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

02/19/2025

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

RE: Rose Pointe Assisted Living # 2452

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 55029 (Completion Date 02/19/2025) and 52024 (Completion Date 12/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/19/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-3030 Toilet rooms and bathrooms.

(2) The assisted living facility must provide each toilet room and bathroom with:

(d) Plumbing fixtures designed for easy use and cleaning and kept in good repair; and

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;

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for

the move in writing and in a language and manner they understand;

(c) Record the reasons in the resident's record; and

(d) Include in the notice the items described in subsection (5) of this section.

(5) The written notice specified in subsection (3) of this section must include the following:

(a) The reason for transfer or discharge;

(c) The location to which the resident is transferred or discharged;

(d) The name, address, and telephone number of the state long-term care ombudsman;

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

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

The Department staff who did the On Site verification:
Carla Rose, NCI Community Licensor
Jessica Salquist, Regional Administrator

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Regional Administrator
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: 158598
Compliance Determination #: 52024
Region/Unit #: RCS Region 1 / Unit B
Investigator: Carla Rose
Investigation Date(s): 12/20/2024 through 12/27/2024
Complainant Contact Date(s): 12/19/2024, 12/27/2024

Allegation(s):

1. Resident transferred to another room.
2. Food prepped in food truck and served in boxes.
3. Housekeeping not keeping up with garbage removal from rooms.
4. Maintenance not keeping up with building repairs.

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 7 Closed records sample size: 0
Observations:	resident rooms housekeepers common area carpets and conditions of building dining service and dinnerware/utensils being used
Interviews:	executive director residents staff resident representatives
Record Reviews:	Staff lists staff schedules (housekeepers and maintenence) work orders or contracts for pending repairs

Investigation Summary:

1. Residents were transferred to new rooms. The identified resident did not have any concerns regarding the transfer. The room was of adequate size per state regulations. The facility stated the identified resident was transferred due to necessary repairs to the original room. No failed practice identified.

2. Food is prepared in temporary food trucks. The food prepared meets state requirements. The kitchen remodel has begun and the executive director stated the contractors have given them a 90-120 day timeline to be completed. Residents that choose to eat in the dining room are served on appropriate dinnerware with appropriate utensils. Residents that choose to take their food back to their rooms,

are served in disposable take out containers. Sampled residents did not have any concerns with the food service or dinnerware. No failed practice identified.

3. The reporter had concerns of housekeeping not keeping up with daily duties such as garbage removal from resident rooms. Housekeepers were observed doing weekly duties of vacuuming and trash removal from rooms. Housekeepers stated they have a schedule that repeats weekly so each room gets vacuumed and mopped, trash is removed and any other housekeeping requests by residents are fulfilled. Sampled resident rooms did not have accumulated garbage. The named resident and sampled residents did not have any concerns with the weekly services provided by the housekeepers. No failed practice identified.

4. The reporter stated they had concerns of dirty carpets in the building, mold in the facility, and maintenance not keeping up with their duties. The carpets in the facility hallways and individual rooms had large black and gray stains throughout. Sampled residents stated they had requested that the carpet in their room be deep cleaned but the request had not been taken care of yet. The executive director and maintenance staff stated the stains could not be removed and the carpets needed to be replaced. There were spots of black mold on the ceilings in the main hallways and one resident room that had a wet musty smell. Maintenance staff stated the spot on the ceiling needed to be cut out and repaired but they had not had a chance to do the work yet. One of the sampled residents' cold water faucet did not work and the facility was aware. Sampled residents had water temperatures that exceeded 120 degrees that the facility corrected prior to the conclusion of the investigation. Failed practice identified and 2 citations under the following: WAC 388-78A-3090 (1)(a)(b), WAC 388-78A-3030 (2)(d) and 1 consultation under WAC 388-78A-2950 (6).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2452
Intake ID: 158656
Compliance Determination #: 52024
Region/Unit #: RCS Region 1 / Unit B
Investigator: Carla Rose
Investigation Date(s): 12/20/2024 through 12/27/2024
Complainant Contact Date(s): 12/19/2024

