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

08/20/2025

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) 64174 (Completion Date 08/20/2025) and 60490 (Completion Date 06/17/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/20/2025 and found no deficiencies.

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

WAC 388-78A-2920 Area for nursing supplies and equipment.

(1) In each building, the assisted living facility must provide for the safe and sanitary storage and handling of nursing equipment and supplies appropriate to the needs of their residents, as well as for the soiled nursing equipment by providing:

(a) A "clean" utility area for the purposes of storing and preparing nursing supplies, or durable and disposable medical equipment equipped with:

(i) A work counter or table; 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;

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

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

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: 181444
Compliance Determination #: 60490
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 06/03/2025 through 06/17/2025
Complainant Contact Date(s): 06/03/2025, 06/17/2025

Allegation(s):

1. Only one care staff working in the facility.
2. Inadequate housekeeping and maintenance.
3. Fire sprinklers are rusted out.
4. Black mold.
5. Resident being fed only cereal and peanut butter sandwiches.
6. Medical supplies being stored next to toilet.
7. Residents unclean, unshaven, and incontinent.
8. Inadequate coordination of wound care.

Investigation Methods:

Sample:
Total residents: 89
Resident sample size: 4
Closed records sample size: 1

Observations:
Residents
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Alleged Victim's Representative/Reporter
Executive Director
Residents
Resident Representative
Maintenance Director
Resident Care Coordinator

Record Reviews:
-Disclosure of Services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plans
-Abuse and Neglect Policy
-Shower documentation
-Staff schedule

-Housekeeping Policy
-Remediation records
-Weekly menus
-Progress notes
-Provider visit notes
-Medication administration records
-Automatic sprinkler system inspection report
-Facility map

Investigation Summary:

1. Interview with the Alleged Victim's Representative showed that their staffing concerns started after the resident left the facility. Residents were interviewed, and they stated staff responded timely when assistance was needed. The residents denied having unmet care needs. Interviews with facility management showed there was never a time when only one staff was working. Review of the as-worked staff schedule showed that the facility routinely staffed multiple care staff at the same time. Staff were observed available to assist with resident care. No failed facility practice.
2. Observations and interviews showed that facility hallways, common areas, and a resident apartment were not maintained and kept clean and in good repair. Failed practice identified and cited under WAC 388-78A-3090 Maintenance and housekeeping (1)(a)(c). This is a recurring citation previously cited on 06/18/2024 for subsections (1)(a)(c) and on 12/27/2024 for subsections (1)(a).
3. Interview with facility management showed that the facility's fire system was inspected quarterly. Record review verified that an automatic sprinkler system inspection was completed on 03/13/2025, and no deficiencies were noted. No rust was observed on the facility's fire sprinklers during the facility tour. No failed facility practice.
4. Interview with the Alleged Victim's Representative showed that they had not personally seen mold in the facility. Interview with facility management showed that black mold was found in one facility room approximately one year ago. Record review showed that contractors were hired at that time and the affected building materials were removed. No signs of mold were observed during the facility tour. Resident interviewed voiced no concerns about mold in the facility. No failed facility practice.
5. The Alleged Victim's Representative was interviewed. They reported they saw residents eating foods other than peanut butter sandwiches and cereal. Interview with facility management showed that while peanut butter sandwiches and cereal were always available, there was never a time when those were the only food options. Residents interviewed denied concerns about the facility food. Review of weekly menus showed that the facility routinely provided alternative food options for each meal. Facility management was observed available to address food related concerns. No failed facility practice.
6. Observations and interviews showed that the facility did not store nursing supplies and equipment in a safe and sanitary manner. Failed practice was identified and cited under WAC 388-78A-2920 Area for nursing supplies and equipment (1)(a)(i). This is a recurring citation previously cited on 06/18/2024 for subsections (1)(a).
7. Interview with the Alleged Victim's Representative showed that their concerns about personal care were related to other facility residents. Residents and resident representatives were interviewed, and no concerns were voiced about inadequate incontinence care or haircare. Residents were observed, and no signs of distress or unmet needs were identified. Staff were observed available to assist with resident care needs. No failed facility practice.
8. Interview and record review showed that the facility failed to take appropriate

action when it was identified that the Alleged Victim had wound healing complications. Failed practice was identified and cited under WAC 388-78A-2120 Monitoring residents' well-being (4).

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 06/10/2025 and 06/03/2025 of:

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

This document references the following complaint number(s): 181511, 181444, 181338

The following sample was selected for review during the unannounced on-site visit: 4 of 89 current residents and 1 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 # 503490
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 2 of 8	Licensee: RP Operations, LLC	06/17/2025

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.

Residential Care Services — 06/24/2025 (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.

Administrator (or Representative) — 6.25.25 (Date)

WAC 388-78A-2920 Area for nursing supplies and equipment.

