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

APPLE SPRINGS ASSISTED LIVING LLC
APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE
1001 SENNA STREET
OMAK, WA 98841

RE: APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE License # 1277

Dear Administrator:

This letter addresses Compliance Determination(s) 74005 (Completion Date 03/09/2026) and 71201 (Completion Date 01/08/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/09/2026 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-2120-4, WAC 388-78A-2210-2-a, WAC 388-78A-2290-3, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-3-e, WAC 388-78A-2290-4, WAC 388-78A-2290-4-a, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d, WAC 388-78A-2090-6-e, WAC 388-78A-2474-2-b, WAC 388-112A-0080-5

The Department staff who did the on-site verification:
Carla Rose, NCI 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

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1277	Compliance Determination # 71201
Plan of Correction	APPLE SPRINGS RETIREMENT AND ASSISTED LIVING	Completion Date
Page 1 of 11	Licensee: APPLE SPRINGS ASSISTED LIVING LLC	01/08/2026

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 01/06/2026, 01/07/2026 and 01/08/2026 of:

APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE
1001 SENNA STREET
OMAK, WA 98841

The following sample was selected for review during the unannounced on-site visit: 7 of 50 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Patricia Eddy, Community Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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 — 01/22/2026 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) — 1/27/2026 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor mental health concerns for 1 of 7 sampled residents (Resident 7). This failure resulted in the resident not taking their medication as prescribed, contributed to a decline in their mental health status, and placed them at risk for harm and injury.

Findings included...

Review of Resident 7's Individual Service Plan (ISP, the facility's titled negotiated service agreement), dated 09/04/2025, showed the resident self-administered their medications and had diagnoses of [redacted] and [redacted]. Further review showed no documented plan to monitor the resident's mental health and self-medication abilities or interventions for staff to utilize in the case of a mental health crisis.

Review of Resident 7's facility assessment, dated 09/04/2025, showed that the resident required monitoring for extrapyramidal symptoms (movement disorders, like tremors, stiffness, restlessness, or involuntary spasms, caused by certain psychiatric medications). Further review showed that nursing staff were to work closely with Resident 7's providers to keep the resident on the most therapeutic dose ranges of medication possible while minimizing unnecessary side effects. The assessment showed that the resident's medications were risperidone (antipsychotic medication) and

benztropine (medication used to treat symptoms of movement disorders caused primarily by antipsychotics).

Review of Resident 7's observation notes showed the following:

12/22/2025 – The facility was contacted by a medical provider's office that was concerned about Resident 7 being in a mental health crisis.

12/29/2025 – The facility was contacted by a 911 operator stating the resident had requested an ambulance. Staff entered Resident 7's room and found the resident lying in bed with both hands bloody. The resident stated they were on the phone with a mental health provider and that they had been trying to get mental health services. The resident stated they had been 'sawing' on their left wrist since midnight.

Review of Resident 7's incident report, dated 12/29/2025, showed staff went into the resident's room at 8:45 AM. The resident had a small bloody pocketknife and stated they were trying to commit suicide. The report further stated that the resident had stopped taking all their medications a month prior.

In an interview on 01/08/2026 at 9:35 AM, Staff G, Registered Nurse, stated they spoke to Resident 7 after they received the call from the medical provider's office on 12/22/2025. Staff G asked if the resident was okay and if they needed help. The resident told Staff G that they were in the middle of setting up appointments, they were okay and did not need help. Staff G stated that they did not set up an alert for staff to monitor the resident.

In an interview on 01/08/2026 at 9:55 AM, Staff F, Executive Director, stated they were unaware that Resident 7 was to be monitored for symptoms related to psychiatric medications. Staff F stated that Resident 7's mental health had not been monitored.

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, APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE is or will be in compliance with this law and / or regulation on (Date) 2/22/2026.

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

Dewan Cooper
Administrator (or Representative) Date 1/27/26

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to administer medications as prescribed to 1 of 7 sampled residents (Resident 3). This failed practice resulted in a lack of blood pressure monitoring and placed the resident at risk of health complications.