Allegation(s):
Residents wrongfully given discharge notices

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 7 Closed records sample size: 0
Observations:	named residents sampled residents
Interviews:	named residents sampled residents staff administrator
Record Reviews:	eviction notices progress notes investigations behavior plans notices provided to residents

Investigation Summary:
1. The facility gave discharge notices to identified residents without completing necessary steps to avoid discharge. The discharge notice did not contain the reason for transfer, the location to which the residents will be transferred or contact information for the ombuds. Did not make any attempts to prevent or avoid the discharge for either resident. The facility did not have any other documentation to support the discharge of the residents. Failed practice identified under 388-78A-2660 (1)(4); RCW 70.129.110 (3)(a)(b)(c)(d)(5)(a)(c)(d).

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

Statement of Deficiencies	License #: 2452	Compliance Determination #52024
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 1 of 7	Licensee: RP Operations, LLC	12/27/2024

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 12/20/2024 and 12/27/2024 of:

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

This document references the following complaint number(s): 158598, 158656

The following sample was selected for review during the unannounced on-site visit: 7 of 85 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Carla Rose, NCI Community Licensor

Received by RCS 1/21/2025

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.

J Salguist
Residential Care Services

12/30/2024
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.

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 an unannounced on-site complaint investigation on 12/20/2024 and 12/27/2024 of:

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

This document references the following complaint number(s): 158598, 158656

The following sample was selected for review during the unannounced on-site visit: 7 of 85 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Carla Rose, NCI Community Licensor

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

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.

Statement of Deficiencies	License #: 2452	Compliance Determination # 52024
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 2 of 7	Licensee: RP Operations, LLC	12/27/2024

Administrator (or Representative) — Date: 1-2-25

WAC 388-78A-3030 Toilet rooms and bathrooms.

(2) The assisted living facility must provide each toilet room and bathroom with:

(d) Plumbing fixtures designed for easy use and cleaning and kept in good repair; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to repair the cold-water faucet in the residents' bathroom sink for 1 of 2 Residents (Resident 3) sampled for having operational water faucets. This failure prevented Resident 3 from having the ability to access cold water to adjust the water temperature in their bathroom sink.

Findings included...

In an interview on 12/20/2024 at 11:35 AM, Resident 3 stated that the cold water in their bathroom sink did not work, and they only had hot water to wash their hands. Resident 3 stated that they made verbal requests "every week for months" for maintenance to repair the faucet, but the repairs were not done.

Observation on 12/20/2024 at 11:35 AM, showed the faucet for the cold water in Resident 3's (Room [redacted]) bathroom sink did not work.

In an interview on 12/27/2024 at 10:00 AM, Staff B, Maintenance Director, stated that they were aware of the broken faucet in Resident 3's bathroom but they had not scheduled repairs prior to the investigation by the department.

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) 1-5-25

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

Administrator (or Representative) Date

WAC 388-78A-3030 Toilet rooms and bathrooms.

(2) The assisted living facility must provide each toilet room and bathroom with:

(d) Plumbing fixtures designed for easy use and cleaning and kept in good repair; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to repair the cold-water faucet in the residents' bathroom sink for 1 of 2 Residents (Resident 3) sampled for having operational water faucets. This failure prevented Resident 3 from having the ability to access cold water to adjust the water temperature in their bathroom sink.

Findings included…

In an interview on 12/20/2024 at 11:35 AM, Resident 3 stated that the cold water in their bathroom sink did not work, and they only had hot water to wash their hands. Resident 3 stated that they made verbal requests "every week for months" for maintenance to repair the faucet, but the repairs were not done.

Observation on 12/20/2024 at 11:35 AM, showed the faucet for the cold water in Resident 3's (Room [redacted]) bathroom sink did not work.

In an interview on 12/27/2024 at 10:00 AM, Staff B, Maintenance Director, stated that they were aware of the broken faucet in Resident 3's bathroom but they had not scheduled repairs prior to the investigation by the department.

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.

