STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

POPA ENTERPRISES LLC
LEISURE SENIOR CARE CENTER
412 166TH AVE NE
BELLEVUE, WA 98008

RE: LEISURE SENIOR CARE CENTER License # 751334

Dear Provider:

This letter addresses Compliance Determination(s) 81055 (Completion Date 07/24/2026) and 78162 (Completion Date 06/02/2026).

The Department completed a follow-up inspection of your Adult Family Home on 07/24/2026 and found that you have corrected the violations listed in the Full report dated 06/02/2026. Your home is back in compliance as of 07/14/2026 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 388-76-10430-1, WAC 388-76-10430-2-c

The Department staff who did the on-site verification:
Linda Dunn, Nursing Consultant Institutional

If you have any questions, please contact me at (253)234-6007.

Sincerely,

Lydia Owusu-Acheampong, Community Field Manager
Region 2, Unit G
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
20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 05/28/2026 of:
LEISURE SENIOR CARE CENTER
412 166TH AVE NE
BELLEVUE, WA 98008

The following sample was selected for review during the unannounced on-site visit: 1 of 7 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Linda Dunn, Nursing Consultant Institutional

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit G
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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

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

6-9-2026
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.

Rebecca Popa
Provider (or Representative)

6/16/2026
Date

WAC 388-76-10430 Medication system.

(1) If the adult family home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications.

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

(c) Medication log is kept current as required in WAC 388-76-10475 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure their medication system met all laws and rules for medication administration when they pre-poured medications for 4 of 4 residents (Residents 1, 2, 3, and 4). They also failed to keep the medication log updated for 1 of 1 Residents (Resident 4). These failures placed Residents 1, 2, 3, and 4 at risk of not receiving medication as prescribed and at risk for medication errors.

Findings included...

Record review of the Department's "Nurse Delegation for Nursing Assistants and Home Care Aides" training course (https://www.dshs.wa.gov/sites/default/files/publications/documents/22-1736.pdf) dated November 2023, showed under the heading The Five Rights of Medication Administration/2 Right Medication that staff delegated to administer medications were to make sure to give medications only from labeled containers. Further review showed instructions to not remove medications from the medication packaging or prepare medications ahead of time until ready to give the medication.

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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

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Provider (or Representative) | Date

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On 05/28/2026 at 9:29 AM, observation showed seven residents (Residents 1, 2, 3, 4, 5, 6, and 7) lived in and received care at the AFH.

In an interview on 05/28/2026 at 10:56 AM, Staff A, Representative/Resident Manager, stated that they practiced as a licensed nurse and all residents in the AFH received nurse delegation (a state program that allows a Registered Nurse to delegate certain tasks to qualified nursing assistants or home care aides who work in specific settings that would otherwise be performed only by a licensed nurse, such as administration of prescribed medicines). Staff A stated that they were responsible for the nurse delegation of AFH staff to administer medications to residents.

Record review of the AFH Nurse Delegation Records for Residents 1, 2, 3, and 4 dated 04/18/2026, showed Staff A delegated medication administration to Staff C, Caregiver, and Staff D, Caregiver. The delegation records showed Staff A verified Staff C and Staff D had completed the Department's Nurse Delegation training program.

<Pre-poured Medication>
05/28/2026 at 12:10 PM, observation showed Staff D opened a locked door which contained individual storage units for all AFH residents. Staff D then prepared medication dosages for Residents 1, 2, 3, 4, and 6. Observation showed seven plastic 30 cubic centimeter (cc) medication cups on a shelf individually labeled with the first name of one of the seven residents in the AFH. An unlabeled 30cc cup with 5 white pills was observed on the shelf to the right of the labeled cups. Further observation showed Staff D removed multiple "bingo cards" (A bingo card is a tamper-proof method of packaging medications used by pharmacies to organize medications by the time of day the medications are to be given) from medication storage bins labeled with Residents 1, 2, 3, and 4's names. Staff D removed medications from the labeled bingo cards and placed the pills into the corresponding 30cc cup that matched the resident name on the bingo card. Observation showed Staff D removed two pills from Resident 4's bingo card and placed the medications in the clear cup labeled with Resident 4's name. Observation showed Staff D removed two pills from the unmarked clear 30cc cup and placed the pills into the cup labeled with Resident 2's name. Staff D then placed the unmarked 30cc cup that contained three pills back on the shelf to the right of the medication storage containers.

During an interview on 05/28/2026 at 12:14 PM, Department Staff (DS) asked Staff D to identify the two unlabeled pills that Staff D had placed in Resident 2's medication cup. Staff D stated that the pills were "chest congest" [sic] medication and explained, "I know what they are because I took them out [of a bingo card] yesterday."

Observation on 05/28/2026 at 12:45 PM, showed Staff C at the bedside of Resident 4. A bowl of pureed food and a glass of thickened liquid were observed on a bedside table. A clear 30cc cup with Resident 4's first name was also observed on the table. A white pill was observed in the 30cc cup, and a small cut pill was observed on top of the thick liquid in the glass.

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In an interview on 05/28/2026 at 12:47 PM, Staff C stated that the white pill in the plastic cup would be administered to Resident 4 after the resident finished their meal. Staff C stated that the pill on top of the thick liquid would dissolve into the liquid and they would administer the medication via the drink to Resident 4. Staff C stated that Staff D had prepared the medication earlier for Resident 4.

In further interview at 1:30 PM, Staff C stated that they had administered both medications to Resident 4.

On 05/28/2026 at 1:35 PM, observation of the medication storage area shelf showed medications prepared by Staff D at 12:10 PM, remained in cups labeled for Residents' 1, 2 and 3.

<Medication Log>
Record review on 05/28/2026 at 1:33 PM of Resident 4's medication log dated 05/01/2026 to 05/31/2026, showed Resident 4 was prescribed Hyoscyamine SL .125 milligram [(mg) a medication placed under the tongue to dissolve in the mouth) tablet three times a day to be given sublingually for saliva disturbance]. Under the date 05/28/2026 and at the 2:00 PM time slot, the record showed the initials of Staff D, indicating Staff D had administered the medication to Resident 4. Further review of the medication log showed Resident 4 was also prescribed Quetiapine Fumarate 25 mg tablet ½ tablet twice daily, scheduled at 2:00 PM, for restlessness, with orders the medication could be crushed prior to administration. Under the date 05/28/2026 and the 2:00 PM time slot, there were no staff initials.

During an interview on 05/28/2026 at 2:27 PM, Department Staff (DS) reviewed Resident 4's medication log with Staff C and confirmed that Staff C had administered both 2:00 PM medications to Resident 4. Staff C stated that they had forgotten to initial the medication log for the 2:00 PM dose of Quetiapine Fumarate after administering the medication. When DS pointed out that Staff D had initialed the medication log for the 2:00 PM dose of Hyoscyamine, DS observed Staff C place their initials over Staff D's initials on the medication log.

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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, LEISURE SENIOR CARE CENTER is or will be in compliance with this law and / or regulation on (Date) 07/14/2026.

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

Rebecca Popa
Provider (or Representative)

6/16/2026
Date

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

_____ _____

Provider (or Representative) Date

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