Findings included...

Review of Resident 3's Individual Service Plan (the facility's titled negotiated service agreement), dated 03/27/2025, showed the resident was diagnosed with [redacted] and [redacted] Further review showed the facility was responsible for Resident 3's medication administration.

Review of Resident 3's Medication Administration Records (MARs) for October 2025, November 2025 and December 2025, showed an order for metoprolol (medication prescribed to control BP) to be administered twice a day. The order included directions to hold the medication if the resident's Heart Rate (HR) was below 50 or if the systolic blood pressure (SBP, top number of the BP) was below 90. The MARs showed documentation of the resident's heart rate but did not include any documentation of the resident's BP.

Review of a list of medication orders from Resident 3's medical provider, dated

05/01/2025, showed the metoprolol order included directions to hold the medication if the resident's HR was below 50 or if the SBP was below 90.

In an interview on 01/07/2025 at 12:30 PM, Staff H, Resident Services Director, stated that the medication technicians only checked Resident 3's HR when they administered metoprolol. Staff H further stated they were unaware that the metoprolol orders included BP parameters.

In an interview on 01/07/2025 at 1:00 PM, Resident 3 stated that the medication technicians did not check their BP each time the metoprolol was administered.

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, APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE is or will be in compliance with this law and / or regulation on (Date) 2/22/2026.

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

Administrator (or Representative) 1/27/2026 Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop a written plan and agreement for family administered medications and supply of medical equipment for 1 of 3 residents (Resident 4) sampled for family plan agreements. This failure resulted in a lack of medical treatment and placed the resident at risk of health complications.

Findings included...

Review of Resident 4's Individual Service Plan (the facility's titled negotiated service agreement), dated 11/03/2025, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed that the facility was responsible for Resident 4's medication administration.

Review of a provider order, dated 09/17/2025, showed that Resident 4 was prescribed weekly Ozempic injections (medication prescribed to control blood sugar and for weight loss).

Review of Resident 4's Medication Administration Records (MARs) for September 2025, October 2025, November 2025, December 2025, and January 2026, showed an order for the resident's blood sugar to be checked daily. Review of the November 2025 MAR showed the resident did not have their blood sugar checked on 11/29/2025 and 11/30/2025 with a note that documented "waiting on BG [blood glucose] strips from family". Further review showed the order for Ozempic did not appear on the MAR until December 2025 and that the facility only documented one out of four doses in December as administered.

Review of a faxed communication to Resident 4's provider, dated 11/29/2025, showed that the facility notified the provider that they were not checking Resident 4's blood sugar because they were waiting on the family to provide the blood sugar test strips.

Review of a faxed communication to Resident 4's provider, dated 12/02/2025, showed that the facility requested an updated order for Resident 4's Ozempic and to notify the physician that the family was administering the Ozempic.

In an interview on 01/07/2025 at 4:15 PM, Staff H, Resident Services Director, stated that Resident 4's family kept the Ozempic in their possession and administered it from the time it was ordered in September 2025, through November 2025. Staff H then stated that in December 2025 the family gave the Ozempic to the facility to keep in the medication cart and that a family member came in each week to administer the Ozempic. Staff H also confirmed that the family provided the blood sugar test strips. When asked if they had a family plan for the Ozempic administrations and the blood sugar test strips, Staff H stated they did not because they were unaware of the requirement to do so.

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, APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE is or will be in compliance with this law and / or regulation on (Date) 2/22/26 .

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

Susan Cooper 1/27/26

Administrator (or Representative) Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete safety assessments for smoking for 2 of 7 sampled residents (Resident 1 and 6). This failure placed the residents at risk of harm from smoking unsupervised when they were not assessed to safely to do so.

Findings included...

<Resident 1>

Review of Resident 1's assessment, dated 09/19/2025, showed a completed smoking assessment that indicated the resident followed the facility's smoking policy, did not smoke in their room at night, kept smoking materials in their possession and used them safely.