Statement of Deficiencies	License #: 2452	Compliance Determination # 52024
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 3 of 7	Licensee: RP Operations, LLC	12/27/2024

Administrator (or Representative) — Date: 1-10-25

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;

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure carpets were clean for 2 of 3 facility hallways (Hallway 1 and 2) and carpet cleaning for 3 of 7 sampled residents (Resident 2, 3, and 5). The facility also failed to assess and repair areas with mold for 2 of 3 hallways (Hallway 2 and Memory care) and 1 of 7 sampled residents (Resident 7). This failure caused resident dissatisfaction and placed residents at risk of harm due to unsanitary living conditions.

Findings included...

< carpets>

Observation on 12/20/2024, during a facility walk through and resident interviews, showed the following areas had large black and grey stains on the carpets.

- Hallway 1 (rooms 1 -24), throughout the hallway.
- Hallway 2 (rooms 25- 42), throughout the hallway.
- Resident 2's room (Room [redacted]) inside the doorway of their room.
- Resident 3's room (Room [redacted]) throughout the living area of their room.
- Resident 5's room (Room [redacted]) outside of the bathroom door within their room.
- Resident 8's room (Room [redacted]) throughout the entryway within their room.

In an interview on 12/20/2024 at 10:30 AM, Staff B, Maintenance Director, stated carpet stains in the hallways were large and difficult to remove. Staff B then stated they do not regularly clean the carpets in resident rooms unless requested by the resident. Staff B further stated that the carpets in the hallways and resident rooms needed to be replaced but there were no scheduled plans to do so.

In an interview on 12/20/2024 at 11:35 AM, Resident 3 stated that they made multiple requests over the "last six months" for the carpet in their room (Room [redacted]) to be

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;

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure carpets were clean for 2 of 3 facility hallways (Hallway 1 and 2) and carpet cleaning for 3 of 7 sampled residents (Resident 2, 3, and 5). The facility also failed to assess and repair areas with mold for 2 of 3 hallways (Hallway 2 and Memory care) and 1 of 7 sampled residents (Resident 7). This failure caused resident dissatisfaction and placed residents at risk of harm due to unsanitary living conditions.

Findings included…

< carpets>

Observation on 12/20/2024, during a facility walk through and resident interviews, showed the following areas had large black and grey stains on the carpets:

- Hallway 1 (rooms 1 -24), throughout the hallway.
- Hallway 2 (rooms 25- 42), throughout the hallway.
- Resident 2's room (Room [redacted]) inside the doorway of their room.
- Resident 3's room (Room [redacted]) throughout the living area of their room.
- Resident 5's room (Room [redacted]) outside of the bathroom door within their room.
- Resident 8's room (Room [redacted]) throughout the entryway within their room.

In an interview on 12/20/2024 at 10:30 AM, Staff B, Maintenance Director, stated carpet stains in the hallways were large and difficult to remove. Staff B then stated they do not regularly clean the carpets in resident rooms unless requested by the resident. Staff B further stated that the carpets in the hallways and resident rooms needed to be replaced but there were no scheduled plans to do so.

In an interview on 12/20/2024 at 11:35 AM, Resident 3 stated that they made multiple requests over the "last six months" for the carpet in their room (Room [redacted]) to be

cleaned.

In an interview on 12/20/2024 at 12:45 PM, Resident 5 stated the last time the carpets in their room (Room [redacted]) had been cleaned, they were left with a sticky residue. Resident 5 stated that when residents requested maintenance work or carpets to be cleaned “it could be days to months” before the request is completed.

In an interview on 12/20/2024 at 1:35 PM, Staff A, Executive Director, stated that they were aware of significant stains in the carpets, but the facility had been unsuccessful in removing them with their carpet cleaner. Staff A further stated that the carpets needed to be replaced with laminate flooring, but they did not have any scheduled timeline.

In an interview on 12/27/2024 at 10:00 AM, Staff B stated that some maintenance requests are written on a workorder request clipboard, and some are given as verbal requests. Staff B then stated that sometimes verbal requests are not documented and that they just try to remember them. Staff B further stated that they do not document when work orders are completed.

