Adult Family Home Resident Negotiated Care Plan", dated [redacted]/2024, showed R4 moved into the AFH on [redacted]/2024. Record showed R4 was dependent on others for mobility, prone to and at risk for falls, and had a fall prevention plan that stated 15- or 30-minute checks, monitor for pain, and sensor alarms – floor (pressure pad).

On 04/29/2025 at 3:20 PM, Collateral Contact 1 (CC1), former facility staff member, stated that R4 had "bad aim" when going to the bathroom, the Provider did not clean up the mess, the floor under R4's toilet was getting discolored, R4's room always smelled strongly of urine and the soiled briefs were put into the laundry room or in the regular kitchen garbage by the Provider.

On 04/30/2025 at 11:18 AM observation showed bubbles and yellow colored liquid in R4's toilet in their private bathroom. The bedroom garbage can was full of urine- and feces-soiled disposable briefs.

On 04/29/2025 at 3:20 PM, Collateral Contact 1 (CC1), former facility staff member, stated that R4 was a severe fall risk and there were times when R4's alarm mat would go off and Provider would continue what they were doing and take a few minutes to go check. CC1 stated that the Provider was on night shift Sunday-Wednesdays and worked 24 hours on Tuesdays and Wednesdays. CC1 stated once the previous owner left responsibility of the AFH, three of five employees were fired. CC1 stated Provider works multiple days in a row without any help and they believed it was affecting the care being provided to the residents. CC1 stated when they showed up for work after Provider's multiple days with no help, the residents were angry and overwhelmed and the whole house would smell strongly of urine.

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, Rose Adult Family Home 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.

_____ _____

Provider (or Representative) Date

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

(1) In locked storage;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to keep medications in locked storage while 4 of 4 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]) were home. This failure placed all residents at risk for harm due to having access to unsecured medications.

Findings included…

Review of R1's record titled "Care Plan", dated 10/03/2024, showed R1 moved into the AFH on [redacted]/2021. Record showed R1 was moderately impaired, poor with making decisions, and required psychopharmacological medications.

Review of R1's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 10/10/2024, showed diagnoses including [redacted]. Record showed R1's decision making was severely impaired. Record showed R1 required assistance and nurse delegation for oral, topical, inhalers, and PRN (as needed) medications and showed R1 took psychopharmacological medications. Caregiver instructions for medications included that medications should be kept in locked storage, and the facility was to manage/order refill medications from the pharmacy. R1's current significant behaviors were listed as medication abuse or misuse, if any pills were out where R1 could get them, they will consume them even if they are not theirs. Caregivers were to follow the home's policy and procedure with medication management and not to leave medications unsupervised at any time.

Review of R2's record titled "Adult Family Home Resident Negotiated Care Plan", dated 12/28/2023, showed R2 moved into the AFH on [redacted]/2023. R2 required nurse delegation for medication management and was prescribed psychopharmacologic medications. Caregiver instructions for medication management included the facility was to manage/order refill medications from the pharmacy, medications should be kept in locked storage, and caregivers should dispose of medications per the medication disposal policy.

Review of R2's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/24/2025, showed diagnoses that included [redacted]. R2 had a known history or was currently being treated for depression and anxiety and was taking psychoactive medications. R2 had short-term and long-term memory issues and their decision making was severely impaired. R2 required assistance and nurse delegation for medication management and caregiver instructions included the facility to manage/order refill medications from the pharmacy and medications should be kept in

locked storage.

Review of R3's record titled "Routine Care Plan", dated 07/15/2024, showed R3 required nurse delegation for all medications, R3 had long-term memory problems and sleep disturbances causing them to sleep during the day and be awake at night.

Review of R3's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/12/2024, showed diagnoses including [redacted]. Record showed R3's decision-making was severely impaired and they had chronic pain treated by pain medications. R2 required assistance and nurse delegation for oral, topical, injections, and PRN (as needed) medications and caregiver instructions included the facility to manage/order refill medications from the pharmacy and medications should be kept in locked storage.

Review of R4's record titled "Adult Family Home Resident Negotiated Care Plan", dated [redacted]/2024, showed R4 moved into the AFH on [redacted]/2024. Record showed medication management for R4 stated medication should be kept in locked storage.

On 04/30/2025 at 1:06 PM, review of R4's record titled "Private Pay Admission Agreement", showed that medications will be kept in locked storage.

On 04/30/2025 at 11:03 AM observation showed the two medication drawers by the computer desk in an area accessible to residents were unlocked and pulled open by Provider. The drawers were full of medications.

On 04/30/2025 at 11:03 AM Provider stated the medication drawers were unable to be locked and they were working on getting them to lock properly. Provider stated their understanding of the medication storage requirement as "yeah we have to have a key".

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, Rose Adult Family Home 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.

Provider (or Representative) Date

WAC 388-76-10750 Safety and maintenance. The adult family home must:

(1) Keep the home both internally and externally in good repair and condition with a safe, comfortable, sanitary, and homelike environment that is free of hazards;

(3) Provide clean, functioning, safe, adequate household items and furnishings to meet the needs of each resident;

(5) Provide safe and functioning systems for:

(l) Any other feature of the home;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the adult family home (AFH) failed to keep the home internally in good repair with functioning, safe, adequate household items for 1 of 4 residents [Resident 1 (R1)] and failed to keep all toxic substances and hazardous materials in locked storage while 4 of 4 residents [Resident 1 (R1), Resident 2 (R2), Resident 3 (R3), and Resident (R4)] were home. This failure resulted in R1's bathroom toilet not having a toilet seat and placed all residents at risk for harm from exposure to unsecured cleaning chemicals.

