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

RP Operations, LLC
Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

RE: Rose Pointe Assisted Living License # 2452

Dear Administrator:

This letter addresses Compliance Determination(s) 72460 (Completion Date 02/06/2026) and 69505 (Completion Date 12/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/06/2026 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-2660-1, RCW 70.129.140.1, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-a, WAC 388-78A-2950-5, WAC 388-78A-2950-6, WAC 388-78A-3100-2, WAC 388-78A-3100-1, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-b, WAC 388-78A-2320-1-b, WAC 388-78A-2230-1-c, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2400-2, WAC 388-78A-3040-3, WAC 388-78A-2040-1

The Department staff who did the on-site verification:
Joy Pipgras, LTC Surveyor
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

Residential Care Services
Investigation Summary Report

Provider/Facility: Rose Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2452
Intake ID: 204271
Compliance Determination #: 69505
Region/Unit #: RCS Region 1 / Unit B
Investigator: Carla Rose
Investigation Date(s): 12/01/2025 through 12/10/2025
Complainant Contact Date(s):

Allegation(s):
Narcotic patch not removed when new patch applied.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 18 Closed records sample size: 0
Observations:	Alleged victim (AV) Sampled residents Medication cart
Interviews:	Residents Medication technicians Nurse manager
Record Reviews:	Medication administration records Investigations Medications policies Delegation records Progress notes

Investigation Summary:
A narcotic patch was left on the alleged victim (AV) when it should have been removed when the new patch was applied. The nurse manager was unaware of the process to safely remove, dispose of, and apply new patch. Nurse manager said they were not responsible for training staff on the proper procedure and that it was the responsibility of the nurse delegator. The order for patch stated that the old patch must be removed when the new patch was applied. A medication technician discovered that the previous medication technician had not removed the old patch when they applied the new patch. The nurse manager did not put interventions in place, investigate, or document the medication error. Failed practice identified under WAC 388-78A-2210 (1)(b)(2)(b) for Medication Services.

Conclusion / Action:

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

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

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 and complaint investigation on 12/01/2025, 12/02/2025, 12/03/2025, 12/04/2025 and 12/09/2025 of:

Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

This document references the following complaint numbers: 202375, 201020, 204271.

The following sample was selected for review during the unannounced on-site visit: 18 of 89 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Brian Zbylski, ALF Licensor
Carla Rose, NCI 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.

JSalquist
Residential Care Services

12/24/2025
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.

Teresa Yate
Administrator (or Representative)

12-30-25
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:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

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 7 of 18 sampled residents (Resident 7, 9, 14, 15, 16, 17 and 18) and failed to ensure that food was not served on disposable dinnerware in 2 of 2 living areas (Memory Care and Assisted Living). This failure resulted in Resident 14 feeling insulted to have to use disposable dinnerware and Resident 9 not being able to use their own bathroom.

Findings included...

<Dignity>

Observation on 12/01/2025 at 9:20 AM showed 10 residents in the memory care (living area designated for residents with significant cognitive deficits that had an increased need for assistance) activity room with no staff present. Resident 15 was observed sitting three feet away from the television and sleeping. Observation showed that Resident 18 sat directly behind Resident 15, and their knees were touching the back of Resident 15's reclining wheelchair, with no view of the television.

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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(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.

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(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

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 7 of 18 sampled residents (Resident 7, 9, 14, 15, 16, 17 and 18) and failed to ensure that food was not served on disposable dinnerware in 2 of 2 living areas (Memory Care and Assisted Living). This failure resulted in Resident 14 feeling insulted to have to use disposable dinnerware and Resident 9 not being able to use their own bathroom.

Findings included…

<Dignity>

Observation on 12/01/2025 at 9:20 AM showed 10 residents in the memory care (living area designated for residents with significant cognitive deficits that had an increased need for assistance) activity room with no staff present. Resident 15 was observed sitting three feet away from the television and sleeping. Observation showed that Resident 18 sat directly behind Resident 15, and their knees were touching the back of Resident 15’s reclining wheelchair, with no view of the television.

Observation on 12/01/2025 at 12:08 PM, during the memory care unit's lunch service, showed that Resident 15 had scrambled eggs on their clothing.

Review of the facility menu showed eggs were served for breakfast on 12/01/2025.

