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

BETHANY PLACE INC
BETHANY PLACE INC
9111 E Upriver Dr
Spokane, WA 99206

RE: BETHANY PLACE INC License # 1552

Dear Administrator:

This letter addresses Compliance Determination(s) 71360 (Completion Date 01/13/2026) and 67331 (Completion Date 11/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/13/2026 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, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: BETHANY PLACE INC
Provider Type: Assisted Living Facility
License/Cert.#: 1552
Compliance Determination #: 67331
Intake ID: 197199
Investigator: Stephanie Jenks
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/16/2025 through 11/18/2025
Complainant Contact Date(s): 10/17/2025, 11/12/2025

Allegation(s):

1. Inadequate diabetic care.
2. Facility utilizing emergency services too often.
3. Resident hit and killed by vehicle in front of facility.
4. Facility claiming to be independent living facility but billing for assisted living facility services.
5. Staff not trained or qualified to care for residents.
6. Staff parked in fire lane.
7. Staff refused to arrange medical care for resident with ear pain.
8. Staff requested emergency medical services staff to request resident drug test at hospital.
9. Staff not arranging transportation for residents to get to primary care or urgent care.
10. Facility refuses to allow staff to call AMR for non-emergent transport.

Investigation Methods:

Sample:
Total residents: 68
Resident sample size: 4
Closed records sample size: 2

Observations:
Alleged Victim
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter
Chief Operations Officer
Alleged Victim
Resident
Administrative Assistant
Medication Technicians
Alleged Victim's Representative

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets

*Resident care plans
*Hospital after-visit summaries
*Progress notes
*Medication administration records
*Facility license
*Staff credentials
*Staff training records
*Staff CPR cards
*Provider orders
*Resident assessments
*Staff training checklist
*Diabetic monitoring sheet
*Medication Administration Overview Policy

Investigation Summary:

1. Record review showed that a diabetic resident had not consistently received their medications as ordered. Interview with facility staff showed that diabetic orders in the resident's medication administration records were not always clear. Failed facility practice identified and cited under WAC 388-78A-2210 Medication services (1)(b)(2)(a).
2. This allegation falls outside of Resident Care Services jurisdiction.
3. Interview with facility management showed that the incident occurred off facility campus in 2021. Facility management stated that the Alleged Victim was independent in the community. Record review confirmed that the Alleged Victim was able to leave the facility without assistance. The Alleged Victim could not be observed or interviewed as they were deceased at the time of the onsite visit. The Alleged Victim's Representative was interviewed, and they reported having felt safe with the resident at the facility. Staff were observed available to supervise resident safety. No failed facility practice.
4. Interview with facility management showed that the facility operated as an assisted living facility. Record review confirmed that the facility was licensed as an assisted living facility. Residents were interviewed, and no concerns were voiced about the facility's billing practices. Facility management was observed available to address concerns related to billing and licensing. No failed facility practice.
5. Record review showed that staff had the necessary credentials and training to work at the facility. Facility staff were interviewed. They were knowledgeable about resident care requirements and reported feeling safe on the job. Residents were interviewed, and no concerns were voiced about the competence of staff. Facility management was observed available to address resident care concerns. No failed facility practice.
6. Interview with facility management showed they were unaware of a designated fire lane on the facility campus. The facility campus was observed, and no marked or designated fire lanes were observed. No obstacles preventing facility access were observed. Interview with emergency services personnel showed that the incident occurred in the past and only one time. Facility management was observed available to address concerns related to facility access. No failed facility practice.
7. Record review showed that the facility obtained ear drops for the Alleged Victim the same day the resident initially complained of ear pain. The Alleged Victim could not be observed or interviewed as they discharged from the facility prior to the onsite visit. Three attempts were made to reach the Alleged Victim's Representative but they could not be reached. Residents were interviewed and they reported that they received medical care when needed. Staff were observed available to address resident concerns. No failed facility practice.
8. This allegation falls outside of Residential Care Services jurisdiction.
9. Review of the facility's disclosure of services showed that the facility coordinated

with multiple transportation providers to meet the residents' transportation needs. Interview with facility management showed that the facility had a van for resident transportation to appointments. Residents were interviewed, and no concerns were voiced about access to medical care. Facility management was observed available to address concerns related to transportation and medical care accessibility. No failed facility practice.
10. This allegation falls outside of Residential Care Services jurisdiction.

Conclusion / Action:

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

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

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 10/16/2025 of:

BETHANY PLACE INC
9111 E Upriver Dr
Spokane, WA 99206

This document references the following complaint number(s): 197199

The following sample was selected for review during the unannounced on-site visit: 4 of 68 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator
Stephanie Jenks, Community Field Manager

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 — 11/25/2025 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) — 11/26/2025 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.

(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 implement a system to promote safe medication services that ensured residents who required medication assistance, received their medications as prescribed for 1 of 3 residents (Resident 2) reviewed for diabetic care. This failed facility practice resulted in unmanaged blood sugar blood sugar levels, continued high blood sugar, and a potentially avoidable trip to the hospital for Resident 2.

Findings included...

Review of a Negotiated Service Agreement (NSA) for Resident 2, dated 10/01/2025, showed the facility was to assist the resident with taking all as needed and routine medications according to doctor's orders. The NSA showed Resident 2 had type 1 diabetes (a condition resulting in high levels of sugar in the blood). The NSA showed that Resident 2 was an insulin dependent diabetic, indicating that the resident required

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Findings included…

Review of a Negotiated Service Agreement (NSA) for Resident 2, dated 10/01/2025, showed the facility was to assist the resident with taking all as needed and routine medications according to doctor's orders. The NSA showed Resident 2 had type 1 diabetes (a condition resulting in high levels of sugar in the blood). The NSA showed that Resident 2 was an insulin dependent diabetic, indicating that the resident required

insulin in order to manage their blood sugar levels.