(1) In each building, the assisted living facility must provide for the safe and sanitary storage and handling of nursing equipment and supplies appropriate to the needs of their residents, as well as for the soiled nursing equipment by providing:

(a) A "clean" utility area for the purposes of storing and preparing nursing supplies, or durable and disposable medical equipment equipped with:
(i) A work counter or table; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide sufficient sanitary storage space for nursing supplies and equipment, with work surfaces for preparation of supplies, in 3 of 5 facility locations (Room [redacted], the bathroom on the south end of the memory care dining room, and the staff bathroom in the nurses' office on Hall 1). This failed practice placed residents at increased risk for illness and health complications related to exposure to unsanitary resident care supplies and equipment.

Findings included...

In an interview on 06/03/2025 at 9:37 AM, Collateral Contact 1 stated that when they used the staff bathroom, they saw sterile items stacked in the shower next to the toilet.

In an interview on 06/03/2025 at 11:48 AM, Staff A, Executive Director, stated that the facility did store medical supplies in the bathroom. Staff A stated they had to because of a lack of storage space.

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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Findings included…

In an interview on 06/03/2025 at 9:37 AM, Collateral Contact 1 stated that when they used the staff bathroom, they saw sterile items stacked in the shower next to the toilet.

In an interview on 06/03/2025 at 11:48 AM, Staff A, Executive Director, stated that the facility did store medical supplies in the bathroom. Staff A stated they had to because of a lack of storage space.

Observation on 06/03/2025 at 12:18 PM showed that mattresses, walkers, and wheelchairs were being stored in Room [redacted]. The sheetrock had been removed from the walls and the surfaces of the room itself were uncleanable.

Observation on 06/03/2025 at 1:23 PM showed that nursing supplies including wipes, gloves, and briefs were being stored in the bathroom on the south side of the memory care dining room. There was no table or counter observed in the bathroom.

Observation on 06/03/2025 at 1:33 PM showed that the shower next to the toilet in the staff bathroom (inside the nurses' office on hall 1) contained adult washcloths and plastic carts full of personal protective equipment and urine specimen cups. There was no table or counter observed in the bathroom.

This is a recurring citation previously cited on 06/28/2024 for subsections (1)(a).

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) 8.1.25.

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

Administrator (or Representative) — Date: 6.25.25

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(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 that general maintenance was completed, water stains were addressed, and carpets were clean for 2 of 3 facility halls, (Hall 1 and Hall 2), and carpets were clean for 1 of 5 sampled residents (Resident 2). The facility failed to ensure that light fixtures were maintained for 1 of 2 facility halls (Hall 2). The facility failed to ensure that general maintenance

Observation on 06/03/2025 at 12:18 PM showed that mattresses, walkers, and wheelchairs were being stored in Room [redacted]. The sheetrock had been removed from the walls and the surfaces of the room itself were uncleanable.

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Plan/Attestation Statement

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and cleaning tasks were completed for 2 of 2 resident common areas (the dining room and the television room) and 2 of 5 sampled resident rooms (Resident 1 and Resident 2). This failed practice resulted in resident dissatisfaction and placed residents at risk for injury, harm due to unsanitary living conditions, and a decreased quality of life.

Findings included…

Observation on 06/03/2025 at 12:21 PM showed an electrical outlet with no cover on the east wall of the television room.

Observation on 06/03/2025 at 12:23 PM showed water damage to the ceiling in front of Room [redacted]. The stain was one foot in diameter.

Observation on 06/03/2025 at 12:25 PM showed a cracked and separated door jam on an unmarked room on the east side of Hall 1.

Observation on 06/03/2025 at 12:27 PM showed the carpet in Room [redacted]'s hallway appeared dirty with multiple brownish stains of varying sizes.

Observation on 06/03/2025 at 12:28 PM showed there was a dark brown substance surrounding the base of the toilet in Room [redacted].

Observation on 06/03/2025 at 12:29 PM showed that the slats of a ceiling vent in Room [redacted] were covered in dust. A portion of the wall had paint scraped off of it. The linoleum floor appeared dirty. The door jam had many dings and dents where the paint and wood were chipped off.

Observation on 06/03/2025 at 12:29 PM showed an area of water damage on the ceiling above an unmarked door on the west side of Hall 1. The area of water damage was greater than a foot in diameter.

Observation on 06/03/2025 at 12:31 PM showed two brown stains on the carpet in the Hall 1. The stains were one half to one foot in diameter. The stains were surrounded by multiple other stains of varying sizes.

Observation on 06/03/2025 at 12:36 PM showed that the carpet outside Room [redacted] was almost entirely covered with brown stains of varying sizes.

Observation on 06/03/2025 at 12:39 PM showed that the chair rail along the north side of the dining room had chipped and peeling paint. Peeling wallpaper was also observed.

Observation on 06/03/2025 at 12:41 PM showed a thick layer of dust on the cabinet shelves on the east side of the dining room.

Observation on 06/03/2025 at 12:42 PM showed that the light fixture on the ceiling outside of the laundry room adjacent to the dining room had one out of four light bulbs missing. Only one of the three remaining light bulbs worked. There was no cover over the light bulbs.

Observation on 06/03/2025 at 12:43 PM showed that the light fixture on the ceiling outside the memory care door had three out of four light bulbs missing. There was no cover over the light bulbs. The area was dimly lit.

Observation on 06/03/2025 at 12:43 PM showed there was insulation exposed where the washer lines entered the wall in the laundry room on Hall 2.

