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 License # 2452

Dear Administrator:

This letter addresses Compliance Determination(s) 58363 (Completion Date 04/23/2025) and 55591 (Completion Date 03/05/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/23/2025 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-2300-1-c-ii, WAC 388-78A-2300-1-c-iv, WAC 388-78A-2300-1-c-v, WAC 388-78A-2300-1-f, WAC 388-78A-2300-1-g, WAC 388-78A-2140-7, WAC 388-78A-2630-1-a

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

If you have any questions, please contact me at (509)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: 165886
Compliance Determination #: 55591
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 02/28/2025 through 03/05/2025
Complainant Contact Date(s): 02/28/2025, 03/05/2025

Allegation(s):
Resident note being fed properly.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Executive Director Residents Reporter Resident Representative
Record Reviews:	*Disclosure of Services *Characteristic roster *Staff roster *Resident face sheets *Resident care plans *Progress notes *Facility fee scale *Resident billing statements *Weekly menus *Menu Change Policy *Resident care assessment

Investigation Summary:
Interviews and record reviews showed that the facility failed to ensure their weekly menus were dated appropriately, that the menus were maintained for six months, that residents were served a variety of foods, that menu substitutions had equal

nutrient value, and that alternative choices were provided. Failed practice identified and cited under WAC 388-78A-2300 Food and nutrition services (1)(c)(ii)(iv)(v)(f)(g).

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: 167717
Compliance Determination #: 55591
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 02/28/2025 through 03/05/2025
Complainant Contact Date(s): 02/28/2025, 03/10/2025

Allegation(s):
Resident with memory deficits sent to appointment alone with inadequate clothing.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 5 Closed records sample size: 0
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Executive Director Reporter Alleged Victim Alleged Victim's Representative Residents
Record Reviews:	*Disclosure of Services *Characteristic roster *Staff roster *Resident face sheets *Resident care plans *Progress notes *Facility fee scale *Resident billing statements *Weekly menus *Menu Change Policy *Resident care assessment

Investigation Summary:

Review of the Alleged Victim's care plan showed that it failed to identify whether or not the resident was able to safely leave the facility unsupervised. The Alleged Victim's Representative was interviewed, and they stated that the resident needed supervision when leaving the facility due to memory deficits. Review of the department's reporting database showed no facility reports for the abandonment of the Alleged Victim. Failed practice identified and cited under WAC 388-78A-2140 Negotiated service agreement contents (7) and WAC 388-78A-2630 Reporting abuse and neglect (1)(a).

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 an unannounced on-site complaint investigation on 02/28/2025 of:

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

This document references the following complaint number(s): 165886, 167556, 167717

The following sample was selected for review during the unannounced on-site visit: 5 of 93 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

Statement of Deficiencies	License #: 2452	Compliance Determination #55591
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 2 of 7	Licensee: RP Operations, LLC	03/05/2026

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

03/17/2025
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)

3.18.25
Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(ii) Indicate the date, day of week, month and year;

(iv) Are kept at least six months;

(v) Provide a variety of foods; and

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that their weekly menus were dated appropriately, that the menus were maintained for six months, that residents were served a variety of foods, that menu substitutions had equal nutrient value, and that alternative choices were provided for 3 of 3 residents (Resident 2, Resident 3, and Resident 4). This failed practice placed residents at risk for inadequate nutrition and decreased quality of life.

Findings included...

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

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(ii) Indicate the date, day of week, month and year;

(iv) Are kept at least six months;

(v) Provide a variety of foods; and

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that their weekly menus were dated appropriately, that the menus were maintained for six months, that residents were served a variety of foods, that menu substitutions had equal nutrient value, and that alternative choices were provided for 3 of 3 residents (Resident 2, Resident 3, and Resident 4). This failed practice placed residents at risk for inadequate nutrition and decreased quality of life.

Findings included…

Review of the facility's weekly menus, dated for January, showed there was no documentation to show which year the menus were for. Review of the weekly menus showed there was no menu for the week of January the 12th. Review of the weekly menus showed there was no record of the alternative choices that were served. Review of the weekly menus showed that on 01/26, the breakfast, lunch, and dinner menu options were scribbled out but there was no documentation to show what was served instead. Review of the weekly menus showed that on 01/27 and 01/28, there was no propane, so the residents were served cereal, applesauce, yogurt, fruit and granola for breakfast both days. The menu showed that pizza and a brownie was served for lunch on 01/27, and ham and a cookie was served for lunch on 01/28.

