STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC
GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

RE: GUARDIAN ANGEL HOMES (THE COTTAGE) License # 1513

Dear Administrator:

This letter addresses Compliance Determination(s) 77244 (Completion Date 05/12/2026) and 73707 (Completion Date 03/18/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/12/2026 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-2210-1-b

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: GUARDIAN ANGEL HOMES (THE COTTAGE)
License/Cert.#: 1513
Compliance Determination #: 73707
Investigator: Melissa Milanez
Provider Type: Assisted Living Facility
Intake ID: 213118
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 03/03/2026 through 03/18/2026
Complainant Contact Date(s): 03/25/2026

Allegation(s):

1. Staff were rushed to learn how to pass out medications, which contributed to medication errors.
2. Residents are not receiving care and services needed.
3 Some of the houses smell like urine, are unsanitary, and unorganized.
4. Residents are not being showered regularly and are forced to shower.
5. Nurses are not keeping up on diabetic nail care.
6. The nurse did not inform staff of a resident's diet, and the resident had a choking incident.
7. Staff get fired and they are left short staffed.
8. Residents are not receiving their meals.

Investigation Methods:

Sample:
Total residents: 75
Resident sample size: 7
Closed records sample size:

Observations:
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Residents
Family members

Record Reviews:
State reporting log
Incident investigation
Facility policies
Staff training records
Staff patterns

Investigation Summary:

1. Interview with the nurse at the facility showed that the facility had recently transitioned to a new medication administration process, which had not been implemented effectively and contributed to errors. Additionally, the nurse stated that they had not consistently followed its policy to audit medication administration records every 30 days, resulting in medication errors not being identified or addressed in a timely manner. Failed practice identified. Please see the Statement of Deficiency for medication systems Washington Administrative Code 388-78A-2210 (1)(b).
2. Identified residents were observed to be clean and well-groomed. Sampled resident interviews showed that they received assistance with showers, staff were helpful and were attentive to their needs. Observations showed that staff were present and actively engaged in resident care. Staff were assisting residents to and from the dining room and providing assistance as needed. No failed practice identified.
3. Observations of the facility homes showed they were clean, organized, and maintained. During the onsite visit, one home had a noticeable urine odor; however, this was attributed to a resident with a catheter. Staff reported awareness of the odor and had appropriately contacted Hospice services. Hospice staff were present during the onsite visit and confirmed the catheter had recently been changed in response to the concern. Resident interviews showed that housekeeping services were routinely provided and rooms were cleaned regularly, with no concerns reported. Observations showed caregivers actively cleaning the kitchen and washing dishes. No failed practice identified.
4. Observations of residents during the on-site visit showed that residents were well groomed, dressed and clean. Interviews with residents and staff showed that residents received showers twice a week, and upon request. The facility had been made aware of the previous allegation regarding resident being forced to shower, followed their processes, investigated and ruled out abuse and neglect. Staff interviewed demonstrated knowledge of appropriate interventions when residents refuse care, including reapproaching and honoring residents' choices. Additionally, staff stated they were aware of mandatory reporting requirements and were all familiar with how to make a report. No failed practice identified.
5. Interviews and record review showed that a podiatrist routinely visits the facility and provides diabetic nail care services. The nurses stated that there are three licensed nurses on staff who will also provide nail care as needed. Observations during on-site visit showed residents' fingernails and toenails were clean, trimmed, and maintained. Staff stated that routine nail care is completed on shower days, and if diabetic residents required nail care, the nurses would provide that. No failed practice identified.
6. Staff and nurse interviews did not recall any recent choking incidents. Staff stated that care plans are routinely updated, reviewed, and are used to guide care, including diet orders. Additionally, staff confirmed they were trained on how to respond to choking incidents and had no concerns. Record reviews of residents requiring modified diets showed care plans were current and included appropriate dietary instructions regarding mechanical soft diets. Observations showed that staff were present and actively engaged in resident care. No failed practice identified.
7. The administrator stated the facility was actively hiring and on-boarding new staff but that the facility was currently adequately staffed. The staffing coordinator stated they are responsible for scheduling, covering sick calls, and ensuring shifts are filled. Additionally, they stated they have been in the new role as the staffing coordinator for three months now, and during that time all shifts have been covered. They stated they always carry the facility phone to address staffing needs. Residents stated they felt safe and that staff were available to meet their needs. Staff were present and observed assisting residents as needed during on-site visit. No failed practice identified.
8. Observations showed that the residents were eating lunch, and food was

available to them. Interviews with other residents showed that they received meals. Interviews with staff showed that residents and staff stated that they had enough food in the building, did not miss meals, and had snacks offered to them. No failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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 an unannounced on-site complaint investigation on 03/03/2026 of:

GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

This document references the following complaint number(s): 213118, 212509, 213691

The following sample was selected for review during the unannounced on-site visit: 7 of 75 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Laura Williams-Davis
Residential Care Services

04/01/2026
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.