Observation on 12/03/2025 at 11:50 PM, showed Resident 7, Resident 15 and Resident 16 were served lunch. Resident 15 was observed to eat mashed potatoes and gravy using their fingers. Observation showed Residents 7 and Resident 16 did not start eating and were not assisted or cued by staff to eat.

In an interview on 12/04/2025 at 12:40 PM, Resident 9 stated that they had put in multiple requests for a new roommate because their roommate urinated on the floor in the bathroom daily. Resident 9 further stated that they frequently had to use the bathroom in the lobby to avoid stepping into the urine.

Observation on 12/04/2025 at 1:05 PM, showed a large puddle on the floor at the base of the toilet in Resident 9's bathroom. The room had an odor of urine.

<Dinnerware>

Observation on 12/01/2025 at 11:45 AM, showed the memory care dining room was set up with disposable dinnerware.

In an interview on 12/01/2025 at 11:47 AM, Staff N, Server, stated they did not have enough time to set up traditional dinnerware.

In an interview on 12/02/2025 at 11:10 AM, Resident 17 stated that they had eaten off disposable plates and silverware for breakfast that morning in the assisted living dining room.

In an interview on 12/02/2025 at 1:00 PM, Resident 14 stated that when they were served food on disposable dinnerware, it felt "insulting."

In an interview on 12/02/2025 at 4:00 PM, Staff F, Executive Director, stated that kitchen staff were aware they were not supposed to serve meals on disposable dinnerware, and that they should have been serving on glassware.

In an interview on 12/03/2025 at 12:05 PM, Staff L, Cook, stated that the facility used disposable dinnerware when they were short staffed.

This is a recurring deficiency previously cited on 12/27/2024 for WAC 388-78A-2680, on 06/18/2024, and on 10/26/2023.

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) ~~02/25/2026~~ 01/24/2026

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

Teresa Yates
Administrator (or Representative)

12-30-2025
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the environment was well maintained, safe and sanitary in 2 of 2 facility areas (Interior and Exterior). This failure placed residents at risk of injury and a decreased quality of life.

Findings included...

Observations on 12/01/2025 at 9:20 AM and 12/03/2025 at 11:32 AM, showed the following:

<Interior>

-Air vents full of debris throughout the facility.

This is a recurring deficiency previously cited on 12/27/2024 for WAC 388-78A-2660, on 06/18/2024, and on 10/26/2023.

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, Rose Pointe Assisted Living 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.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure the environment was well maintained, safe and sanitary in 2 of 2 facility areas (Interior and Exterior). This failure placed residents at risk of injury and a decreased quality of life.

Findings included…

Observations on 12/01/2025 at 9:20 AM and 12/03/2025 at 11:32 AM, showed the following:

<Interior>

-Air vents full of debris throughout the facility.

-Strong odor of urine in the Memory Care Unit (MCU) bathroom, adjacent to the activity room.

-Maintenance staff stated in an interview during the environmental tour that the MCU bathroom shower was not in working order. Observation showed the shower had a torn sheet as a shower curtain.

-MCU activity room contained three chairs that had faux leather covers with numerous rips, cracks, and peeling surfaces and a broken plastic laundry basket with jagged points and sharp edges.

-MCU freezer had spilled food and debris.

-MCU dining room steam tables were covered in food and debris, prior to lunch service and following the breakfast service.

-MCU dining room door frame had rough surfaces that could not be cleaned, and shredded wood that could cause potential harm.

-Assisted living carpets in all halls had numerous black spills and stains.

-Assisted living doorways into resident rooms had numerus corners that were damaged and baseboards that were unattached.

-Multiple doors and kick plates were damaged with residual adhesive on them.

-Room 40's shower/tub did not drain properly, leaving standing water in the base, the bathroom flooring was buckled with black stains that appeared to be seeping through the underside, and a stained toilet bowl.

-Room 9 had leaking water around the toilet with a black substance surrounding the base of the toilet.

-Room 29's heater was not producing heat, and the resident was observed wearing a coat in bed.

<Exterior>

-The far northwest door onto the assisted living courtyard was broken and swung into the exterior siding leaving an eight inch by 10-inch hole.

-Cigarette butts littered the ground behind and surrounding the covered smoking area.