Review of Resident 1's observation notes showed the following:

08/30/2025 – the resident was seen smoking in the gazebo on the premises. Later, the resident was seen smoking next to the outside door and was informed three times that there was no smoking on the premises and that they had to go to the park to smoke.

08/31/2025 – the resident was seen smoking right outside the door by their room and was told they had to go across the street. Later, the resident was seen smoking in the gazebo on the premises.

09/01/2025 – the resident was still trying to smoke at the gazebo and was told to smoke across the street. The resident stated it was too far to walk.

09/02/2025 – staff were notified that the resident was possibly smoking in their room due to a strong odor in the resident's bathroom.

09/03/2025 – resident continued to smoke in the gazebo on the premises.

09/16/2025 – Staff noted the resident smoking in their bathroom. The resident admitted to smoking in their room.

10/22/2025 – The executive director spoke with the resident and their family, and all agreed that the facility would hold the resident's cigarettes in the medication room and that the resident would ask for a cigarette when they wanted to smoke. Staff were to provide one cigarette at a time and ensure the resident was smoking in the designated area.

11/30/2025 – The resident was caught with a pack of cigarettes, given to them from another resident.

12/27/2025 – The resident appeared weak and did not want to walk all the way to the gazebo.

Review of Resident 1's incident report, dated 12/03/2025, showed that the resident went out to smoke and fell on their way back inside the building. The resident crab walked to the door, tried to open it, and banged on the door to be let in.

In an interview on 01/07/2026 at 1:30 PM, Staff F, Executive Director, stated they had not updated Resident 1's smoking assessment.

<Resident 6>

Review of the facility's characteristic roster showed that Resident 6 smoked.

Review of Resident 6's assessment, dated 08/01/2025, showed the resident did not smoke. Further review showed no documentation of a smoking assessment.

Review of Resident 6's observation notes showed the following:

12/16/2025 – the resident asked another resident for cigarettes and went to another room looking for cigarettes. The resident stated that their family was bringing some cigarettes in for them.

12/23/2025 – Discussion with the resident about not propping doors open to smoke and to instead smoke across the street.

In an interview on 01/07/2026 at 3:15 PM, Staff F stated Resident 6 did smoke and confirmed there was no smoking assessment completed for Resident 6.

Plan/Attestation Statement

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

Dean Cooper

Administrator (or Representative) Date 1/27/26

WAC 388-112A-0080 Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC 388-112A-0090 : Adult family homes.

(5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training. Enhanced services facilities.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 70-hour basic training was completed by 1 of 5 staff (Staff B). This failed practice placed residents at risk of receiving assistance from untrained staff.

Findings included...

Review of Staff B's, Caregiver , personnel file showed that they were hired on 09/03/2025 and had not completed the HCA (Home and Community Aide) 70-hour basic long term care worker training. Further review showed that Staff B did not have an HCA certification.

In an interview on 01/08/2026 at 11:20 AM, Staff F, Executive Director, stated that they were unaware that the seventy-hour basic training needed to be completed within 120

days after caregivers were hired.

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, APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE is or will be in compliance with this law and / or regulation on (Date) 2/22/26 .

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

Administrator (or Representative) 1/27/26 Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

APPLE SPRINGS ASSISTED LIVING LLC
APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE
1001 SENNA STREET
OMAK, WA 98841

RE: APPLE SPRINGS RETIREMENT AND ASSISTED LIVING RESIDENCE # 1277

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 01/08/2026 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:
- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

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

eFax: (509) 921-2426
Email: rcsregion1email@dshs.wa.gov
Optional method:
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(iv) Are kept at least six months;

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

The facility did not keep six months of menus and did not keep records of food substitutions. The facility agreed that going forward they would maintain menu and substitution records for six months.

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

The facility did not have an exterior call system in the courtyard. Staff immediately obtained and placed a call system in the courtyard for residents to request assistance if needed prior to the end of the licensing survey.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

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

Enclosure