<mold>

Observation on 12/20/2024 during a facility walk through showed the following:

- Large brown discolored area on the ceiling around an access panel just outside of room 33 (hall 2), with an area inside the discoloration that had black mold.
- Bubbling and peeling paint on the ceiling around an access panel just outside of room 56 (memory care hall), black mold was visible under the paint that had peeled off.
- Large brown discolored area on the ceiling outside room 56 near a fire sprinkler head had spots of black mold forming within the discolored area.
- Resident 7's room (Room [redacted]) had a strong, wet, musty odor coming from within the room.
- Room [redacted] had black and brown stains along the entire bottom of the bathroom vanity.

In an interview on 12/20/2024 at 10:30 AM, Staff B stated that the access panels in the ceiling outside of room 33 gave access to water pipes. Staff B further stated that they previously had a leak in that area and the black mold needed to be cut out and repaired but they had not had time to do so.

In an interview on 12/20/2024 at 12:15 PM, Staff C, Medication Technician, stated they had been concerned about the strong musty odor coming from Resident 7’s room. Staff C stated that they notified Staff A and B about the odor two months ago, but nothing had been done.

Statement of Deficiencies	License #: 2452	Compliance Determination # 52024
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 5 of 7	Licensee: RP Operations, LLC	12/27/2024

In an interview on 12/20/2024 at 1:35, Staff A stated that the odor in Resident 7's room could be related to the clogged plumbing they had in that room this past summer.

In an interview on 12/27/2024 at 10:00 AM, Staff B stated that they were aware of the musty odor in room [redacted] and believed it was due to moisture in the carpet. Staff B said the carpet in room 48 needed to be replaced.

This is a reoccurring deficiency previously cited on 06/18/2024 for subsection (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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) ~~1-13-25~~ 2-10-25

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

Administrator (or Representative) — Date: ~~1-13-25~~ 1-3-25

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

(c) Record the reasons in the resident's record; and

(d) Include in the notice the items described in subsection (5) of this section.

(5) The written notice specified in subsection (3) of this section must include the following:

(a) The reason for transfer or discharge;

(c) The location to which the resident is transferred or discharged;

(d) The name, address, and telephone number of the state long-term care ombudsman;

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

In an interview on 12/20/2024 at 1:35, Staff A stated that the odor in Resident 7's room could be related to the clogged plumbing they had in that room this past summer.

In an interview on 12/27/2024 at 10:00 AM, Staff B stated that they were aware of the musty odor in room [redacted] and believed it was due to moisture in the carpet. Staff B said the carpet in room 48 needed to be replaced.

This is a reoccurring deficiency previously cited on 06/18/2024 for subsection (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, 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

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

(c) Record the reasons in the resident's record; and

(d) Include in the notice the items described in subsection (5) of this section.

(5) The written notice specified in subsection (3) of this section must include the following:

(a) The reason for transfer or discharge;

(c) The location to which the resident is transferred or discharged;

(d) The name, address, and telephone number of the state long-term care ombudsman;

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 interview and record review, the facility failed to follow proper steps prior to issuing a discharge notice to 2 of 2 sampled residents (Resident 1 and 2). This failure contributed to undue stress and a diminished sense of dignity for Residents 1 and 2.

Findings included…

Review of statements written by staff in October 2024, showed that they reported a strong burnt plastic type of odor that came from the area that Resident 2 was in. Staff reported feeling ill due to the odor and went to the hospital for evaluation.

Review of a discharge notice dated [redacted]/2024, showed that Resident 1 was given 30 days' notice to move out of the facility. Further review showed the notice did not contain information that explained why they were discharged, where they would go, or how to contact the ombuds.

Review of a discharge notice dated [redacted]/2024, showed that Resident 2 was given 30 days' notice to move out of the facility. Further review showed the notice did not contain information that explained why they were discharged, where they would go, or how to contact the ombuds.

In an interview on 12/19/2024 at 12:40 PM, Resident 1 stated they were given a 30-day discharge notice on [redacted]/2024. Resident 1 stated there were false allegations of drug use. Resident 1 said the facility never had a formal discussion regarding their concerns and had not offered any opportunity to avoid the discharge. Resident 1 further stated they were unaware of the facility's intent to discharge prior to the day they received the notice of discharge. Resident 1 was crying during the interview and stated that this situation had caused them a significant amount of stress and they felt that staff had wrongfully judged them.