-There were two broken chairs, two hoses, numerous five-gallon buckets, a rake, a shovel, an empty animal cage and other debris on the grounds between the covered smoking area and the MCU.

-Numerous cable television cords were strung over the building on the east side of the building outside of room 27.

-Seven hoses, five rakes and three shovels were observed in resident accessible areas of the building's exterior.

-There were cigarette butts and ashes three feet from the southeast exit door, a non-smoking area.

-Fuel stabilizer was observed on the ground and leaning on the covered smoking area entrance.

-There was garbage and piles of branches on the east side grassy area.

-The plumbing access cover in the front of the building was broken with unattached hinges.

-Loose landscaping bricks were out of place and on the ground around the west side of the building.

-MCU courtyard exhibited multiple spills and visible staining on the pavement. Cigarette butts and ashes were also noted on the ground.

In an interview on 12/02/2025 at 9:55 AM, Resident 5 stated that maintenance requests were not handled in a timely manner. Resident 5 further stated there was no maintenance request book or forms to fill out, and that they had to report maintenance issues to a staff member who would then notify maintenance.

In an interview on 12/02/2025 at 2:22 PM, Staff C, Resident Care Coordinator, stated that maintenance request notifications were sent by text to the maintenance director.

In an interview on 12/02/2025 at 4:00 PM, Staff G, Health and Wellness Director/Registered Nurse, stated that maintenance repairs were an area of concern they needed to work on. Staff G stated the facility did not have a tracking system to identify maintenance requests that were completed or still pending.

In an interview on 12/04/2025 at 12:40 PM, Resident 9 stated that maintenance requests were not handled in a timely manner, and that they felt that their maintenance concerns were not addressed.

This is a recurring deficiency previously cited on 06/17/2025 for subsections (1) (a) (c), 12/27/2024 for subsections (1) (a) (b), and 6/18/2024.

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME
Per FM Stephanie Jenks on 1/23/2026, an extension for this WAC has been granted to be changed to 2/6/2026. -RH

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) ~~02-25-26~~ 02/06/2026

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

Teresa Yates — Administrator (or Representative)

12-30-25 — Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(5) Provide hot and cold water under adequate pressure readily available throughout the assisted living facility;

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain shower/bathing water temperatures between 105 degrees Fahrenheit and 120 degrees Fahrenheit for 1 of 11 residents (Resident 13), to ensure cold water was accessible in the kitchenette of 1 of 11 residents (Resident 9), and to ensure that water temperatures were maintained between 105 degrees Fahrenheit and 120 degrees Fahrenheit in 3 of 3 resident accessible areas of the facility (Lobby Bathroom, Resident Laundry, and Memory Care Common Bathroom). These failures resulted in cold showers for Resident 13, a lack of cold water for Resident 9, and placed residents at risk of burn injuries due to water temperatures above 120 degrees Fahrenheit.

In an interview on 12/02/2025 at 4:00 PM, Staff G, Health and Wellness Director/Registered Nurse, stated that maintenance repairs were an area of concern they needed to work on. Staff G stated the facility did not have a tracking system to identify maintenance requests that were completed or still pending.

In an interview on 12/04/2025 at 12:40 PM, Resident 9 stated that maintenance requests were not handled in a timely manner, and that they felt that their maintenance concerns were not addressed.

This is a recurring deficiency previously cited on 06/17/2025 for subsections (1) (a) (c), 12/27/2024 for subsections (1) (a) (b), and 6/18/2024.

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, Rose Pointe Assisted Living 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.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(5) Provide hot and cold water under adequate pressure readily available throughout the assisted living facility;

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain shower/bathing water temperatures between 105 degrees Fahrenheit and 120 degrees Fahrenheit for 1 of 11 residents (Resident 13), to ensure cold water was accessible in the kitchenette of 1 of 11 residents (Resident 9), and to ensure that water temperatures were maintained between 105 degrees Fahrenheit and 120 degrees Fahrenheit in 3 of 3 resident accessible areas of the facility (Lobby Bathroom, Resident Laundry, and Memory Care Common Bathroom). These failures resulted in cold showers for Resident 13, a lack of cold water for Resident 9, and placed residents at risk of burn injuries due to water temperatures above 120 degrees Fahrenheit.

Findings included...