L Miller
Administrator (or Representative)

4/10/26
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received medications as prescribed and failed to implement systems to support safe medication administration for 7 of 7 residents. This failure resulted in multiple medication administration errors, placing residents at risk for adverse health outcomes.

Findings included....

Record review of the facility's policy titled "Nurse Medication Policy" undated, showed that the community will take responsibility for the resident's medication with the following requirements being met on an ongoing basis: the nurse engaged by the community shall review the medications of each resident every month to ensure that the resident is taking the medication properly, how the residents react to the medication, whether other medications might be indicated, and if medications ordered by the physician are current and medications taken by the resident matches the physician's orders.

In an interview on 03/03/2026 at 12:02 PM, Staff A, Administrator, stated the facility recently transitioned into a new medication administration system process, eliminating dedicated Medication Technician (MT) positions and training caregivers to administer medications. The administrator stated that under the new system, caregivers were

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 Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) _____ Date _____

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Record review of the facility's policy titled "Nurse Medication Policy" undated, showed that the community will take responsibility for the resident's medication with the following requirements being met on an ongoing basis: the nurse engaged by the community shall review the medications of each resident every month to ensure that the resident is taking the medication properly, how the residents react to the medication, whether other medications might be indicated, and if medications ordered by the physician are current and medications taken by the resident matches the physician's orders.

In an interview on 03/03/2026 at 12:02 PM, Staff A, Administrator, stated the facility recently transitioned into a new medication administration system process, eliminating dedicated Medication Technician (MT) positions and training caregivers to administer medications. The administrator stated that under the new system, caregivers were

responsible for both resident care and medication administration across individual cottages. Staff A stated that they were not aware of any medication errors.

In an interview on 03/03/2026 at 12:35 PM, Staff B, Health and Wellness Director, stated they would be the one responsible for conducting medication administration audits and that they were not aware of any medication errors.

Record review of the facility's internal investigation reports completed by Staff B, dated 03/04/2026 and 03/18/2026, showed that twelve residents experienced medication administration errors that had been identified through a review of Medication Administration Records (MARs). Errors included medications not administered as ordered, medications administered outside of prescribed parameters, and treatments not completed as scheduled.

Resident 1

Review of Resident 1's Negotiated Service Agreement (NSA), dated 03/18/2026, showed that the facility managed and assisted Resident 1 with their medications. Resident 1's diagnosis included [redacted].

Review of Resident 1's MAR for February 2026, showed an order for daily wound care to the left upper back from 02/04/2026 - 02/16/2026, which included removing the old dressing, cleaning the wound bed, apply Vaseline ointment, and covering with clean dressing. The MAR showed that wound care was not completed on 02/07, 02/08, 02/14, and 02/15 due to no nurse availability.

Record review of a physician's order dated 02/18/2026, showed that the resident was prescribed Doxycycline 100 mg by mouth twice daily for 7 days for treatment of infection.

In an interview on 03/17/2026 at 3:42 PM, Staff B stated that Resident 1 and experienced adverse outcomes related to missed wound care and had developed an infection requiring antibiotic treatment. Staff B stated that the facility failed to ensure coverage for wound care over the weekend, resulting in treatments not being completed for two consecutive weekends. The nurse acknowledged a breakdown in communication among staff to ensure ordered wound care was completed as prescribed, contributing to the resident's infection.

Resident 2

Review of Resident 2's NSA, dated 03/18/2026, showed that the facility managed and assisted Resident 2 with their medications. Resident 2's diagnosis included [redacted]

and [redacted].

Review of Resident 2's physician orders for February showed:

• Nitrofurantoin 100 mg capsule (antibiotic used to treat urinary tract infection) take one capsule by mouth twice daily at 8:00 AM and 5:00 PM, for 5 days and ensure card is fully used.

Review of Resident 2's MARs for February 2026, showed that staff missed three doses of the antibiotic, including the PM dose on 02/17/2026, and both doses missed on 02/21/2026.

Review of the facility's internal investigation report completed by Staff B, dated 03/04/2026, showed that the medication was placed incorrectly in the MAR and that the resident only received 7 out of 10 doses.