Findings included…

Good Repair and Condition Free from Hazards & Clean, Functioning, Safe, Adequate Household Furnishings
On 04/30/2025 at 11:23 AM observation showed R1’s bedroom had a private bathroom attached. The bathroom toilet did not have a toilet seat or lid on it.

On 06/17/2025 at 12:50 PM, Collateral Contact 4 (CC4), nurse delegator, stated that Collateral Contact 5 (CC5), R1’s legal representative, informed them that R1’s toilet seat was completely off of the toilet and there was no place for R1 to sit.

Review of an photo sent to the department on 06/18/2025 at 11:45 AM by CC5, dated 05/31/2025 at 10:32 AM, showed R1's broken toilet seat. The photo showed the toilet seat was placed on the ground between the wall and the toilet.

Toxic Substances and Hazardous Substances in Locked Storage
On 04/30/2025 at 11:00 AM observation showed cleaning spray in an empty resident room that was unlocked and accessible to residents. Provider removed the cleaning spray and put it in the cleaning supply closet in the kitchen. The supply closet was not locked.

On 04/30/2025 at 11:00 AM Provider stated they knew the regulation for locked hazardous materials.

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, Rose Adult Family Home 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10655 Physical and mechanical restraints. The adult family home must ensure:

(1) Each resident's right to be free from physical and mechanical restraints used for discipline or convenience;

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to ensure each resident's right to be free from physical restraints used for convenience for 1 of 4 residents (Resident 4 [R4]). This failure resulted in R4 being physically restrained in their bed and placed them at risk for harm.

Findings included…

Review of R4's record titled "Adult Family Home Resident Negotiated Care Plan", dated 10/01/2024, showed R4 moved into the AFH on [redacted]/2024. Record showed R4 was dependent on others for mobility, prone to and at risk for falls, and had a fall prevention plan that stated AFH staff were to conduct 15- or 30-minute checks, monitor for pain, and use a floor sensor alarm (pressure pad). Record showed an alarm/equipment disclosure that stated, "Caregivers are to monitor and if the resident was showing signs of being restraint [sic]: 'Restricts the resident's freedom of movement or normal access to their body' the alarm/equipment must stop being used and reevaluated by PCP [primary care physician]/POA [power of attorney]/Resident/Provider etc."

On 04/29/2025 at 3:20 PM, Collateral Contact 1 (CC1), former facility staff member, stated that there were numerous instances where Provider placed pillows under R4's sheet to be used as bumpers (use of cushioned materials to line the perimeter of the bed to restrict movement out of the bed). CC1 stated they asked Provider why they did this and Provider stated it was to prevent R4 from getting out of bed.

On 04/30/2025 at 12:20 PM Provider stated they tried to place pillows as bumpers on R4's bed. Provider stated they would place pillows underneath R3's fitted sheet, two pillows on the side by the window, and one pillow on the side where R3 could get out of bed, to "keep R3 from falling out of bed". Provider stated they attempted this pillow placement, but R3 "kept jumping".

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, Rose Adult Family Home 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10595 Resident rights Advocacy access and visitation rights. The adult family home must not interfere with each resident's right to have access to and from:

(5) Visitors who are visiting the resident with the resident's consent, which:

(a) The resident may withdraw at any time; and

(b) May only be limited when the limitation is to protect the rights or safety of the residents or others in the home and must be documented under WAC 388-76-10401 ;

and

(6) The resident's representative or an entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the adult family home (AFH) failed to ensure residents could have visitors at any time for 4 of 4 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]). This failure violated all residents' rights to have visitors at any time.

Findings included…

On 04/30/2025 at 1:06 PM, review of resident record titled “Private Pay Admission Agreement”, showed “VI. Visiting policy: The Facility has an open visitation policy. Visitors will be required to abide by The facility's policies that pertain to The Resident regarding the use of any facility or service. Disruptive visitors will be required to leave. Disruptive behaviors includes yelling, screaming, use of foul language' drunkenness, hitting, stomping, slapping, shoving, verbal threats of harm to others. The Facility locks the exterior entrances between 8 PM and 8 AM. The Facility encourages a 2-hour prior notice be given when coming to visit between the hours of 8 PM and 8 AM when possible. “

On 04/30/2025 at 10:59 AM observation showed a sign posted on the front door that stated, “visiting hours is between 8 AM-8 PM, doors will be locked after 8 PM, thank you management”.

On 04/30/2025 at 12:04 PM Collateral Contact 2 (CC2), R3’s legal representative, stated that there was a note on the front door that says “I can’t come after 8 PM and I don’t like that because sometimes if I’m gone and don’t get back into town until after 8 PM.”

On 04/30/2025 at 1:08 PM Provider stated that residents’ visitors cannot come to visit after 8 PM.

On 05/01/2025 at 10:48 AM Provider stated after 8 PM visitors were not allowed.

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, Rose Adult Family Home 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10430 Medication system.

(1) If the adult family home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(c) Medication log is kept current as required in WAC 388-76-10475 ;

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to have a system in place to ensure 3 of 4 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3]) received their medications as prescribed. This failure resulted in R1, R2, and R3 not receiving their medications as prescribed and placed them at risk for harm.