Observation on 12/01/2025 at 9:20 AM, showed the water temperature in the common bathroom located in the entrance lobby measured 137.3 degrees Fahrenheit (F), the resident laundry tub measured 137.2 F, and the memory care common bathroom measured 136.1 F.

In an interview on 12/04/2025 at 12:40 PM, Resident 9 stated that the cold water did not work in their kitchenette.

Observation on 12/04/2025 at 1:05 PM, showed that the cold-water knob in Resident 9's kitchenette sink did not work.

In an interview on 12/09/2025 at 10:10 AM, Resident 13 stated that the hot water did not work in their shower. Resident 13 further stated that they notified care staff a "few weeks ago" but maintenance had not repaired it. Observation at that time showed the water in Resident 13's shower did not measure higher than 82.5 F.

This is previous consultation on 12/27/2024 for subsection (6).

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date): ~~02/05/2026~~ 01/24/2026

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

Teresa Yates
Administrator (or Representative)

12/30/2025
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

Findings included…

Observation on 12/01/2025 at 9:20 AM, showed the water temperature in the common bathroom located in the entrance lobby measured 137.3 degrees Fahrenheit (F), the resident laundry tub measured 137.2 F, and the memory care common bathroom measured 136.1 F.

In an interview on 12/04/2025 at 12:40 PM, Resident 9 stated that the cold water did not work in their kitchenette.

Observation on 12/04/2025 at 1:05 PM, showed that the cold-water knob in Resident 9's kitchenette sink did not work.

In an interview on 12/09/2025 at 10:10 AM, Resident 13 stated that the hot water did not work in their shower. Resident 13 further stated that they notified care staff a "few weeks ago" but maintenance had not repaired it. Observation at that time showed the water in Resident 13's shower did not measure higher than 82.5 F.

This is previous consultation on 12/27/2024 for subsection (6).

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, Rose Pointe Assisted Living 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.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that hazardous supplies and materials were locked and secured in 2 of 2 locations (Industrial Laundry Room and Covered Smoking Area). This failure placed residents at risk of harm.

Findings included…

Review of the most recent facility Characteristic Roster showed that 19 assisted living residents were diagnosed with [redacted].

Observation on 12/01/2025 at 9:20 AM and on 12/04/2025 at 11:32 AM, showed the industrial laundry room to be unlocked. Further observation showed the room contained disinfecting acid bathroom cleaner, enzymatic odor eliminator, multi-surface disinfectant cleaner, carpet shampoo, stain remover, universal primer (base coat applied before painting), and a bag of snow removal pellets.

Observation on 12/01/2025 at 9:30 AM showed an unattended and unsecured bottle of fuel stabilizer (chemical additive that preserves fuel quality) leaning against the outside wall of the covered smoking area.

In an interview on 12/01/2025 at 10:12 AM, Staff I, Maintenance Director, stated that the industrial laundry room door should always remain locked.

This is a recurring deficiency previously cited on 6/18/2024.

Plan/Attestation Statement

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

Teresa Yates — Administrator (or Representative)

12/30/2025 — Date

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

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 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a safe medication delivery system and to ensure that medication was administered as prescribed to 1 of 11 residents (Resident 11). This failed practice placed the resident at risk of harm from a medication error that resulted in a potential overdose of narcotic medication.

Findings included...

Review of the facility's policy titled, "Transdermal Medication," dated 08/2015, showed that before applying a new transdermal patch (delivery of medication through the skin) to a resident's skin, the previous patch needed to be removed and disposed of appropriately.

Review of Resident 11's Service Plan Report (the facility's titled negotiated service agreement), dated 08/12/2025, showed that Resident 11 was diagnosed with [redacted] and [redacted]. Further review showed the facility was responsible for Resident 11's medication

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, Rose Pointe Assisted Living 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.

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

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(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 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a safe medication delivery system and to ensure that medication was administered as prescribed to 1 of 11 residents (Resident 11). This failed practice placed the resident at risk of harm from a medication error that resulted in a potential overdose of narcotic medication.

Findings included…

Review of the facility's policy titled, "Transdermal Medication," dated 08/2015, showed that before applying a new transdermal patch (delivery of medication through the skin) to a resident's skin, the previous patch needed to be removed and disposed of appropriately.

