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

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

RE: Rose Pointe Assisted Living License # 2452

Dear Administrator:

This letter addresses Compliance Determination(s) 76019 (Completion Date 04/16/2026) and 72136 (Completion Date 02/18/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/16/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-b

The Department staff who did the on-site verification:
Abigail Vanderkolk, Community Complaint 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: 209540
Compliance Determination #: 72136
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sandra Fast
Investigation Date(s): 01/29/2026 through 02/18/2026
Complainant Contact Date(s): 01/29/2026

Allegation(s):

1. A resident's medications were reportedly marked refused and the resident did not believe they refused the medications.
2. The medication technicians treated the identified resident poorly and did not give them their medications on time.
3. A medication technician told a resident to take their medications after they were dropped on the floor.

Investigation Methods:

Sample:	Total residents: 86 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Family members Identified staff Identified resident
Record Reviews:	Medical records Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:

1. The identified resident's records reviewed showed that the resident had a history that predisposed them to increased lethargy (feeling weak and tired). Their records

further showed that the Medication Technicians (MT)s did not have a pattern of marking medication refusals. The identified resident interviewed stated they were really tired several times. The identified resident observed was calm, had heavy eyelids and struggled to keep them open. The resident showed no signs of distress. All sampled residents interviewed stated no concerns regarding their medication services. The sampled residents observed were calm and showed no distress. The identified MT interviewed stated the correct procedure for when a resident refused their medications. The identified staff observed followed safe medication administration procedures. All sampled MTs stated the correct procedure for when a resident refused their medications. The sampled MTs observed followed safe medication administration procedures. All sampled MTs observed were rounding on residents and gently assisting them to take their medications. No failed facility practice was identified.

2. The identified resident's records reviewed showed that their medications were given as ordered. The health and wellness director interviewed stated that some of the identified residents medications had order parameters that had to be met before they were given. The identified resident interviewed stated no concerns about their treatment by medication technicians. The identified resident observed showed no signs of distress. A MT was observed kindly interacting with the identified resident in a respectful manner. All medication technicians observed were rounding on residents and gently assisting them with their needs. No failed facility practice was identified.

3. The identified resident's records reviewed showed that the resident was allowed to take contaminated medications after they had been dropped on the floor. Failed facility practice was identified according to Washington administrative code 388-78a-2210(1)(b). This deficiency was previously cited on 12/12/2024, and 12/24/2025.

Conclusion / Action:

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

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8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2452	Compliance Determination # 72136
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 1 of 3	Licensee: RP Operations, LLC	02/18/2026

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 01/29/2026 of:

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

This document references the following complaint number(s): 209792, 209212, 209540, 209327

The following sample was selected for review during the unannounced on-site visit: 6 of 86 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community Complaint Investigator

From:
DSHS, Home and Community Living 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 # 72136
Plan of Correction	Rose Pointe Assisted Living	Completion Date
Page 2 of 3	Licensee: RP Operations, LLC	02/18/2026

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.

Residential Care Services — 02/24/2026 (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) — 2/24/2026 (Date)

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure safe medication services for 1 out of 6 residents (Resident 1). This failure resulted in Resident 1 ingesting medications that may have been contaminated and placed the resident at risk of health complications.

Findings included...

Review of the facility's policy titled, "Medication Services," with an effective date of July 2018, showed that any spilled, contaminated or dropped medication would be destroyed and a new dose of uncontaminated medication would be obtained.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 10/29, showed that the resident needed staff's assistance with self-administration of all their medications.

Review of Resident 1's progress note, dated 01/19/2026 at 7:03 PM showed, showed a few of the resident's medications were dropped on the floor. Further review of the resident's progress note showed that the resident was allowed to take the contaminated medications that had been on the floor.

In an interview on 02/18/2026 at 11:31 AM, Staff A, Executive Director, stated that Resident 1 had taken medications after they had been dropped on the floor. Staff A further stated that the resident decided to take the contaminated medication.

In an interview on 01/22/2026 at 1:43 PM, Resident 1 stated that Staff B, Medication Technician, brought them their medications and that the medications were dropped on the floor. The resident stated that the medication technician, "scooped up," the dropped medications and told the resident to take them. The resident stated that they took the contaminated medications.

This is a recurring deficiency previously cited on 12/10/2025.

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) 02/03/2026.

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

Ken Yates — Administrator (or Representative)

2/24/26 — Date