Review of a progress note for Resident 2, dated [redacted]/2025 at 10:10 AM, showed the resident admitted to the facility at that date and time.

In an email communication sent to the department on 11/18/2025 at 11:43 AM, Staff C, Chief Operations Officer, stated that Resident 2 admitted to the facility without medication orders.

Review of a doctor's order for Resident 2, dated [redacted]/2025, showed that the resident did not receive insulin orders until that day, two days after their admission to the facility.

Review of a temporary Medication Administration Record (MAR) for Resident 2, dated September 2025, showed that Resident 2 received their first dose of insulin at the facility on [redacted]/2025 at 6:00 PM, over two days since their admission to the facility. The MAR showed that between [redacted]/2025 and 09/22/2025, Resident 2's blood sugar levels were between 350 and 551, significantly higher than the acceptable range.

Review of a new doctor's order for Resident 2, dated 09/22/2025, showed the resident was ordered one unit of insulin lispro (fast acting injected medication used to lower blood sugar) for every four grams of carbohydrates consumed, plus a correction dose before meals and at bedtime using the following sliding scale: blood sugar less than 250 = two units, blood sugars between 251 and 300 = four units, blood sugars between 301 and 350 = six units, blood sugars between 351 and 400 = eight units, blood sugars between 401 and 450 = 10 units, and blood sugars greater than 450 =12 units. The order showed that Resident 2 was ordered 15 units of insulin glargine (long-acting injected medication used to lower blood sugar) twice daily.

In an interview on 10/23/2025 at 2:42 PM, Staff B, Administrative Assistant, stated that the facility did not count grams of carbohydrates consumed by residents. Review of faxes from the facility to the doctor, dated 09/25/2025, showed the facility did not reach out to the doctor to have the carbohydrate count order changed until that day, three days after the order was received.

Review of a MAR for Resident 2, dated September 2025, showed the following:
-09/22/2025 at 8:00 PM- The resident did not receive their insulin lispro.
-09/22/2025 at 8:09 PM- The resident's blood sugar was "high."
-09/23/2025 at 12:00 PM- The resident's blood sugar measured 439 and 11 units of insulin lispro were given without a carbohydrate count.
-09/23/2025 at 5:00 PM- The resident's blood sugar measured 547 and 13 units of insulin lispro were given without a carbohydrate count.
-09/23/2025 at 8:00 PM- The resident did not receive their insulin lispro or their insulin glargine .

-[redacted]/2025 at 8:00 AM- The resident's blood sugar measured 482 and 13 units of insulin were given without a carbohydrate count.
-09/25/2025 at 8:00 AM- The resident's blood sugar measured 314 and seven units of insulin lispro were given without a carbohydrate count.

Review of a hospital after-visit summary for Resident 2, dated [redacted]/2025, showed the resident was seen at the hospital that day for hyperglycemia (high blood sugar levels).

Review of a progress note for Resident 2, dated [redacted]/2025 at 12:00 AM, showed the resident was discharged from the emergency room after being seen for elevated blood sugar.

Review of a doctor's order for Resident 2, dated 09/25/2025, showed the resident's insulin lispro order was changed to 15 units with each meal with additional insulin using the following sliding scale: blood sugars between 150 and 200 = one unit, blood sugars between 200 and 250 = two units, blood sugars between 250 and 300 = three units, blood sugars between 300 and 350 = four units, blood sugars between 350 and 400 = five units, and blood sugars greater than 400 = six units.

Review of a MAR for Resident 2, dated September 2025, showed the following:
-09/25/2025 at 5:00 PM- The resident's blood sugar measured 330 and they received six units of insulin lispro, instead of the correct dose of 19 units.
-09/26/2025 at 5:00 PM- The resident's blood sugar measured 222 and they received two units of insulin lispro, instead of the correct dose of 17 units.
-09/27/2025 at 5:00 PM- The resident's blood sugar measured 394 and they received five units of insulin lispro, instead of the correct dose of 20 units.
-09/28/2025 at 5:00 PM- The resident's blood sugar measured 320 and they received four units of insulin lispro, instead of the correct dose of 19 units.

In an interview on 10/17/2025 at 3:59 PM, Collateral Contact 1, Emergency Responder, stated that the facility resident's trips to the hospital with high blood sugar were preventable.

In an interview on 10/28/2025 at 10:15 AM, Staff C was asked if anyone was auditing the MARs to ensure that the correct amount of sliding scale insulin was being given to the residents. Staff C stated they looked at the MARs weekly though they did not look specifically for sliding scale insulin amounts.

In an interview on 10/28/2025 at 3:50 PM, Staff A, Medication Technician, stated that they did not think the residents' insulin orders were always clear or easy to understand.

Statement of Deficiencies	License #: 1552	Compliance Determination # 67331
Plan of Correction	BETHANY PLACE INC	Completion Date
Page 5 of 5	Licensee: BETHANY PLACE INC	11/18/2025

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, BETHANY PLACE INC is or will be in compliance with this law and / or regulation on (Date) 11/26/2025 .

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

Administrator (or Representative) Date 11/26/2025