Review of Resident 11's Service Plan Report (the facility's titled negotiated service agreement), dated 09/12/2025, showed that Resident 11 was diagnosed with [redacted] and [redacted]. Further review showed the facility was responsible for Resident 11's medication

administration and that the resident required nurse delegation (process in which a resident is assessed by a registered nurse allowing medication technicians to perform certain nursing tasks after receiving appropriate training).

Review of Resident 11's provider order, dated 08/26/2025, showed an order for a fentanyl patch (medicated patch applied to the skin that contains a narcotic pain reliever) to be administered every 72 hours. The provider order showed that staff were to remove and dispose of the used patch before applying the new patch.

Review of Resident 11's nurse delegation records, dated 10/01/2025, showed instructions to "locate and remove previous fentanyl patch first."

In an interview on 12/09/2025 at 9:10 AM, Staff J, Medication Technician, stated that when they applied the fentanyl patch on 12/04/2025, they discovered that Resident 11 had two patches on their back. Staff J stated that they immediately brought it to the attention of Staff G, Health and Wellness Director/ Registered Nurse.

In an interview on 12/09/2025 at 9:15 AM, Staff G was asked about the process of applying and removing fentanyl patches. Staff G stated that they were unsure what the process was and that training for fentanyl patches was the responsibility of the registered nurse delegator (registered nurse that oversees caregivers performing nursing tasks).

In an interview on 12/09/2025 at 11:20 AM, Staff G stated that they were aware of incident that involved a fentanyl patch being left on Resident 11 when it should have been removed. Staff G stated they did not document or report the medication error

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

Plan/Attestation Statement

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Teresa Yates
Administrator (or Representative)

12-30-25
Date

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Review of Resident 11's nurse delegation records, dated 10/01/2025, showed instructions to "locate and remove previous fentanyl patch first."

In an interview on 12/09/2025 at 9:10 AM, Staff J, Medication Technician, stated that when they applied the fentanyl patch on 12/04/2025, they discovered that Resident 11 had two patches on their back. Staff J stated that they immediately brought it to the attention of Staff G, Health and Wellness Director/ Registered Nurse.

In an interview on 12/09/2025 at 9:15 AM, Staff G was asked about the process of applying and removing fentanyl patches. Staff G stated that they were unsure what the process was and that training for fentanyl patches was the responsibility of the registered nurse delegator (registered nurse that oversees caregivers performing nursing tasks).

In an interview on 12/09/2025 at 11:20 AM, Staff G stated that they were aware of incident that involved a fentanyl patch being left on Resident 11 when it should have been removed. Staff G stated they did not document or report the medication error.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement nurse delegation requirements for 1 of 3 residents (Resident 1) who received blood sugar checks and insulin injections from facility staff. This failed practice placed the resident at risk for medication errors and harm due to receiving nurse delated tasks from untrained staff.

Findings included…

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator:

- Assesses the patient's nursing care needs and determines whether the patient's condition is stable and predictable.

- Ensures the nursing assistant (NA) or home care aid (HCA) has completed the core delegation training and insulin delegation training.

- Assesses the ability of the NA or HCA to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

- Ensures safe and effective services are provided.

Review of the facility's policy titled, "RN [Registered Nurse] Delegation," dated 05/01/2025, showed that a Registered Nurse Delegator (RND) would determine the competency and qualifications of staff who performed a nurse delegated task (a task performed by a medication technician that has received additional training and oversight) and would evaluate residents' appropriateness for nurse delegation. The policy showed that the RND was required to instruct individuals (caregivers) on how to properly inject insulin (medication used to lower sugar in the blood) and that the RND was required to supervise caregivers who performed nurse delegation.

Review of Resident 1's Service Plan Report (the facility's titled negotiated service agreement), dated 06/02/2025, showed the resident was diagnosed with [redacted] and that the facility was responsible for administering (requiring nurse delegation) Resident 1's medications.

Review of Resident 1's October 2025 Medication Administration Record (MAR) showed the following orders:

Insulin (injectable medication used to lower blood sugar), dated 10/06/2025, to be administered at bedtime

Daily blood sugar checks (measurement of sugar in the blood), dated 10/10/2025.

Review of the nurse delegation records binder showed no documentation of Resident 1 having been assessed or that staff qualifications and competency had been reviewed by the RND.

In an interview on 12/03/2025 at 12:08 PM, Staff H, Medication Technician, stated that staff performed blood sugar checks and insulin administration (nurse delegated tasks) daily for Resident 1.