Findings included…

Resident 1
Review of R1's AFH record titled "Care Plan", dated 10/03/2024, showed R1 moved into the AFH on [redacted]/2021. Record showed R1 was moderately impaired and poor with making decisions and required psychopharmacological medications.

Review of R1's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 10/10/2024, showed relevant diagnoses including [redacted] and [redacted]

[redacted], and [redacted] Record showed R1's decision making was severely impaired. Record showed R1 required assistance and nurse delegation for oral, topical, inhalers, and PRN (as needed) medications and showed R1 took psychopharmacological medications. Caregiver instructions for medications included that medications should be kept in locked storage, and the facility was to manage/order refill medications from the pharmacy.

On 06/17/2025 at 12:50 PM, Collateral Contact 4 (CC4), nurse delegator, stated that R1 was out of their Risperidone (antipsychotic medication that treats mental health conditions) and stated Provider did not know how to order medications from the pharmacy and assumed the medications would be delivered.

On 06/18/2025 at 8:57 AM, review of R1's medication administration record (MAR) titled "May 2025 MAR", showed written instructions for Risperidone 1 milligrams (mg), give one tablet by mouth BID (twice daily) at 8 AM and 2 PM for mood. Record showed R1 was not given their risperidone at 8 AM on 05/27/2025-[redacted]/2025 for reasoning "medication not available". Record showed medication was marked as given for the 2 PM dose on all of these days.

On 06/18/2025 at 9:17 AM, Collateral Contact 5 (CC5), R1's legal representative, stated that R1's medications were not filled when they transferred R1 out of the home on [redacted]/2025. CC5 stated that R1's Risperidone and Depakote (used to treat various types of seizure disorders) were completely out and when they called for an emergency refill, they were notified the medications were last filled on 04/21/2025 and should have been refilled again on 05/21/2025. CC5 stated Provider told them they didn't know why R1 did not get their medications, they were supposed to be there. CC5 stated, "if it had been 10 days past the refill date, you'd think that would be Provider's main priority for getting those filled."

On 06/18/2025 at 3:00 PM, Provider stated that R1 was out of their medication for 3-4 days.

Resident 2

Review of R2's record titled "Adult Family Home Resident Negotiated Care Plan", dated 12/28/2023, showed R2 moved into the AFH on [redacted]/2023. R2 required nurse delegation for medication management and was prescribed psychopharmacologic medications. Caregiver instructions for medication management included the facility was to manage/order refill medications from the pharmacy, medications should be kept in locked storage, and caregivers should dispose of medications per the medication disposal policy.

Review of R2's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/24/2025, showed relevant diagnoses that included [redacted], and [redacted] and showed R2 received hospice care. R2 had a known history or

was currently being treated for depression and anxiety and was taking psychoactive medications. R2 had short-term and long-term memory issues and their decision making was severely impaired. R2 required assistance and nurse delegation for medication management and caregiver instructions included the facility to manage/order refill medications from the pharmacy and medications should be kept in locked storage.

Review of R2's record titled "Nurse Delegation Nursing Visit", dated 03/24/2025, showed the Provider was being initially delegated to provide services for R2. Record showed that the nurse delegator went over the 5 rights (of medication administration), Provider demonstrated ability to administer PO (oral) and topical medications. Provider verbalized medication procedure. Nurse Delegator instructed Provider to notify them of any changes including medication change of condition of resident, skin issues and inability to perform tasks, if any meds were missed, held or refused, or if a resident had passed away.

Review of R2's record titled "Hospice Admission Orders", dated 05/16/2025 showed orders to start:
Morphine concentrate (medication to treat pain) 0.25 mL (milliliters) (5 mg), PO (by mouth) Q4 (every four hours) PRN (as needed) for pain/shortness of breath.
Lorazepam (medication used to treat anxiety disorders) 0.5 mg, 1 tab PO Q4 PRN for anxiety/shortness of breath.
Haloperidol (Haldol) (antipsychotic medication used to treat mental health disorders) 0.5 mg, 1 tab PO Q4 PRN for agitation/nausea.
Senna (laxative used to treat constipation) 8.6 mg, 1 tab PO daily PRN constipation or 2 tabs for no bowel movement in 3 days.
Continue existing medications as prescribed.

Review of R2's record titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 06/03/2025, showed R2's complete medication list which included:
Order Start Date: 05/24/2025. Acetaminophen 500 mg tablet, oral every 4 hours PRN for mild pain and/or fever. 1 tablet (500 mg) by mouth every 4 hours, as needed, for mild pain and/or fever.
Order Start Date: 05/16/2025. Donepezil (medication used to manage symptoms of Alzheimer's Disease) 10 mg tablet, 1 tablet (10 mg) by mouth daily at bedtime for dementia.
Order Start Date: 05/16/2025. Olanzapine (antipsychotic used to help manage certain mental health conditions) 2.5 mg tablet, 1 tablet (2.5 mg) by mouth each evening for mood/behavior.
Order Start Date: 05/16/2025. Spironolactone (a diuretic [water pill]) used to treat high blood pressure and heart failure) 25 mg tablet, 1 tablet (25 mg) by mouth daily for fluid retention/high blood pressure.
Order Start Date: 05/16/2025. Trazodone (medication used to treat depression and insomnia) 50 mg tablet, take 3 tablets (150 mg) by mouth at bedtime for sleep aid.