Resident 3

Review of Resident 3's NSA, dated 03/18/2026, showed that the facility managed and assisted Resident 3 with their medications. Resident 3's diagnosis included [redacted] and staff were to observe for signs of fluid retention, such as swollen legs or shortness of breath.

Review of Resident 3's current physician orders showed:

• Furosemide 20 mg tablet (used for edema) take ½ tablet (10mg) by mouth every day.

Review of Resident 3's progress notes for February 2026, showed that on 02/12/2026 the resident displayed increased dyspnea (difficulty breathing) on exertion and elevated blood pressure. Additionally, staff reported that Resident 3 had been breathing heavily while ambulating. Additionally, a 02/13/2026 progress note showed that the resident was out of Furosemide and medication was not administered.

Review of Resident 3's MARs for January and February 2026, showed that staff failed to administer Furosemide as ordered on five occasions and documented the medication as unavailable. The MAR indicated the medication was not administered from 01/29/2026 through 01/31/2026, and on 02/13/2026 and 02/19/2026.

Resident 4

Review of Resident 4's NSA, dated 03/18/2026, showed that the facility managed and assisted Resident 4 with their medications. Resident 4's diagnoses included [redacted], and [redacted]. Additionally, the NSA showed that Staff B were to monitor and review vitals and health status monthly and as needed. Staff were to document and notify the licensed nurse if outside the following parameters: blood pressure higher than 190/100 or lower than 90/40, or a pulse lower than 40.

Review of Resident 4's current physician orders showed:

- Lidocaine 4% cream to apply topically to the affected area twice daily for pain
- Losartan 50 mg (used to treat high blood pressure) take 1 tablet by mouth twice daily (additional directions: to hold for blood pressure of less than 100 systolic or 50 diastolic)
- Metoprolol 50 mg (used to treat high blood pressure) take 1 tablet by mouth every day hold for systolic blood pressure (SBP-top number) is less than 100 or diastolic blood pressure (DBP-bottom number) less than 50 or hold if hear rate less than 60
- Hydralazine 25 mg take 1 tablet by mouth up to twice daily as needed for two readings of SBP (top number) of 160 or higher. Additional directions included giving 1 tablet by mouth twice daily as needed for SBP greater than 140 and DBP greater than 90.

Review of Resident 4's Medication Administration Record (MAR) for January through March 2026, showed that Lidocaine gel was not administered from 02/02/2026-02/05/2026 and marked as unavailable. Additionally, Resident 4's blood pressure was above 140/90 and as needed Hydralazine was not administered per physician's orders on 1/01/2026 through 01/08/2026, and on 01/10, 01/11, 01/13, 01/14, 01/15, and 01/17, 2026. On 02/03/2026 Losartan was administered when the resident had a blood pressure of 77/47 (normal blood pressure 120/80). In March 2026, Losartan was not held per physician's orders on 03/02, and Metoprolol was not held per physician's orders twice on 03/08, and on 03/16.

Resident 5

Review of Resident 5's NSA, dated 03/18/2026, showed that the facility managed and assisted Resident 5 with their medications. Resident 5's diagnoses included [redacted], and [redacted]. Additionally, the NSA showed that the HWD was to monitor and review vitals and health status monthly and as needed. Staff were to document and notify the licensed nurse if outside of the following parameters: blood pressure is higher than 190/100 or lower than 90/40, or a pulse lower than 40.

Review of Resident 5's current physician orders showed:

- Amlodipine 2.5 mg (used to treat high blood pressure) take 1 tablet by mouth every day. Hold is Systolic Blood Pressure (SBP-top number) less than or equal to 110.
- Torsemide 10 mg (used to treat edema and high blood pressure) take 1 tablet by mouth every day, hold if SBP less than 110.
- Spiriva Respimat 2.5 mcg (used for COPD) inhale 2 puffs by mouth every day.
- Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG (used for COPD) inhale 2 puffs by mouth twice daily.

Review of Resident 5's MAR's for January through March 2026, showed that staff failed to follow provider ordered parameters for blood pressure medications. An order for Torsemide instructed the staff to administer one tablet by mouth daily and to hold the medication if the resident's systolic blood pressure was less than 110. However, Torsemide was administered on 01/17, 02/08, 02/10, and 02/23, when the resident's blood pressure did not meet the ordered parameters for administration. Additionally, Torsemide was held on 01/29, 02/04, and 02/20, with no corresponding blood pressure documentation recorded in the MAR. Further review showed an order for Amlodipine to be held if the systolic blood pressure was less than or equal to 110. However, Amlodipine was administered on 01/17, 01/26, 02/03, 02/08, 02/10, 02/23, and 03/10, and ordered blood pressure parameters were not followed. Additionally, Amlodipine was held on 01/29, 02/04, and 02/20, without documented blood pressure readings to support the clinical decision to hold the medication.