In an interview on 12/04/2025 at 12:00 PM, Staff G, Health and Wellness Director/Registered Nurse, stated that Resident 1 had not been nurse delegated for their insulin injections and blood sugar checks.

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

Plan/Attestation Statement

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

Teresa Yates — Administrator (or Representative)

12-31-25 — Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person:

Review of Resident 1's October 2025 Medication Administration Record (MAR) showed the following orders:

Insulin (injectable medication used to lower blood sugar), dated 10/06/2025, to be administered at bedtime

Daily blood sugar checks (measurement of sugar in the blood), dated 10/10/2025.

Review of the nurse delegation records binder showed no documentation of Resident 1 having been assessed or that staff qualifications and competency had been reviewed by the RND.

In an interview on 12/03/2025 at 12:08 PM, Staff H, Medication Technician, stated that staff performed blood sugar checks and insulin administration (nurse delegated tasks) daily for Resident 1.

In an interview on 12/04/2025 at 12:00 PM, Staff G, Health and Wellness Director/Registered Nurse, stated that Resident 1 had not been nurse delegated for their insulin injections and blood sugar checks.

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Administrator (or Representative) Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that outside health care providers were notified in a timely manner of medication refusals by 2 of 11 sampled residents (Resident 9 and 10). This failure resulted in the provider being unaware that residents were not taking their medications as prescribed and placed the residents at risk for health complications.

Findings included…

<Resident 9>

Review of Resident 9's Service Plan Report (SPR, the facility's titled negotiated service agreement), dated 8/26/2025, showed the resident was diagnosed with [redacted] and [redacted]. The SPR showed that Resident 9 experienced complications related to diabetes, resulting in a non-healing foot wound and subsequent below the knee amputation in June 2025. Further review showed the facility was responsible for administering and overseeing Resident 9's medication administration.

Review of Resident 9's Medication Administration Records (MARs) for September 2025 thru November 2025 showed the resident was prescribed atorvastatin (medication used to lower cholesterol, a fat like substance found in both blood and cells, at bedtime, gabapentin (medication to decrease nerve pain) two times a day, trazodone (medication to help with sleep) at bedtime, aspirin (for heart health) two times a day, and insulin lispro (medication used to control blood sugar) twice a day.

Review of Resident 9's Medication Administration Record (MAR) for September 2025, showed the resident refused atorvastatin 12 times, gabapentin 12 times, trazadone 16 times, aspirin 12 times, and insulin lispro 29 times.

Review of Resident 9's October 2025 MAR showed the resident refused atorvastatin 10 times, gabapentin six times, trazadone 23 times, aspirin 11 times, and insulin lispro 37 times.

Review of Resident 9's November 2025 MAR showed the resident refused atorvastatin 13 times, gabapentin 13 times, trazadone 25 times, aspirin 13 times, and insulin lispro

37 times.

Review of Resident 9's provider visit note, dated 10/09/2025, showed Resident 9's cholesterol levels were elevated, and that the health care provider increased the dose of atorvastatin from 10 milligrams (mg) and to 20 mg. Further review showed that the provider had not been notified of Resident 9's refusals of the atorvastatin.

Review of Resident 9's undated medical chart showed no documentation reflecting that the resident's health care provider had been notified of the resident's refusals.

In an interview on 12/04/2025 at 2:45 PM, Staff B, Medication Technician, stated that Resident 9 refused their medications frequently. Staff B stated the process was to document the medication refusal in the resident's progress notes and notify Staff G, Health and Wellness Director/Registered Nurse , verbally of the refusals. Staff B said that Staff G was aware of Resident 9's refusals.

In an interview on 12/04/2025 at 3:10 PM, Staff G stated that the refusals for Resident 9 were not addressed prior to the department's inquiry, and that they would notify the provider.

<Resident 10>

Review of Resident 10's SPR, dated 04/08/2025, showed the resident was diagnosed with [redacted] and that Resident 10 took a diuretic (medication to reduce fluid accumulation) for swelling. Further review showed the facility was responsible for administering and overseeing Resident 10's medication administration.

Review of Resident 10's MARs for September 2025 thru November 2025 showed the resident was prescribed furosemide (medication to reduce swelling) daily, potassium chloride (supplement administered with furosemide), adult multivitamins daily, and vitamin D3 daily.