On 06/12/2025 at 1:09 PM, review of R2's record titled "May 2025 MAR" showed

instructions to give Donepezil 10 mg (milligrams) – take one tablet (total of 10 mg) HS – at bedtime for Alzheimer's Disease. Record showed R2 did not receive this medication on 05/28/2025-05/30/2025 for reasoning "medication not available".

Review of record titled, "Nurse Delegation Nursing Visit", dated 06/23/2025, showed a note that stated: Notified hospice, Divalproex sodium had only 8 capsules, Haldol was present in home on 05/30/2025 unable to find bottle on 06/23/02025- notified hospice nurse.

On 06/25/2025 at 3:01 PM, review of R2's record titled "June 2025 MAR" showed written instructions to give:
Donepezil (Aricept) 10 mg (milligrams) – take one tablet (total of 10 mg) at bedtime for Alzheimer's Disease. Record showed R2 did not receive this medication on 06/01/2025 for reasoning "medication not available". Prescription start date 05/15/2024.
Spironolactone 25 mg – take one tablet (total of 25 mg) QD (one time daily) for edema (swelling). Record showed R2 did not receive this medication from 06/08/2025-06/17/2025 and on 06/19/2025 for reasoning "medication not available". This medication was marked as given on 06/18/2025 and 06/20/2025, but were listed on the MAR as not given for reasoning "medication not available". Prescription start date 12/23/2023.
Trazodone 50 mg – take three tablets at bedtime to help with sleep. Record showed medication was not given on 06/07/2025-06/11/2025 for reasoning "medication not available". Prescription start date 04/27/2024.

On 06/12/2025 at 3:16 PM Collateral Contact 3 (CC3), hospice staff, stated Provider was present in the home for R2's hospice admission visit and could not blame the fax machine, Provider did not have the correct orders from the hospice care plan, they did not have the correct medications, they did not know how to open the fax application or how to open their messages, and stated it was clear Provider did not know how to use the fax system. CC3 stated they felt the Provider knew what to do with or how to dispose of medications that were no longer prescribed.

On 06/18/2025 at 10:52 AM Provider stated they were present for the initial hospice assessment at the AFH. Provider stated R2 was supposed to be started on hospice on 05/16/2025, but they didn't open or see the faxes from hospice, they didn't know what medications or what R2 was supposed to be taking, and stated there were no changes to the medications except a medication the Provider pronounced that was not understood by department staff. When department staff requested clarification, the Provider again stated a medication name that was not recognizable to department staff. Department staff then asked for clarification if the Provider meant "acetaminophen", the Provider stated they did. Provider then stated if the AFH gets new orders for medications, they notify CC4 and they are the one who made those changes. Provider stated it was 10-12 days after R2 was admitted on hospice when CC4 updated the hospice orders on Syncwise (electronic MAR).

On 06/18/2025 at 3:00 PM, Provider stated they did not know when R2's hospice orders

were supposed to start and stated CC3 did not tell them they were supposed to start the orders when R2 was admitted on hospice. Provider stated, “they don’t tell me that the orders were supposed to start when hospice started”. The Provider stated they understood that R2’s orders were not updated until 15 days after they were admitted on hospice, but stated “we didn’t need to start the medications”.

On 06/18/2025 at 7:10 PM, CC4 wrote in an email to department staff there were concerns about medications and over-the-counter products being accessible in unlocked drawers at the AFH. CC4 stated they suspected the Provider may not fully understand the expectations of an AFH provider, including this aspect. CC4 stated they discussed this with R2’s hospice staff, who shared concerns that Provider may not grasp the changes in medications and doubted the Provider’s ability to understand and follow medication tapering dose (gradually reducing the amount of a medication over time) orders.

On 07/08/2025 at 4:39 PM, Collateral Contact 7 (CC7), hospice staff, stated that R2 would run out of medications and hospice staff would not be notified, and stated there’s no way to know how long R2 had been out of medications. CC7 stated two medications R2 had run out of that they had not been notified of was the behavior medication, olanzapine, and the diuretic, spironolactone. CC7 stated that without the olanzapine, R2 can become very aggressive. CC7 stated for example, R2’s olanzapine was a nighttime/bedtime medication, but the Provider will say R2 got the medication this morning. CC7 stated they have hade to correct the Provider and say it’s a bedtime medication. CC7 said the Provider would then quickly agree that R2 received their medications the previous night, but the medication bottle would be completely empty, so there was no way to know how long the bottle had been empty.

Resident 3

Review of R3’s record titled “Routine Care Plan”, dated 07/15/2024, showed R3 required nurse delegation for all medications, R3 had long-term memory problems and sleep disturbances causing them to sleep during the day and be awake at night.

Review of R3’s record titled “Long Term Care Optional Assessment & Care Planning Tool”, dated 06/12/2024, showed relevant diagnoses including [redacted] and [redacted]. Record showed R3’s decision-making was severely impaired and they had chronic pain treated by pain medications. R2 required assistance and nurse delegation for oral, topical, injections, and PRN (as needed) medications and caregiver instructions included the facility to manage/order refill medications from the pharmacy and

medications should be kept in locked storage.

