STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

RC Aquinde Management LLC
LIVING LIFE CARE HOME ON WILLOW LANE
2136 Willow Ln W
Tacoma, WA 98466

RE: LIVING LIFE CARE HOME ON WILLOW LANE License # 750161

Dear Provider:

This letter addresses Compliance Determination(s) 80065 (Completion Date 07/08/2026) and 78188 (Completion Date 06/01/2026).

The Department completed a follow-up inspection of your Adult Family Home on 07/08/2026 and found that you have corrected the violations listed in the Full report dated 06/01/2026. Your home is back in compliance as of 06/18/2026 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10430-2-d

The Department staff who did the on-site verification:
Lindsay Trent, Adult Family Home Licensor

If you have any questions, please contact me at (253)208-3090.

Sincerely,

Rathana Duong, AFH Field Manager
Region 3, Unit A
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for the unannounced on-site full inspection on 05/29/2026 of:

LIVING LIFE CARE HOME ON WILLOW LANE
2136 Willow Ln W
Tacoma, WA 98466

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Lindsay Trent, Adult Family Home Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit A
PO Box 99250
Lakewood, WA 98496

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 750161	Compliance Determination # 78188
Plan of Correction	LIVING LIFE CARE HOME ON WILLOW LANE	Completion Date
Page 2 of 8	Licensee: RC Aquinde Management LLC	06/01/2026

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

06/11/2026
Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative)

6/18/2026
Date

WAC 388-76-10430 Medication system.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the Adult Family Home (AFH) failed to ensure there were systems in place to ensure residents received medications as needed and medication logs were kept current for 2 of 2 residents (Resident 1 and Resident 3). This failure resulted in inaccurate medication logs and residents not receiving medications as ordered.

Findings included...

Resident 1

Review of Resident 1's Assessment dated 05/15/2026 showed the resident had a diagnosis of [redacted] and required staff's assistance with medication management including medication setup, medication scheduling, medication administration and monitoring.

Review of Resident 1's Medication Administration Records (MAR) and Vital Statistics Logs for 05/01/2026 through 05/28/2026 showed the following:

- Resident 1 was ordered Metoprolol Succinate (for high blood pressure) 50mg at

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bedtime, hold for Systolic Blood Pressure (the top number in a blood pressure reading) less than 110 or Heart Rate (HR) less than 60.

- On 05/08/2026, 05/09/2026, 05/12/2026, 05/16/2026, 05/19/2026, 05/23/2026, 05/25/2026, 05/26/2026 and 05/27/2026, staff documented Resident 1's blood pressure (BP) medication was held at 8:00PM. There was no documentation showing Resident 1's BP and HR had been checked to determine if the medication was needed.

- On 05/23/2026 staff documented Resident 1's BP medication was administered at 8:00PM. There was no documentation showing Resident 1's BP or HR had been checked at 8:00PM prior to administering the medication.

Additionally, the following discrepancies were identified:

- 05/01/2026 staff documented Resident 1's BP medication was held at 8:00PM. At 10:38PM, staff documented the resident's BP was 108/57 and HR was 85. There was no documentation showing the resident's BP and HR had been checked at 8:00PM to determine if the medication was needed.

- 05/03/2026 staff documented Resident 1's BP medication was held at 8:00PM. At 9:14PM, staff documented the resident's BP was 97/57 and HR was 74. There was no documentation showing the resident's BP and HR had been checked at 8:00PM to determine if the medication was needed.

- 05/04/2026 staff documented Resident 1's BP medication was held at 8:00PM. At 10:08PM, staff documented the resident's BP was 109/65 and HR was 80. There was no documentation showing the resident's BP and HR had been checked at 8:00PM to determine if the medication was needed.

- 05/05/2026 staff documented Resident 1's BP medication was held at 8:00PM. At 10:01PM staff documented the resident's BP was 102/59 and HR was 91. There was no documentation showing the resident's BP and HR had been checked at 8:00PM to determine if the medication was needed

- 05/06/2026 at 2:22PM, staff documented Resident 1's BP was 120/63 and HR was 53. Staff documented the resident's BP medication was administered at 8:00PM which was outside of the medication parameters. There was no documentation showing the resident's BP and HR were rechecked prior to administering the medication.

- 05/07/2026 staff documented Resident 1's BP medication was administered at 8:00PM. At 10:00PM, staff documented the resident's BP was 113/65 and HR was 84. There was no documentation showing the resident's BP and HR had been checked at 8:00PM prior to administering the medication.

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- 05/10/2026 staff documented Resident 1's BP medication was administered at 8:00PM. At 10:13PM staff documented the resident's BP was 113/57 and HR was 89. There was no documentation showing the resident's BP and HR had been checked at 8:00PM prior to administering the medication.