In an interview on 12/20/2024 at 11:15 AM, Resident 2 stated they were given a 30-day discharge notice on [redacted]/2024. Resident 2 stated that they were accused of drug use on the facility grounds in October, but the allegations were false. Resident 2 said the facility had not discussed their intentions or offered any opportunity to avoid the discharge. Resident 2 said they were unaware of the facility's intent to discharge prior to the day they received notice of discharge. Resident 2 stated that they were wrongfully accused, and it bothered them.

In an interview on 12/20/2024 at 12:15 PM, Staff C, Medication Technician, stated that they were unaware that any discharge notices had been given to any residents. Staff C stated that if there were suspected drug use of a particular resident, then that resident would be placed on a health alert for staff to monitor for changes in behavior. Staff C

stated they did not have any residents with health alerts to monitor for drug use and they did not have concerns of drug use with Residents 1 or 2.

In an interview on 12/20/2024 at 1:35 PM, Staff A, Executive Director, stated they had concerns of drug use due to an incident in October 2024 when a strong burnt plastic odor was present around Resident 2, staff became ill and were sent to the emergency room (ER) for evaluation. Staff A stated they confronted Resident 2, who denied the allegations. Staff A then stated that Resident 1 was not around Resident 2 at the time of the incident in October but since they were in a relationship together, they likely participated in the same activities. When asked if health alert monitoring was placed on Resident 1 or 2 , Staff A stated if they were, it would be in progress notes. Staff A was asked if they had any formal discussions with Residents 1 or 2 regarding the concerns or made attempts otherwise to avoid the discharge, Staff A stated they had not done so.

Review of Resident 1's facility file as of 12/27/2024 showed it did not contain any documentation to show there were allegations or concerns of drug use. Further review showed no documentation to indicate that the facility had intervened or made any attempts to avoid the discharge.

Review of Resident 2's facility file as of 12/27/2024 showed it contained one documented incident of suspected drug use in October 2024 but no additional documentation afterwards. Further review showed no documentation to indicate that the facility had discussed their concerns, and no interventions were implemented to avoid the discharge.

This is a reoccurring deficiency previously cited on 06/18/2024 for subsection (1).

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) 1-3-25.

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

JL

Administrator (or Representative)

1-2-25

Date

stated they did not have any residents with health alerts to monitor for drug use and they did not have concerns of drug use with Residents 1 or 2.

In an interview on 12/20/2024 at 1:35 PM, Staff A, Executive Director, stated they had concerns of drug use due to an incident in October 2024 when a strong burnt plastic odor was present around Resident 2, staff became ill and were sent to the emergency room (ER) for evaluation. Staff A stated they confronted Resident 2, who denied the allegations. Staff A then stated that Resident 1 was not around Resident 2 at the time of the incident in October but since they were in a relationship together, they likely participated in the same activities. When asked if health alert monitoring was placed on Resident 1 or 2 , Staff A stated if they were, it would be in progress notes. Staff A was asked if they had any formal discussions with Residents 1 or 2 regarding the concerns or made attempts otherwise to avoid the discharge, Staff A stated they had not done so.

Review of Resident 1's facility file as of 12/27/2024 showed it did not contain any documentation to show there were allegations or concerns of drug use. Further review showed no documentation to indicate that the facility had intervened or made any attempts to avoid the discharge.

Review of Resident 2's facility file as of 12/27/2024 showed it contained one documented incident of suspected drug use in October 2024 but no additional documentation afterwards. Further review showed no documentation to indicate that the facility had discussed their concerns, and no interventions were implemented to avoid the discharge.

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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

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

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

RE: Rose Pointe Assisted Living # 2452

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 12/27/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

Jessica Salquist, Field Manager
Residential Care Services

Region 1, Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

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

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

(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

The water temperatures in two resident rooms were not within the required temperature limits of 105 to 120 degrees. The facility corrected the water temperatures prior to the conclusion of the investigation.

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

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

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:
• Please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

Enclosure

Sincerely,

Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

Enclosure