On 05/01/2025 at 10:37 AM, review of R3's record titled, "April 2025 Medication Administration Record (MAR)" showed written instructions to give:
Levothyroxine (Synthroid) (medication used to treat hypothyroidism) 150 mcg (micrograms) – take one tablet (total of 150 mcg) QD (one time daily) for hypothyroidism. Record showed R3 did not receive their Levothyroxine 150 mcg from 04/19/2025-04/30/2025 and the reasoning stated, "medication not available".
Trazodone (Desyrel) (medication used to treat depression and insomnia) 100 mg (milligrams) – take one tablet (total of 100 mg) at bedtime for insomnia. Record showed R3 did not receive their Trazodone 100 mg from 04/15/2025-04/19/2025 and 04/21/2025-04/24/2025 and the reasoning stated, "medication not available".

On 06/12/2025 at 11:12 AM, Provider stated they were having issues with the pharmacy and refilling R3's medications. Provider stated the pharmacy is supposed to mail all resident's medications.

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, Rose Adult Family Home 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10225 Reporting requirement.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(d) Other appropriate professionals working with the resident;

(e) Persons identified in the negotiated care plan; and

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to report a significant change for 1 of 4 residents (Resident 2 [R2]) to their registered nurse delegator. This failure resulted in a delay in R2 receiving delegation services after they began receiving hospice services and placed R2 at risk for harm.

Findings included...

Review of R2's record titled "Nurse Delegation Nursing Visit", dated 03/24/2025, showed the Provider received delegation training. The record showed Provider was instructed to notify the delegator of "any changes including medication change of condition of resident, skin issues and inability to preform tasks. If any meds are missed, held or refused, if resident has passed away."

Review of record titled "Syncwise Note", dated 03/24/2025, showed that the Provider was officially delegated on 03/24/2025 and was given instructions to call the RND (Nurse Delegator) when: medications change, clients moves, new orders received, client dies, client condition changes, problem/unable to perform nursing task, client is admitted to emergency department, hospital or skilled nursing facility SNF). Additional written instructions included in the Syncwise note and visibly posted in the AFH stated to notify the Nurse Delegator of:
"1. Change in Condition
any significant change in a resident's physical, mental, or behavioral status
initiation of hospice or palliative care services
notable changes such as increased confusion, decreased mobility, change in appetite, or signs of infection
3. Medication Changes
Any new, discontinued, or modified medication orders
Physician or pharmacy updates regarding dosage, timing, or route of administration
6. Missed or refused medications:
If a resident refuses medication or if a medication nis missed or not administered for any reason
Documentation must also be completed in accordance with the medication administration record (MAR) policy.
Responsibilities of the provider and caregivers:
Notify the nurse delegator promptly via phone, email, or secure messaging
Accurately document the incident or change in the resident's chart
Ensure all caregivers are oriented and trained on this policy during onboarding and annually thereafter
Maintain open communication with the nurse delegator to ensure all delegated tasks are performed safely and legally."

Review of R2's record titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 06/03/2025, showed R2 was admitted onto hospice services on 05/16/2025 and Provider was present for the hospice admission.

On 06/17/2025 at 12:50 PM, Collateral Contact 4 (CC4), nurse delegator, stated Provider did not notify them about R2 starting on hospice services. CC4 stated they were notified about R2's hospice services on 05/30/2025 and stated to Provider that if there was any change in resident condition, they needed to be notified.

On 06/18/2025 at 3:00 PM, Provider stated Collateral Contact 3 (CC3), hospice staff, did

not tell them to notify CC4 and stated, “I did not know I was supposed to notify this”. Provider stated CC3 asked who updated the orders in the computer, they responded that CC4 does, then stated they called CC4 in front of CC3 and CC4 said they did not know about the hospice services. Provider stated, “I did not know I was supposed to notify the nurse delegator” and stated CC4 was notified about a week after R2 started hospice services. Provider stated if the AFH received new orders for medications, they notify CC4 and they are the person who makes those changes. Provider stated they assumed CC4 was getting the faxes from hospice and that is why they did not notify CC4.

On 06/18/2025 at 7:10 PM, CC4 wrote in an email that they provided a notice to be posted at all the AFHs they delegate services to. CC4 stated this notice was present in the home when they started delegating, but noticed it was no longer posted when they went back onsite. CC4 stated they documented this in Syncwise and was also listed under all the task sheets for notification purposes.

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, Rose Adult Family Home 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10195 Adult family home Staff Generally. The adult family home must ensure:

(1) When one or more residents are in the home, enough staff are available in the home to meet the needs of each resident, except as provided in WAC 388-76-10200 ;

This requirement was not met as evidenced by:

Based on interview and record review the Adult Family Home (AFH) failed to provide enough staff to safely meet the care needs of 1 of 4 residents (Resident 2 [R2]). This failure placed R2 at risk for not receiving needed care and services.

Findings included…

On 04/30/2025 at 1:08 PM, review of resident record titled “Adult Family Home Disclosure of Services”, undated, showed "When the provider is not present in the

home, the provider will schedule the appropriate days and times for a CNA or LTC worker in the home."

Review of R2's record titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 06/03/2025, showed R2 was admitted onto hospice services on 05/16/2025. The record showed that R2 had a notable decline over the past three months. R2 was able to use a walker with assistance three months ago, and now was [redacted]. They now required assistance with 6 out of 6 activities of daily living (ADLs). R2 was incontinent of both bowel and bladder. R2 was [redacted] and required a 2-person assist with transfers.