Review of the September 2025 MAR showed Resident 10 refused furosemide 13 times, potassium 13 times, multivitamin 29 times, and vitamin D3 29 times.

Review of the October 2025 MAR showed Resident 10 refused furosemide 19 times, potassium 17 times, multivitamin 28 times, and vitamin D3 30 times.

Review of the November 2025 MAR showed Resident 10 refused furosemide six times, potassium six times, multivitamin 11 times, and vitamin D3 11 times.

In an interview on 12/03/2025 at 9:15 AM, Staff G stated that the medication refusal protocol was to notify the provider if there was a pattern of three days of refusals. Staff G stated they were supposed to read the 24-hour report which showed resident medication refusals. Staff G further stated that they needed to work on notifying the providers of refusals in a timelier manner.

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

Plan/Attestation Statement

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

Teresa Yates — Administrator (or Representative)

12/31/2025 — Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that confidential health information was secured in 1 of 3 medication carts (Cart 3) and in 1 of 1 laundry room list (industrial laundry room). This failure placed residents at risk of having their confidential personal health information exposed.

Findings included...

Observation on 12/02/2025 at 2:13 PM showed the medication cart outside of the memory care unit to be unattended with the Medication Controlled Substance book laying on top. Further observation showed it was unattended for six minutes before being secured by Staff G, Health and Wellness Director/Registered Nurse.

In an interview on 12/02/2025 at 3:30 PM, Staff H, Medication Technician, stated that it was their fault it had been left on the cart by accident.

In an interview on 12/09/2025 at 9:15 AM, Staff G stated that the medication refusal protocol was to notify the provider if there was a pattern of three days of refusals. Staff G stated they were supposed to read the 24-hour report which showed resident medication refusals. Staff G further stated that they needed to work on notifying the providers of refusals in a timelier manner.

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Administrator (or Representative) Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that confidential health information was secured in 1 of 3 medication carts (Cart 3) and in 1 of 1 laundry room list (Industrial laundry room). This failure placed residents at risk of having their confidential personal health information exposed.

Findings included…

Observation on 12/02/2025 at 2:13 PM showed the medication cart outside of the memory care unit to be unattended with the Medication Controlled Substance book laying on top. Further observation showed it was unattended for six minutes before being secured by Staff G, Health and Wellness Director/Registered Nurse.

In an interview on 12/02/2025 at 3:30 PM, Staff H, Medication Technician, stated that it was their fault it had been left on the cart by accident.

Observation on 12/04/2025 at 11:32 AM showed the laundry room was unlocked. Inside was a confidential list of residents that wore incontinent briefs and what sizes they wore.

In an interview on 12/01/2025 at 10:12 AM, Staff I, Maintenance Director, stated that the industrial laundry room door should always remain locked.

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

Plan/Attestation Statement

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

Teresa Yates — Administrator (or Representative)

12-31-2025 — Date

WAC 388-78A-3040 Laundry.

(3) The assisted living facility must use washing machines that have a continuous supply of hot water with a temperature of 140 F measured at the washing machine intake, that automatically dispenses a chemical sanitizer as specified by the manufacturer, or that employs alternate sanitization methods recommended by the manufacturer

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that washing machines had a continuous supply of hot water of at least 140 degrees Fahrenheit or used automatically dispensed chemical sanitizer for 2 of 2 washing machines (Machines 1 and 2). This failure placed residents at risk of communicable disease exposure due to soiled linens being improperly laundered.

Findings included...

Observation on 12/01/2025 at 9:20 AM showed an industrial washing machine with an "Out of Order" sign on it.

Observation on 12/04/2025 at 11:32 AM showed the laundry room was unlocked. Inside was a confidential list of residents that wore incontinent briefs and what sizes they wore.

In an interview on 12/01/2025 at 10:12 AM, Staff I, Maintenance Director, stated that the industrial laundry room door should always remain locked.

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Administrator (or Representative) Date

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(3) The assisted living facility must use washing machines that have a continuous supply of hot water with a temperature of 140 F measured at the washing machine intake, that automatically dispenses a chemical sanitizer as specified by the manufacturer, or that employs alternate sanitization methods recommended by the manufacturer.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that washing machines had a continuous supply of hot water of at least 140 degrees Fahrenheit or used automatically dispensed chemical sanitizer for 2 of 2 washing machines (Machines 1 and 2). This failure placed residents at risk of communicable disease exposure due to soiled linens being improperly laundered.