- 05/11/2026 at 11:27AM, staff documented Resident 1's BP was 108/53 and HR was 71. Staff documented the resident's BP medication was held at 8:00PM. There was no documentation showing the resident's BP and HR were rechecked at 8:00PM to determine if the medication was needed.

- 05/13/2026 at 12:23PM, staff documented Resident 1's BP was 108/50 and HR was 82. Staff documented that resident's BP medication was administered at 8:00PM which was outside of the medication parameters. There was no documentation showing the resident's BP and HR were rechecked at 8:00PM prior to administering the medication.

- 05/14/2026 staff documented Resident 1's BP medication was administered at 8:00PM. At 10:53PM, staff documented Resident 1's BP was 108/65 and HR was 77 which was outside of the medication parameters. There was no documentation showing the resident's BP and HR had been checked at 8:00PM prior to administering the medication.

- 05/15/2026 staff documented Resident 1's BP medication was held at 8:00PM. At 10:42PM, staff documented the resident's BP was 98/62, HR was 79. There was no documentation showing the resident's BP and HR had been checked at 8:00PM to determine if the medication was needed

- 05/17/2026 staff documented Resident 1's BP medication adminstered at 8:00PM. At 9:29PM staff documented the resident's BP 148/98, HR was 88. There was no documentation showing the resident's BP and HR had been checked at 8:00PM prior to administering the medication

- 05/18/2026 at 10:57AM, staff documented Resident 1's BP was 114/59 and HR was 71. Staff documented the resident's BP medication was held at 8:00PM. There was no documentation showing the resident's BP and HR had been rechecked at 8:00PM to determine if the medication was needed.

- 05/20/2026 at 10:55AM, staff documented Resident 1's BP was 112/57 and HR was 79. Staff documented the resident's BP was held at 8:00PM. There was no documentation showing the resident's BP and HR had been rechecked at 8:00PM to determine if the medication was needed.

- 05/22/20266 staff documented Resident 1's BP medication was held at 8:00PM. At 9:

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45PM, staff documented the resident's BP was 97/51, HR was 78. There was no documentation showing the resident's BP and HR had been checked at 8:00pm to determine if the medication was needed.

- 05/28/2026 at 10:07PM, staff documented the resident's BP was 115/57, HR was 88 and the medication was administered at 8:00PM.

Observations on 05/29/2026 at 1:00PM showed all of Resident 1's medications were available for administration.

Resident 3

Review of Resident 3's Assessment dated 02/24/2026 showed the resident had a diagnosis of [redacted] and required staff to monitor blood pressure and provide assistance with managing medications.

Review of Resident 3's Medication Administration Records (MAR)and Vital Statistics Logs for 05/01/2026 through 05/28/2026 showed the following:

- Resident 3 was ordered Amlodipine (for high blood pressure) 2.5mg daily, hold for Systolic Blood Pressure (the top number in a blood pressure reading) less than 110.

- On 05/06/2026 and 05/19/2026 staff documented Resident 3's BP medication was administered at 8:00PM. There was no documentation showing Resident 3's blood pressure (BP) was checked prior to administering the medication.

Additionally, the following discrepancies were identified:

- 05/02/2026 at 8:26AM, staff documented Resident 3's BP was 104/59 and the medication was administered at 8:00PM which was outside of the medication parameters. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

- 05/03/2026 staff documented Resident 3's BP medication was administered at 8:00PM. At 9:16PM staff documented the resident's BP was 120/81. There was no documentation showing the resident's BP had been checked at 8:00PM prior to administering the medication.

- 05/04/2026 staff documented Resident 3's BP medication was administered at 8:00PM. At 10:07PM staff documented the resident's BP was 113/69. There was no documentation showing the resident's BP had been checked at 8:00PM prior to

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administering the medication.

- 05/07/2026 staff documented Resident 3's BP medication was administered at 8:00PM. At 9:59PM staff documented the resident's BP was 113/69. There was no documentation showing the resident's BP had been checked at 8:00PM prior to administering the medication.

- 05/09/2026 at 11:00AM, staff documented Resident 3's BP was 110/73 and medication was administered at 8:00PM. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

- On 05/10/2026 staff documented Resident 3's BP medication was administered at 8:00PM. At 10:12PM staff documented the resident's BP was 132/84. There was no documentation showing the resident's BP had been checked at 8:00PM prior to administering the medication

- 05/12/2026 staff documented Resident 3's BP medication was administered at 8:00PM. At 8:58PM staff documented the resident's BP was 115/70. There was no documentation showing the resident's BP had been checked at 8:00PM prior to administering the medication

- 05/13/2026 at 9:26AM, staff documented Resident 3's BP was 110/75 and the medication was administered at 8:00PM. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

- 05/15/2026 at 8:56AM, staff documented Resident 3's BP was 113/75 and the medication was administered at 8:00PM. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

- 05/16/2026 at 11:37AM, staff documented Resident 3's BP was 103/72 and the medication was administered at 8:00PM which was outside of the medication parameters. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

- 05/20/2026 at 8:14AM, staff documented Resident 3's BP was 107/72 and the medication was administered at 8:00PM which was outside of the medication parameters. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

- 05/22/2026 at 4:28PM staff documented Resident 3's BP was 126/83 and the medication was administered at 8:00PM. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

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- 05/23/2026 at 10:41AM, staff documented Resident 1's BP was 101/69 and the medication was administered at 8:00PM which was outside of the medication parameters. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication.