Review of the facility's weekly menus, dated for February, showed there was no documentation to show which year the menus were for. Review of the weekly menus showed there was no record of the alternative choices that were served. Review of the weekly menus showed that on 02/14, the kitchen was frozen so cereal was served for breakfast and pizza was served for lunch. Review of the weekly menus showed that on 2/17, cereal was served for breakfast and pizza was served for lunch.

In an interview on 02/28/2025 at 8:01 AM, Staff B, Medication Technician, stated there was no back-up plan when the portable kitchen trailer went out. Staff B stated there was a two week period when the residents had cereal for every breakfast, pizza for every lunch, and sandwiches for every dinner.

In an interview on 02/28/2025 at 9:06 AM, Staff A, Executive Director, reported that about two to three weeks prior, the facility went through a whole week of frozen pipes in the mobile kitchen so they served cold cereal and pizza as they had no heat or power in the mobile kitchen. Staff A stated they were sure the residents were sick of pizza and cereal.

In an interview on 03/05/2025 at 10:09 AM, Resident 2 stated there were several times over the last two months in which a peanut butter and jelly sandwich and the salad bar were the only options for lunch. Resident 2 stated they were served a lot of pizza and cold cereal in the last two months. Resident 2 stated they did not feel they were getting adequate nutrition.

In an email communication sent on 03/05/2025 at 10:58 AM, Staff A stated they did not have the facility menu for the week of January 12, 2025.

In an interview on 03/05/2025 at 3:20 PM, Staff B stated that the facility's menus were not updated with what was actually served for part of January of 2025 because the kitchen director walked off the job and quit. Staff B stated that residents complained to them daily about the food when they were being served cereal, pizza, and sandwiches daily in January. Staff B stated that the only time the facility offers an alternative besides peanut butter and jelly is when they are serving fish. Staff B stated that two memory care residents, Resident 3 and Resident 4, were put on "no meat" diets about a

week and a half ago. Staff B stated that meat is typically served with every lunch and with most dinners so the residents were just given peanut butter and jelly sandwiches instead.

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) 4-10-25.

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

Administrator (or Representative) — Date: 3-18-25

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(7) The resident's ability to leave the assisted living facility premises unsupervised; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to identify, in the resident's negotiated service agreement, the residents' ability to leave the assisted living facility premises unsupervised for 1 of 1 resident (Resident 1). This failed practice placed residents who required supervision when leaving the facility at risk for harm and increased confusion.

Findings included...

Review of an undated negotiated service agreement for Resident 1, showed that the resident had moderate dementia (a group of conditions characterized by impairment of memory and judgement) with significant short-term memory loss and possible long-term memory loss.

In an interview on 02/28/2025 at 8:08 AM, Collateral Contact 1 (CC1), Spokane Cardiology Staff, stated that on 02/17/2025, the office staff where CC1 worked had to watch Resident 1 for nearly an hour because Resident 1's facility sent them to their medical appointment alone and had not arranged a return ride for the resident. CC1

week and a half ago. Staff B stated that meat is typically served with every lunch and with most dinners so the residents were just given peanut butter and jelly sandwiches instead.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(7) The resident's ability to leave the assisted living facility premises unsupervised; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to identify, in the resident's negotiated service agreement, the residents' ability to leave the assisted living facility premises unsupervised for 1 of 1 resident (Resident 1). This failed practice placed residents who required supervision when leaving the facility at risk for harm and increased confusion.

Findings included…

Review of an undated negotiated service agreement for Resident 1, showed that the resident had moderate dementia (a group of conditions characterized by impairment of memory and judgement) with significant short-term memory loss and possible long-term memory loss.

In an interview on 02/28/2025 at 8:08 AM, Collateral Contact 1 (CC1), Spokane Cardiology Staff, stated that on 02/17/2025, the office staff where CC1 worked had to watch Resident 1 for nearly an hour because Resident 1's facility sent them to their medical appointment alone and had not arranged a return ride for the resident. CC1

stated that Resident 1 could not even remember that they already had their appointment when CC1 went to find the resident in the clinic. CC1 stated that it was very apparent that Resident 1 had memory impairments.

In an interview on 02/28/2024 at 9:06 AM, Staff A, Executive Director, stated that sending Resident 1 to their doctor's appointment alone had been a big mistake on the facility's part. Staff A stated they had a new resident care coordinator who had not realized that Resident 1 needed an escort when leaving the facility.