Additionally, the MAR showed that Budesonide (inhaler) was not administered for eight doses and marked as not available from 03/05 through 03/10, and Spiriva (inhaler) was not administered on 02/18 and 02/19 and marked as not available.

Review of the facility's internal investigation report completed by Staff B, dated 03/10/2026 at 12:00 pm, showed that the resident was administered another resident's medications, including acetaminophen, two multi vitamins and zinc.

In an interview on 03/17/2026 at 3:42 pm, Staff B stated that they took responsibility for the medication error as the medication technician involved had been assigned to administer medications in a different unit where they were unfamiliar with the residents and medication process.

Resident 6

Review of Resident 6's NSA, dated 03/18/2026, showed that the facility managed and assisted Resident 6 with their medications. Resident 6's diagnosis included [redacted] and staff were to notify nursing immediately with sudden increases in blood pressure, severe headaches, or dizziness.

Review of Resident 6's current physician orders showed:

- Atorvastatin 40 mg take 1 tablet by mouth every night at bedtime
- Metoprolol 25 mg tablet take 1 tablet by mouth twice daily, hold if BP less than 100/50 or pulse less than 50.

Review of Resident 6's MAR's for January through March 2026, showed that facility staff failed to follow provider ordered parameters for medication administration. An order for Metoprolol instructed staff to administer one tablet by mouth twice daily and to hold the medication if the resident's systolic blood pressure was less than 100/50 or pulse less than 50. However, Metoprolol was administered on 01/03, 01/04, and 02/18, when the resident's blood pressure and/or pulse did not meet the ordered parameters for administration. Additionally, Metoprolol was not administered on 02/07, with no corresponding blood pressure or pulse documentation recorded in the MAR to support the clinical decision. Record review also showed, Atorvastatin and Metoprolol were not administered to Resident 6 on 03/09/2026 due to no medication trained staff available in house to administer the medications.

Resident 7

Review of Resident 7's NSA, dated 03/18/2026, showed that the facility managed and assisted Resident 7 with their medications. Resident 7's diagnosis included [redacted].

Review of Resident 7's current physician orders showed:

- Pramipexole 0.5 mg tablet (helps improve tremors and stiffness) give 1 mg by mouth four times a day for Parkinsons disease.

Review of Resident 7's progress notes for February showed that on 02/06/2026, 02/10/2026, 02/17/2026, and 02/18/2026 Pramipexole was not administered due to medication unavailable.

Review of Resident 7's MARs for February 2026, showed that staff failed to administer Pramipexole on 02/06, 02/10, 02/17, and 02/18 and documented medication as unavailable.

Review of the facility's internal investigation report completed by Staff B, dated 03/04/2026, showed that the medication was not administered on four occasions. However, the nurse confirmed the medication was present in the medication cart and available for administration and not sure why it was not administered.

Continued Interview on 03/17/2026 at 3:42 PM, Staff B stated that the increase in medication errors was related to the facilities' recent transition to a new medication administration system, in which caregivers were trained to administer medications and provide caregiving tasks. Staff B acknowledged that the new training process and the new medication administration process had not been effective. Staff B stated that they had not followed the facility's medication policy and failed to complete MAR audits every 30 days as indicated in the policy and that contributed to why medication errors were not identified sooner. This is a repeated deficiency previously cited on 08/03/2023 Washington Administrative Code (WAC) 388-78a-2210(1)(b).

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date) May 02, 2026

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

L Miller
Administrator (or Representative)

4/10/2026
Date

Continued interview on 03/17/2026 at 3:42 PM, Staff B stated that the increase in medication errors was related to the facilities' recent transition to a new medication administration system, in which caregivers were trained to administer medications and provide caregiving tasks. Staff B acknowledged that the new training process and the new medication administration process had not been effective. Staff B stated that they had not followed the facility's medication policy and failed to complete MAR audits every 30 days as indicated in the policy and that contributed to why medication errors were not identified sooner. This is a repeated deficiency previously cited on 08/03/2023 Washington Administrative Code (WAC) 388-78a-2210(1)(b).

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

_____ _____

Administrator (or Representative) Date