On 07/08/2025 at 5:17 PM, review of AFH record titled "Staff Shift Schedule and Rotation", showed the following:

"Rotation strategy: to ensure fairness and keep the schedule balanced, we alternate the day and night shifts on a weekly basis. This way, one staff member can work the day shift in Week 1 and the night shift in Week 2, and vice versa. This rotation also means that each staff member alternates between working the day and night shifts every week, and they both get a day off.

Shift Schedule for 2-Week Cycle, Week 1:
Staff 1: Day Shift (7 AM - 8:30 PM), off on Thursday
Staff 2: Night Shift (8:30 PM - 8:30 AM), off on Wednesday
Week 2
Staff 1: Night Shift (8:30 PM - 8:30 AM), off on Wednesday
Staff 2: Day Shift (7 AM - 8:30 PM), off on Thursday"

On 07/08/2025 at 12:51 PM, Provider stated they have one caregiver working during the day and one caregiver working during the night. Provider stated they did not have two caregivers working at the same time on a regular basis because "I only have three" (total caregivers). Provider denied any of the AFH residents required 2-person assist for transfers, but then stated R2 was a 2-person assist when they needed a shower. Provider then stated, "for transfers, it's 2-person". Provider verbalized their understanding that because R2 was a 2-person assist, "I have to have two caregivers at all times".

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, Rose Adult Family Home 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.

Provider (or Representative) Date

WAC 388-76-10020 License Ability to provide care and services. The provider must have the:

(1) Understanding, ability, emotional stability and physical health necessary to meet the psychosocial, personal, and special care needs of the vulnerable adults under the home's care; and

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to ensure the Provider had the understanding and abilities necessary to meet the psychosocial, personal, and special care needs of 4 of 4 vulnerable adults (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]) under the home's care. This failure placed all residents at risk for harm.

Findings included…

Review of department records showed the AFH opened for operation on 03/11/2025 after a change of ownership (CHOW).

Review of Resident 2's "Nurse Delegation Nursing Visit", dated 03/24/2025, showed the registered nurse delegator was unable to delegate Provider on 03/17/2025. The visit note showed, "Went out to delegate Provider and they weren't ready. Inability to verbalize understanding and demonstrate medication administration. Instructed to review nurse delegation core book and nurse delegation diabetes."

On 06/17/2025 at 12:50 PM, Collateral Contact 4 (CC4), nurse delegator, stated Provider "barely speaks any English", they don't think Provider had "hardly any understanding of what it meant to be an AFH provider" or about medications or orders, and stated it took five nurse visits before they would delegate to Provider because their understanding and ability to repeat back the education was poor. CC4 stated Provider had three

competent caregivers that they felt confident in, but Provider is the only delegated staff in the AFH because they fired all other staff. CC4 stated Provider did not know they needed basic things, like care plans, and stated Provider did not know how to order medications from the pharmacy and assumed the medications would be delivered. CC4 stated they partly did not delegate to Provider for a long time because they did not want the Provider to fire the staff in the home and stated Collateral Contact 2 (CC2), R3's legal representative, asked them not to delegate to Provider as well. CC4 stated the Provider was delegated on 03/24/2025, for certain tasks not including diabetic care, then two weeks later Provider fired the other qualified staff. CC4 stated Provider did not know how to invoice the private pay residents and did not know how to log into Syncwise (the AFH's electronic documentation system). CC4 stated, "How could I delegate to someone who didn't have the basic understanding of how to log into the system for giving medications?"

Review of R2's "Nurse Delegation Nursing Visit", dated 06/23/2025, showed the registered nurse delegator was unable to find a bottle of Haldol (antipsychotic medication used to help with certain mental health conditions and nervous system problems) that was present in the AFH on 05/30/2025 and notified the hospice nurse.

Review of R2's record titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 06/04/2025, showed that on 05/30/2025, a report of concern was filed with Adult Protective Services "due to caregiver failure to notify facility nurse delegator of hospice admission, incorrect orders in MAR, lack of basic understanding of obligations and duties as owner/operator of a AFH facility, ran out of scheduled medications, and unsafe care environment putting our patient at risk."

On 06/12/2025 at 3:16 PM Collateral Contact 3 (CC3), hospice staff, stated they have tried and tried to communicate with Provider, there is a "definite language barrier", and there seems to be no basic understanding of what the owner's responsibilities are. CC3 stated Provider was present in the home for R2's hospice admission visit and "could not blame the fax machine". CC3 stated Provider did not have the correct orders from the hospice care plan, they did not have the correct medications, they did not know how to open the fax application or how to open their messages, and stated it was clear Provider did not know how to use the fax system. CC3 stated they "do not believe that the Provider knows what they were doing, they do not have confidence the Provider is aware of their duties as owner, and there was no sense of obligation". CC3 stated they felt the Provider did not know what to do with or how to dispose of medications that were no longer prescribed. CC3 stated the Provider did not have R2's plan of care, containing medications and doctor's orders, for the first two weeks of hospice services and stated they wondered how the Provider could be running a home if they did not know they needed to have care plans and could not read or understand the care plans.