In an interview on 03/04/2025 at 11:15 AM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1 was placed in the facility's memory care after the resident's hospital and rehabilitation stay in [redacted] of 2024 and [redacted] of 2025. CC2 stated that Resident 1 called them on the day of the resident's medical appointment and asked CC2 why they were there. CC2 stated that someone from the facility called CC2 apologizing and stating they had not realized Resident 1 had gone to their appointment alone. CC2 stated that it had been determined while Resident 1 was in memory care that the resident should not leave the facility alone. CC2 stated that Resident 1 had global amnesia (a neurological disorder that causes a sudden, temporary inability to form new memories and recall recent and past events) in addition to dementia, and that their memory issues had gotten much worse since their hospital and rehabilitation stay.

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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) 4-10-25.

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

Administrator (or Representative) — Date: 3-18-25

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

stated that Resident 1 could not even remember that they already had their appointment when CC1 went to find the resident in the clinic. CC1 stated that it was very apparent that Resident 1 had memory impairments.

In an interview on 02/28/2024 at 9:06 AM, Staff A, Executive Director, stated that sending Resident 1 to their doctor's appointment alone had been a big mistake on the facility's part. Staff A stated they had a new resident care coordinator who had not realized that Resident 1 needed an escort when leaving the facility.

In an interview on 03/04/2025 at 11:15 AM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1 was placed in the facility's memory care after the resident's hospital and rehabilitation stay in [redacted] of 2024 and [redacted] of 2025. CC2 stated that Resident 1 called them on the day of the resident's medical appointment and asked CC2 why they were there. CC2 stated that someone from the facility called CC2 apologizing and stating they had not realized Resident 1 had gone to their appointment alone. CC2 stated that it had been determined while Resident 1 was in memory care that the resident should not leave the facility alone. CC2 stated that Resident 1 had global amnesia (a neurological disorder that causes a sudden, temporary inability to form new memories and recall recent and past events) in addition to dementia, and that their memory issues had gotten much worse since their hospital and rehabilitation stay.

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Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report potential neglect to the department's Complaint Resolution Unit hotline for 1 of 1 resident (Resident 1). This failed practice inhibited the department's ability to investigate the concern promptly and placed Resident 1 with cognitive impairment, who was transported to an appointment unattended with no return ride scheduled at risk.

Findings included…

Review of an undated negotiated service agreement for Resident 1 showed that the resident had moderate dementia (a group of conditions characterized by impairment of memory and judgement) with significant short-term memory loss and possible long-term memory loss.

In an interview on 02/28/2025 at 8:08 AM, Collateral Contact 1 (CC1), Spokane Cardiology Staff, stated that on 02/17/2025, the office staff where CC1 worked had to watch Resident 1 for nearly an hour because Resident 1's facility sent them to their medical appointment unattended and had not arranged a return ride for the resident. CC1 stated that Resident 1 could not even remember that they already had their appointment when CC1 went to find the resident in the clinic. CC1 stated that it was very apparent that Resident 1 had memory impairments.

In an interview on 02/28/2024 at 9:06 AM, Staff A, Executive Director, stated that sending Resident 1 to their doctor's appointment alone had been a big mistake on the facility's part. Staff A stated they had a new resident care coordinator who had not realized that Resident 1 needed an escort when leaving the facility.

In an interview on 03/04/2025 at 11:15 AM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1 was placed in the facility's memory care after the resident's hospital and rehabilitation stay in [redacted] of 2024 and [redacted] of 2025. CC2 stated that Resident 1 called them on the day of the resident's medical appointment and asked CC2 why they were at their appointment. CC2 stated that someone from the facility called CC2 apologizing and stating they had not realized Resident 1 had gone to their appointment alone. CC2 stated that it had been determined while Resident 1 was in memory care that the resident should not leave the facility alone. CC2 stated that Resident 1 had global amnesia (a neurological disorder that causes a sudden, temporary inability to form new memories and recall recent and past events) in addition to dementia, and that their memory issues had gotten much worse since their hospital and rehabilitation stay.

Review of the department's complaint intakes for February of 2025 showed that no facility reports were made for Resident 1 regarding the incident.

Statement of Deficiencies	License #: 2452	Compliance Determination #55591
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 7 of 7	Licensee: RP Operations, LLC	03/05/2025

Plan/Attestation Statement

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[signature]	3-18-25
Administrator (or Representative)	Date

Plan/Attestation Statement

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Administrator (or Representative) Date