Observation on 06/03/2025 at 12:46 PM showed that the carpet in the hallway on Hall 2 had multiple brown stains of varying sizes.

Observation on 06/03/2024 at 12:47 PM showed that a light fixture on the ceiling of Hall 2 had three out of four light bulbs missing. There was no cover over the light bulbs.

Observation on 06/03/2025 at 12:49 PM showed two small boxes on the east wall of Hall 2. There were exposed wires sticking out of the boxes.

In an interview on 06/03/2025 at 12:52 PM, Resident 1 stated they wrote down a task on the maintenance list though it was never done and the list disappeared. Resident 1 stated the task they wrote down was for cleaning the filter on their heater/air conditioner. Resident 1 stated it had not been done in six months.

In an interview on 06/10/2025 at 12:58 PM, Staff B, Maintenance Director, stated that someone stole their carpet cleaner so the carpet was really bad. Staff B stated that some of the stains would never come out. Staff B stated that the filters in the heater/air conditioning units in the residents' rooms needed to be taken out and rinsed every three to four months. Staff B stated that most of the water stains on the ceilings were the result of leaks that had already been repaired.

This is a recurring citation previously cited on 06/18/2024 for subsection (1)(a)(c) and 12/27/2025 for subsection (1)(a).

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: 6.25.25

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to take appropriate action following the identification of wound healing complications for 1 of 1 resident (Resident 2). This failed practice resulted in emotional distress and wound deterioration for the resident.

Findings included...

Review of Resident 2's April 2025 Medication Administration Record (MAR) showed that Resident 2 was started on linezolid (a medication used to treat infection) on 03/29/2025. The MAR showed that Resident 2 was started on ciprofloxacin (a medication used to treat infection) on 04/01/2025.

Review of a medical provider visit note, dated 04/01/2025, showed that Resident 2 was being seen every three weeks by their podiatrist (a doctor specializing in feet) for the resident's left foot diabetic ulcer (open sore). The note showed that Resident 2 was put in a soft cast due to wound progression. The note showed that Resident 2 was doing their own wound care between podiatry visits, indicating that no home health services were arranged.

Review of a progress note for Resident 2, dated 05/07/2025 at 12:48 PM, showed the resident returned from an appointment for their [redacted] wound that day and notified staff that they (the resident) had to have their [redacted]

Plan/Attestation Statement

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Administrator (or Representative) Date

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Review of a progress note for Resident 2, dated 05/07/2025 at 12:46 PM, showed the resident returned from an appointment for their [redacted] wound that day and notified staff that they (the resident) had to have their [redacted].

Review of a progress note for Resident 2, dated 05/10/2025 at 3:33 PM, showed the resident was depressed about the idea of [redacted] their [redacted]

Review of a progress note for Resident 2, dated 05/12/2025 at 12:56 PM, showed the resident was tearful while discussing the [redacted] of their [redacted]

Review of a progress note for Resident 2, dated 05/16/2025 at 4:41 AM, showed the resident was hoping for a miracle turnaround so they continued to do the nightly treatments on their own foot.

Review of a progress note for Resident 2, dated 05/18/2025 at 2:27 AM, showed the resident was worried about the planned [redacted] of [redacted]

Review of a progress note for Resident 2, dated 05/30/2025 at 12:50 PM, showed the resident appeared tearful and anxious leading up to their surgery.

In an interview on 06/03/2025 at 9:37 AM, Collateral Contact 1 (CC1) stated that Resident 2 got a blister about a year ago, the wound got progressively worse, and the bone became infected. CC1 stated they were not sure who was providing Resident 2's wound care. CC1 stated that Resident 1 was on antibiotics (medications used to treat infection) for over a year. CC1 stated that Resident 2's [redacted] was [redacted] on [redacted]/2025. CC1 stated that Resident 2 had previous [redacted] of their [redacted] on [redacted], indicating they were already at increased risk for wound healing complications leading to [redacted]

In an interview on 06/03/2025 at 11:48 AM, Staff A, Executive Director, stated that the facility did not provide wound care, and they believed Resident 2's wound care was provided three times weekly by home health.

In an interview on 06/10/2025 at 10:47 AM, CC1 stated that if Resident 2 was left to do their own wound care, they probably would have neglected to do it at times. CC1 stated they had concerns that no one seemed to be checking on Resident 2's wound. CC1 stated that the bone in Resident 2's [redacted] was exposed before going to the hospital for the [redacted]

In an interview on 06/10/2025 at 12:41 PM, Staff C, Resident Care Coordinator, stated they were aware Resident 2's wound had reopened, though the resident no longer had home health. Staff C stated that no one was doing Resident 2's wound care unless the resident was doing it themselves, indicating that no home health services were arranged to assist Resident 2 with dressing changes for their infected wound with exposed bone.

Statement of Deficiencies	License #: 2452	Compliance Determination # 80490
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 8 of 8	Licensee: RP Operations, LLC	06/17/2025

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) 8-1-25.

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

Administrator (or Representative) — Date: 6.25.25

Plan/Attestation Statement

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Administrator (or Representative) Date