On 06/18/2025 at 3:00 PM, Provider stated they did not know when R2's hospice orders were supposed to start and stated CC3 did not tell them they were supposed to start the orders when R2 was admitted on hospice. Provider stated, "they don't tell me that the orders were supposed to start when hospice started". Provider stated they understood what their responsibilities were as the provider, but "for some reason, I

need to know what my responsibility is for R2 and for hospice".

On 06/18/2025 at 9:17 AM, Collateral Contact 5 (CC5), R1's legal representative, stated that when Collateral Contact 1 (CC1), previous AFH staff member, was fired from the home, they were scared for R1's wellbeing. CC5 stated that R1 had happily lived in the AFH for five years, but once Provider took over after the change of ownership, everything changed. CC5 stated they did not feel that R1 was safe in the AFH because the Provider fired everyone but themself and one other caregiver "and that's not enough caregivers to keep R1 safe".

On 06/18/2025 at 4:34 PM, Collateral Contact 6 (CC6), R2's legal representative, stated they noticed a change since the new ownership took over, not in a good way, and it make them want to check out other facilities for R2,. CC6 stated it seemed the Provider was always the only one there, rarely did they see other staff, and stated the Provider was "probably over doing it". CC6 stated their concern was the Provider who was burnt out most of the time.

On 06/18/2025 at 7:10 PM, CC4 wrote in an email that they suspected the Provider may not fully understand the expectations of an AFH provider. CC4 stated they discussed this with R2's hospice staff, who shared concerns that Provider may not grasp the changes in medications and doubted the Provider's ability to understand and following medication tapering dose (gradually reducing the amount of a medication over time) orders. CC4 stated that it was challenging to gauge the Provider's understanding when anything was explained to them; the Provider often said they understood, but later stated they did not know.

On 07/08/2025 at 4:39 PM, Collateral Contact 7 (CC7), hospice staff, stated that it's very clear English was not the Provider's primary language and when you talked to them, it appeared they knew what you're talking about and was going to follow through, but it's very clear Provider didn't catch everything. CC7 stated the Provider had issues with medication management, and they've had to increase the amount of visits to the AFH due to medication issues. When it comes to the Provider's understanding about medications and medication refills, CC7 stated, "I'm not certain they understand". CC7 stated that R2 will run out of medications and hospice staff would not be notified notified and stated there's no way to know how long R2 had been out of medications. CC7 stated for example, R2's olanzapine (mental health medication) was a nighttime/bedtime medication, but the Provider will say R2 got the medication this morning. CC7 stated they have hade to correct the Provider and say it's a bedtime medication. CC7 said the Provider would then quickly agree that R2 received their medications the previous night, but the medication bottle would be completely empty, so there was no way to know how long the bottle had been empty. CC7 stated their concern is about the Provider's understanding of English to be able to properly administer medications and couldn't tell if it's a matter of competency or if it was a heavy language barrier.

Refer to Washington Administrative Code (WAC) 388-76-10400(1)(2)(3)(a)(b)(c), 388-

76-10255(1)(2)(3), 388-76-10485(1), 388-76-10750(1)(3)(5)(l), 388-76-10655(1), 388-76-10595(5)(a)(b)(6), 388-76-10430(1)(2)(c)(d), 388-76-10225(2)(d)(e), 388-76-10195(1).

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, Rose Adult Family Home 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.

_____ _____
Provider (or Representative) Date

WAC 388-76-10255 Infection control. The adult family home must develop and implement an infection control system that:

(1) Uses nationally recognized infection control standards;

(2) Emphasizes frequent hand washing and other means of limiting the spread of infection;

(3) Follows the requirements of chapter 49.17 RCW, Washington Industrial Safety and Health Act to protect the health and safety of each resident and employees; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the adult family home (AFH) failed to ensure infection control practices that emphasized handwashing were followed when care was provided to 3 of 4 residents (Residents 1 [R1], Resident 2 [R2], and Resident 3 [R3]). This failure placed all residents at risk for infection.

Findings included…

On 07/08/2025 at 5:17 PM, review of AFH record titled “Infection Control, Hand Washing, and Prevention of Communicable Disease”, undated, showed:
"1) Handwashing: Staff will wash hands frequently, and specifically: Upon arrival to the facility at start of shift and before leaving facility, before and after administering medications, and after removing gloves, after using the bathroom, before preparing or handling or eating food, before handling dishes, after handling soiled laundry or bedding, after performing household cleaning tasks, after handling garbage, before and after assisting residents with personal hygiene tasks, and after coming into contact with any soiled substances, surfaces, or body fluids. Staff will assist residents to wash their

hands after each of these activities as well. When washing hands, a 20 second hot water method at the sink will be used. When hand washing is not possible, an alcohol based sanitizer will be used. 4) Body fluid precautions will be observed to protect both residents and staff."

On 06/17/2025 at 12:50 PM, Collateral Contact 4 (CC4), registered nurse delegator, stated that due to issues like hand hygiene and basic understanding, they had to go back to the AFH five different times in order to provide delegation training to Provider.

On 07/08/2025 at 12:51 PM, Provider stated they did not have any infection control training for this AFH, but stated they did at their previous job. Provider stated they have an infection control policy from the previous owner, but nothing for the AFH currently.

Resident 1
Review of R1's record titled "Care Plan", dated 10/03/2024, showed R1 moved into the AFH on [redacted]/2021. The record showed universal precautions that stated the caregiver will use latex/plastic gloves when in contact with any secretions to prevent the spread of infections, thorough hand washing with soap will be done before and after gloving, gloves will be put on and discarded at the end of each task.