Findings included…

Observation on 12/01/2025 at 9:20 AM showed an industrial washing machine with an “Out of Order” sign on it.

In an interview on 12/01/2025 at 9:22 AM, Staff I, Maintenance Director, stated that the industrial washing machine had been inoperable "for about six months" and that all laundry had been washed in the resident laundry room.

Observation on 12/01/2025 at 9:25 AM showed the resident laundry room to have two washing machines. Further observation showed no automatic sanitizing dispensers.

In an interview and observation on 12/02/2025 at 2:30 PM, Staff I stated they could not obtain a water temperature from the main source, but that the water temperature was the same as the tub sink in the laundry room. The tub sink water temperature measured 117.1 degrees Fahrenheit.

In an interview on 12/02/2025 at 4:00 PM, Staff F, Executive Director, confirmed that the industrial washer had not been working since June 2025. Staff F confirmed that all laundry including soiled linens, was washed in the resident laundry room.

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

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

Tina Yates — Administrator (or Representative)

12/31/2025 — Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a medical testing site waiver license to perform on-site blood sugar checks and COVID tests for residents in 2 of 2 living areas (Memory Care and Assisted Living). This failure resulted in the facility performing medical testing without oversite, which placed the residents at risk of receiving inaccurate test results.

In an interview on 12/01/2025 at 9:22 AM, Staff I, Maintenance Director, stated that the industrial washing machine had been inoperable “for about six months” and that all laundry had been washed in the resident laundry room.

Observation on 12/01/2025 at 9:25 AM showed the resident laundry room to have two washing machines. Further observation showed no automatic sanitizing dispensers.

In an interview and observation on 12/02/2025 at 2:30 PM, Staff I stated they could not obtain a water temperature from the main source, but that the water temperature was the same as the tub sink in the laundry room. The tub sink water temperature measured 117.1 degrees Fahrenheit.

In an interview on 12/02/2025 at 4:00 PM, Staff F, Executive Director, confirmed that the industrial washer had not been working since June 2025. Staff F confirmed that all laundry including soiled linens, was washed in the resident laundry room.

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Administrator (or Representative) Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a medical testing site waiver license to perform on-site blood sugar checks and COVID tests for residents in 2 of 2 living areas (Memory Care and Assisted Living). This failure resulted in the facility performing medical testing without oversite, which placed the residents at risk of receiving inaccurate test results.

Findings included...

Review of the Department of Health's Facility Search website on 11/21/2025, showed that the facility's Medical Test Site Certificate of Waiver License (CLIA) had expired on 09/30/2025.

In an interview on 12/01/2025 at 9:00 AM, Staff G, Health and Wellness Director/Registered Nurse, stated that the facility did blood sugar checks and COVID testing on-site.

In an interview on 12/01/2025 at 9:30 AM, Staff M, Regional Director, stated that a new management company had assumed duties on 10/01/2025. Staff M stated that the old management company had not renewed the facility's CLIA waiver. Staff M further stated that the new management company had applied for a new CLIA waiver on 10/08/2025 but that the approval had not been completed by the department of health.

Plan/Attestation Statement

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01/24/2026

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

Teresa Yates
Administrator (or Representative)

12/31/2025
Date

Per telephone conversation on 01/02/2026 with acting Administrator, Teresa Yates, the BIC date has been changed to 01/24/2026. ME

Findings included…

Review of the Department of Health's Facility Search website on 11/21/2025, showed that the facility's Medical Test Site Certificate of Waiver License (CLIA) had expired on 09/30/2025.

In an interview on 12/01/2025 at 9:00 AM, Staff G, Health and Wellness Director/Registered Nurse, stated that the facility did blood sugar checks and COVID testing on-site.

In an interview on 12/01/2025 at 9:30 AM, Staff M, Regional Director, stated that a new management company had assumed duties on 10/01/2025. Staff M stated that the old management company had not renewed the facility's CLIA waiver. Staff M further stated that the new management company had applied for a new CLIA waiver on 10/08/2025 but that the approval had not been completed by the department of health.

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