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

04/01/2025

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) 57272 (Completion Date 04/01/2025) and 54301 (Completion Date 02/13/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/01/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

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

License/Cert.#: 2452
Intake ID: 165973
Compliance Determination #: 54301
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 02/05/2025 through 02/13/2025
Complainant Contact Date(s): 02/12/2025, 02/13/2025

Allegation(s):

1. Resident who requires assistance with obtaining mediations not receiving medications as ordered.
2. Call lights not working.

Investigation Methods:

Sample:	Total residents: 88 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Kitchen
Interviews:	Executive Director Wellness Director Alleged Victim Former Staff Reporter Resident
Record Reviews:	*Disclosure of Services *Characteristic roster *Staff roster *Resident face sheets *Resident care plans *Medication administration records *Progress notes *Weekly menus *Medication Services Policy *Nursing Services Policy *Service receipt

Investigation Summary:

1. Review of the Alleged Victim's care plan showed that they required assistance with obtaining their medications. Review of the Alleged Victim's medication administration records showed that the resident's medications were unavailable at times. Failed facility practice identified and cited under WAC 388-78A-2240 Nonavailability of medications.
2. Interview with facility management showed there had been no recent complaints related to call light malfunction. The call light system was observed to be operational. The facility had a secondary means to alert staff of resident call lights in the event of a malfunction with the portable units carried by staff. No call light concerns were voiced during resident and resident representative interviews. Facility management was observed available to address resident concerns. No failed facility practice.

Conclusion / Action:

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

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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 02/05/2025 of:

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

This document references the following complaint number(s): 163569, 163748, 165973

The following sample was selected for review during the unannounced on-site visit: 3 of 88 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

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

Rose point

Statement of Deficiencies	License #: 2452	Compliance Determination # 54301
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 2 of 4	Licensee: RP Operations, LLC	02/13/2025

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 Salquist
Residential Care Services

02/18/2025
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)

2-19-25
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain medications in a timely manner for a resident who required assistance with reordering medications for 1 of 1 resident (Resident 1). This failed practice resulted in unstable moods, sleeplessness, anxiety, pain, and decreased quality of life for Resident 1. Additionally, this failed practice placed residents at increased risk for unmanaged symptoms, health complications, and decreased quality of life.

Findings included...

Review of a negotiated service agreement intervention for Resident 1, last revised on 07/17/2024, showed that the resident required assistance with reordering their medications.

Review of a medication administration record (MAR) for Resident 1, dated November of 2024, showed that the resident's fluticasone (a medication used to decrease airway inflammation in the lungs) was unavailable for 26 out of 38 scheduled doses.

Review of a MAR for Resident 1, dated December of 2024, showed that the resident's lidocaine patch (a medication used to treat pain) was unavailable on 12/19/2024 and 12/20/2024. The MAR showed that the resident's prednisone (a medication used to treat conditions associated with inflammation) was unavailable on 12/04/2024. The MAR

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Residential Care Services | Date

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Administrator (or Representative) | Date

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Review of a MAR for Resident 1, dated December of 2024, showed that the resident's lidocaine patch (a medication used to treat pain) was unavailable on 12/19/2024 and 12/20/2024. The MAR showed that the resident's prednisone (a medication used to treat conditions associated with inflammation) was unavailable on 12/04/2024. The MAR

showed that Resident 1's fluticasone was unavailable for five out of seven scheduled doses between 12/01/2024 and 12/04/2024. Further review of the MAR showed that the Resident 1's lamotrigine (a medication used to stabilize mood) was unavailable for 10 scheduled doses between 12/03/2024 and 12/10/2024.

Review of a MAR for Resident 1, dated January of 2025, showed that the resident's brexpiprazole (a medication used to treat depression) was unavailable on 01/01/2025 and 01/21/2025. Review of the MAR showed that Resident 1 took their as needed hydrocodone (a medication used to treat pain) two to three times daily except for on 01/12/2025, when they took the medication only once. On 01/13/2025, the medication was documented as unavailable.

In an interview on 02/05/2025 at 2:30 PM, Staff A, Wellness Director, stated there had been delays with obtaining medication refills timely, and that it was a multifaceted issue. Staff A stated that Resident 1 was without their pain medication for two days in January of 2025.

In an interview on 02/05/2025 at 2:22 PM, Resident 1 stated that they went without their mood stabilizer for two weeks because it was not reordered. Resident 1 stated they had a lot of problems during the time they were out of their mood stabilizer. Resident 1 stated their mood was "all over the place" and they felt angry. Resident 1 stated they had to start the medication all over again but at a lower dose.

In an interview on 02/12/2025 at 10:47 AM, Collateral Contact 1 (CC1), Behavioral Health Staff, stated that Resident 1 had gone without their medications at least three times in the last three months. CC1 stated that Resident 1 had difficulty sleeping and had withdrawals as a result of going without their mood stabilizer. CC1 stated that Resident 1 went without their pain medication from January 12, 2025, to January 13, 2025. CC1 stated that Resident 1 ran out of their antidepressants in January of 2025. CC1 stated that Resident 1 was already struggling with mental health issues and then they became constantly anxious about whether or not they would receive their medications. CC1 stated that Resident 1 was frustrated.

In an interview on 02/13/2025 at 9:59 AM, Resident 1 stated that the facility was responsible for reordering their medications, though Resident 1 felt like they had to babysit the process to make sure they did not run out of medications. Resident 1 stated they went 36 hours without their pain medication in January of 2025, and that their pain was very high at that time and they could not sleep.

This is a recurring citation previously cited on 06/18/2024.

Statement of Deficiencies	License #: 2452	Compliance Determination # 54301
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 4 of 4	Licensee: RP Operations, LLC	02/13/2025

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3-18-25.

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

Administrator (or Representative) — Date: 2-19-25

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