Review of R1's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 10/10/2024, showed diagnoses including [redacted]. The record showed R1 required an indwelling urinary catheter (a thin flexible tube that's inserted into the bladder to drain urine continuously). Caregiver instructions for catheter care included always washing hands before and after doing catheter care using soap and warm water and to keep the skin and catheter clean.

On 04/30/2025 at 11:23 AM, observation showed R1's private bathroom had a white bucket on the ground in the corner with a foley catheter bag inside the bucket and brown stains were in the bottom of the bucket. The foley catheter tubing was draped on the railing next to the toilet, there was no covering on the end of the catheter tube, and the exposed end of the tube was touching the wall. Continued observation showed Provider touched the end of the foley catheter tubing with ungloved and unwashed hands.

On 04/30/2025 at 11:23 AM, Provider stated the foley catheter bag and tubing were R1's nighttime bag.

Resident 2
Review of R2's record titled "Adult Family Home Resident Negotiated Care Plan", dated

12/28/2023, showed R2 moved into the AFH on [redacted]/2023.

Review of R2's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/24/2025, showed diagnoses that included [redacted] and showed R2 received hospice care. Caregiver instructions for universal precautions showed caregiver may always use latex/plastic gloves when in contact with any secretions to prevent the spread of infection, thorough hand washing with soap will be done before and after gloving, and gloves will be put on and discarded at the end of each task.

On 04/30/2025 at 11:47 AM, observation showed Provider performing perineal care (the cleaning of the perineal area, which is the region between the anus and the genitals) for R2. Provider took a cup from R2's private bathroom that was sitting on the edge of the sink to get warm water. Provider placed the pink bin that was sitting on top of a stool in R2's bathroom into the sink. The warm water from the cup was poured into the pink bin and the bin was placed back onto the stool in the bathroom directly in front of the toilet. Provider did not perform hand hygiene, put on gloves, then closed the blinds in R2's room. Provider lowered the head of the bed, closed the bedroom door for privacy, then grabbed soap from R2's bathroom and placed it in the pink warm water bin. The pink bin was brought out and placed on R2's bedside table and wheeled closer to the bed. Provider removed R2's incontinence brief, then touched the garbage can. Provider then pulled bath wipes from their package and put them into the warm water bin and began cleaning R2's genitals, which appeared red and irritated. Provider then grabbed a new, clean brief with their same gloves on, rolled R2 towards them with R2 laying on their left side. The feces soiled wipes were placed into garbage can. Provider grabbed the packet of wipes with the same soiled gloves and rolled R2 towards the opposite side, facing the wall. Provider dumped the pink bin of water into R2's bathroom sink and did not rinse the pink bin. Provider touched R2's bedside table with same soiled gloves on, and placed R2's blankets back on them while wearing the same soiled gloves. The garbage bag with the soiled brief and wipes was removed from R2's room while Provider was still wearing the same gloves. Provider removed gloves and threw away the garbage in the kitchen garbage can. Provider rinsed their hands in the kitchen sink at 12:02 PM with no soap use observed.

Resident 3

Review of R3's record titled "Routine Care Plan", dated 07/15/2024, showed R3 required extensive assistance with toileting, had bladder and bowel incontinence, and wore incontinence briefs. Caregiver instructions for universal precautions included that the caregiver will use latex/plastic gloves when in contact with any secretions to prevent the spread of infection, thorough hand washing with soap will be done before and after gloving, gloves will be put on and discarded at the end of each task.

Review of R3's record titled "Long Term Care Optional Assessment & Care Planning Tool", dated 06/12/2024, showed relevant diagnoses including [redacted], and [redacted]. R2 had stress incontinence (leaking urine when pressure is put on the bladder), required

incontinence briefs day and night, and caregiver instructions included checking R3 every 2 hours for incontinence and to wash, rinse, and dry soiled areas.

On 04/30/2025 at 11:29 AM, observation showed Provider removed foot rests from R3's wheelchair in the living room. Provider wheeled R3 back to their bedroom. Provider then grabbed a trash bag, opened it, and placed it on the floor. Provider put on gloves without performing hand hygiene, and lifted R1 from their wheelchair by placing their arms under R3's arms in a hugging position. Provider was standing with R3 and pulled R3's pants halfway down, then turned and laid R3 on their bed. Provider wiped the front of R3's perineal area, then removed R3's pants with same gloves on. Provider then wiped R3's buttocks. While wearing the same gloves, Provider put a new incontinence brief on R3 then pulled on R3's pants halfway and put R3's socks on. Provider then changed the mat on R3's wheelchair and stood R3 up from the bed with the same hugging technique. R3 had their hands behind Provider's neck while Provider pulled R3's pants and incontinence brief up, then R3 grabbed at Provider's shirt. Provider grabbed R3's arm, will still wearing the same gloves, to tell R3 to let go. Provider removed their gloves and wheeled R3 back into the living room. Provider then grabbed the trash bag from R3's bedroom floor with ungloved hands and walked it to the laundry room. Provider went into the kitchen and immediately touched food leftovers stored in a Tupperware container and placed the leftovers in a pan to reheat for lunch. Provider then rinsed their hands in the kitchen sink without soap use observed for less than 10 seconds.

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, Rose Adult Family Home 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.

_____ _____

Provider (or Representative) Date