STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

LINCOLN COUNTY PUBLIC HOSPITAL DIST
QUAIL COURT
PO BOX 368
ODESSA, WA 99159

RE: QUAIL COURT License # 1194

Dear Administrator:

This letter addresses Compliance Determination(s) 78008 (Completion Date 05/21/2026) and 76252 (Completion Date 05/05/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/21/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660-2, RCW 70.129.140.1

The Department staff who did the on-site verification:
Patricia Eddy, Community Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1194	Compliance Determination # 76252
Plan of Correction	QUAIL COURT	Completion Date
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 04/21/2026 and 04/23/2026 of:
QUAIL COURT
506 E AMENDE DR
ODESSA, WA 99159

The following sample was selected for review during the unannounced on-site visit: 4 of 11 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Patricia Eddy, Community Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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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 — 05/11/2026 Date

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

Administrator (or Representative) — 5/11/26. Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that care was provided with dignity for 1 of 4 sampled residents (Resident 2). This failure resulted in the resident being spoken to in a condescending manner and placed the residents at risk for a decreased quality of life.

Findings included...

Review of Resident 2's facility assessment, dated 03/02/2026, showed that the resident had a diagnosis of [redacted] and had "outbursts" at times. The assessment showed the resident needed occasional verbal reminders and cues, occasional staff reassurance for issues and concerns, and occasional need to call family or support persons.

Review of the facility's observation notes for Resident 2 showed the following:

Note on 02/28/2026 at 2:15 PM, written by Staff B, Nursing Assistant Certified (NAC),

documented that Resident 2 thought they had taken their morning medication when they had not. The note further stated that the Resident 2 tossed a paper pill cup across the table towards Staff B and that Staff B told the resident their behavior was "extremely rude and uncalled for." The note showed that Resident 2 stated they did not do anything wrong and that Staff B told the resident the behavior was "unbecoming and disrespectful." The note showed that Staff B stated that they were tired of dealing with it, that they'd had enough of the resident's rudeness and disrespect, and that they were "done."

Note on 03/13/2026 at 4:30 PM, written by Staff A, Administrator, documented that they had spoken to Resident 2 regarding an incident where the resident was rude to a staff member (Staff B) during bingo . The note showed that Resident 2 stated that they found the staff member (Staff B) to be "stern and aggressive," and that they would respond more positively if approached differently.

Note on 03/26/2026 at 2:30 PM, written by Staff B, documented that Resident 2 was upset they were given oatmeal for breakfast, that Staff B informed the resident that they did not have to give substitutes for breakfast, and that it was "extremely disrespectful and rude to make such negative comments about the meal when [Staff B] could have given [Resident 2] the breakfast burrito instead."

Note on 03/27/2026 at 10:45 AM, written by Staff B, document that Resident 2 made a comment about breakfast options and that Staff B stated that respectful communication was "expected." The note showed Resident 2 became upset and stated that they did not say anything.

Note on 04/11/2026 at 1:15 PM, written by Staff B, documented that Resident 2 could not say anything nice about the cook or the food. The note showed that Staff B told Resident 2 that it was not the cook's fault and that if the resident "had nothing nice to say then [they] shouldn't say anything at all."

Note on 04/16/2026 at 9:15 AM, written by Staff B, documented that Resident 2 was confused about where they were and why they were there.

In an interview on 04/22/2026 at 10:08 AM, Resident 2 stated that they have had negative experiences with Staff B since Staff B began working at the facility. Resident 2 stated that Staff B talked negatively about other residents to Resident 2, used "foul language," and often "talked down" to them and other residents. Resident 2 further stated that they had spoken to Staff A about Staff B's behavior and based on Staff A's response, felt like they had to "put up with it."

In an interview on 04/22/2026 at 3:45 PM, Staff A stated that there had been difficulties between Resident 2 and Staff B. Staff A stated that Staff B was a good worker and did not understand why Resident 2 was rude to Staff B. Staff A stated that whenever they talked to Resident 2 about their behavior, Resident 2 often became upset and said they

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did not remember being rude to Staff B. Staff A stated they had reviewed observation notes written by Staff B and was "appalled" at what Staff B had written. Staff A reported they had informed Staff B that they could not speak to residents that way. Staff A stated Staff B had stated that the residents were in their "right mind" and should not behave that way (rudely). Staff A further stated that incidents continued to occur between Staff B and Resident 2 and they were not sure how to fix the situation.

In an interview on 04/23/2026 at 2:00 PM, Staff B stated there were some issues with how Resident 2 spoke to them. Staff B stated that they wrote their observation notes exactly how the observations occurred. Staff B stated that Resident 2 was "mean," and they often told Resident 2 that their comments were inappropriate and rude. Staff B stated that Resident 2 did have a diagnosis of [redacted] and stated they believed that Resident 2's behavior was not related to the [redacted] diagnosis but that Resident 2 was "in their right mind," and was "just a mean person." Staff B stated that Resident 2's representative told the facility to put Resident 2 "in their place," when the resident had behavioral problems. Staff B confirmed that Resident 2 had memory issues that were progressing. Staff B further stated that the last time they reviewed Resident 2's care plan and assessment was when they first began working at the facility.

In an interview on 04/23/2026 at 3:30 PM, Staff A stated that Resident 2's representative did not tell the facility to put Resident 2 in their place. Staff A stated that resident assessments and care plans were readily accessible to all staff at all times and that staff were encouraged to review assessments and care plans often to ensure they were providing appropriate care.

In an interview on 05/05/2026 at 12:07 PM, Resident 2's representative stated that Staff B was "immature," and that they told Staff A that Staff B needed to realize what they were getting into when working with residents that had memory issues. Resident 2's representative stated they told Staff A that Staff B should not be "sarcastic" or "snotty," and that they needed to be respectful.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, QUAIL COURT is or will be in compliance with this law and / or regulation on (Date) 5/15/2026 .

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

Administrator (or Representative) 5/11/26 Date