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

New Day Senior Living Management LLC
Aspen Quality Care
9626 N Colfax Rd
Spokane, WA 99218

RE: Aspen Quality Care # 2636

Dear Administrator:

This document references Compliance Determination 59515 (05/16/2025), which included complaint number(s) 176938.

The Department completed a complaint investigation of your Assisted Living Facility on 05/16/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Anne Sinclair, NCI Community Complaint Investigator

Consultation:

RCW 70.129.020 Exercise of rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident and assist the resident which include:

(4) In the case of a resident who has not been adjudged incompetent by a court of competent jurisdiction, a representative may exercise the resident's rights to the extent provided by law.

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

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

The facility had limited a resident's visitor per the resident's Power of Attorney (POA) request. The facility had educated staff to resident rights regarding visitation and notified the POA and named residents, of visitation access as it applies to resident rights, while investigator was onsite.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the facility to determine if you have corrected all deficiencies.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

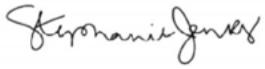
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur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

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

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: Aspen Quality Care
Provider Type: Assisted Living Facility
License/Cert.#: 2636
Compliance Determination #: 59515
Intake ID: 176938
Investigator: Anne Sinclair
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 05/13/2025 through 05/16/2025
Complainant Contact Date(s): 04/30/2025, 05/15/2025, 05/16/2025, 05/20/2025

Allegation(s):
Resident rights allegation.

Investigation Methods:

Sample:
Total residents: 17
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Residents
Facility assistant manager
Facility manager
MedTech
Family
Resident representatives

Record Reviews:
Named resident care plan/face sheet/progress notes
Sample resident care plan/face sheet/progress notes
Disclosure of Services
Abuse/neglect reporting policy
Characteristic roster
Staff roster

Investigation Summary:
Facility had been informed by named resident's Powers of Attorney (POA) to limit visitor access to the resident. The facility limited the visitor named by the POA, from visiting the named resident. Facility was educated on resident rights related to access to and limitations of visitors and guests to facility, and was educated on POA scope related to resident rights. Facility had educated all staff present immediately to resident rights related to visitor access. Consultation provided for WAC 388-78A-2660 Resident Rights. RCW 70.129.020(4) Exercise of rights.

Conclusion / Action:

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