- 05/24/2026 staff documented Resident 3's BP medication was administered at 8:00PM. At 9:41PM staff documented the resident's BP was 120/70. There was no documentation showing the resident's BP had been checked at 8:00PM prior to administering the medication

- 05/26/2026 at 8:40AM, staff documented Resident 3's BP was 112/78 and the medication was administered at 8:00PM. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering medication.

- 05/27/2026 at 9:16AM, staff documented Resident 3's BP was 112/77 and the medication was administered at 8:00PM. There was no documentation showing the resident's BP had been rechecked at 8:00PM prior to administering the medication

- 05/28/2026 at 9:17AM, staff documented Resident 3's BP was 107/75 and the medication was held at 8:00PM. There was no documentation showing the resident's BP had been rechecked at 8:00PM to determine if the resident needed the medication.

Observations on 05/29/2026 at 1:20PM showed all of Resident 3's medications were available for administration.

During an interview on 05/29/2026 at 2:10PM, the Provider stated that the AFH was transitioning from handwritten Vital Logs to electronic records and the staff usually documented both the electronic record and the handwritten logs, but they were not able to locate the handwritten logs. The Provider stated that the staff may have been checking the vital signs prior to administering the medications but not documenting the vital signs in the electronic records until after the medications had been administered. The Provider immediately instructed the staff to document in both the electronic record and handwritten logs to ensure the medications were administered and documented according to the medication orders.

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Statement of Deficiencies	License #: 750161	Compliance Determination # 78188
Plan of Correction	LIVING LIFE CARE HOME ON WILLOW LANE	Completion Date
Page 8 of 8	Licensee: RC Aquinde Management LLC	06/01/2026

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, LIVING LIFE CARE HOME ON WILLOW LANE is or will be in compliance with this law and / or regulation on (Date) 6/18/2026

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

C Gfgruiti — Provider (or Representative)

6/18/2026 — Date

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

RC Aquinde Management LLC
LIVING LIFE CARE HOME ON WILLOW LANE
2136 Willow Ln W
Tacoma, WA 98466

RE: LIVING LIFE CARE HOME ON WILLOW LANE # 750161

Dear Provider:

The Department completed a full inspection of your Adult Family Home on 06/01/2026 and found that your home does not meet the Adult Family Home Licensing requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect the home to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

Rathana Duong, AFH Field Manager
Residential Care Services
Region 3, Unit A
Preferred methods:

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eFax: (253) 589-7240
Email: rcsregion3email@dshs.wa.gov
Optional method:
PO Box 99250
Lakewood, WA 98496

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (06/01/2026), no later than 07/16/2026 or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-76-10415 Food services. The adult family home must:

(1) Ensure that the safe food handling training requirements of chapter 388-112A WAC are met; and

Review of the Provider's training records showed that their WA Food Worker Certification Card expired on 10/06/2025. The Provider sent documentation to the Department showing new WA Food Worker Certification Card was obtained on 05/29/2026 to correct the deficiency prior to completion of the inspection.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
• Ask questions and provide written information to help clarify or dispute the deficiencies.

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

If You Have Any Questions:

• Please contact me at (253)208-3090.

Sincerely,

Rathana Duong, AFH Field Manager
Region 3, Unit A
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Enclosure

Plan
(Plan of Correction)

You Must:
Return the plan, on the enclosed report, within 10 calendar days after you receive this letter.

Include the following in your plan for each deficiency:
• The date you have or will correct each deficiency; and
• Provide a signature and date certifying that you have or will take corrective measures to correct each cited deficiency.

Send your plan to:
Rathana Duong, AFH Field Manager
Residential Care Services
Region 3, Unit A
Preferred methods:
eFax: (253) 589-7240
Email: rcsregion3email@dshs.wa.gov
Optional method:
PO Box 99250
Lakewood, WA 98496

INFORMAL DISPUTE RESOLUTION [RCW 70.128]

You May:
Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an **'IDR Request Form'** for **each** citation or enforcement you plan to dispute. You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

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Provider Process for Choosing a Panel or Traditional IDR:

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a **Panel IDR**, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDRs** the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

This document was prepared by Residential Care Services for the Locator website.

Send your supporting documents to:

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

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