STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

1018 AFH LLC
Rivercrest Adult Family Home
13013 SE Rivercrest Dr
Vancouver, WA 98683

RE: Rivercrest Adult Family Home License # 756215

Dear Provider:

This letter addresses Compliance Determination(s) 80895 (Completion Date 07/29/2026) and 76809 (Completion Date 06/03/2026).

The Department completed a follow-up inspection of your Adult Family Home on 07/29/2026 and found that you have corrected the violations listed in the Complaint report dated 06/03/2026. Your home is back in compliance as of 07/18/2026 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 388-76-10330-1, WAC 388-76-10375, WAC 388-76-10375-1, WAC 388-76-10375-2, WAC 388-76-10400-4, WAC 388-76-10400-2, WAC 388-76-10400-3-a, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d, WAC 388-76-10430-1, WAC 388-76-10015, WAC 388-76-10015-1, WAC 388-76-10015-2, WAC 388-76-10015-3, WAC 388-76-10315, WAC 388-76-10315-1, WAC 388-76-10315-1-a, WAC 388-76-10315-1-b, WAC 388-76-10315-1-c, WAC 388-76-10315-1-d, WAC 388-76-10315-1-d-i, WAC 388-76-10315-1-d-ii, WAC 388-76-10315-1-d-iii, WAC 388-76-10315-1-d-iv, WAC 388-76-10315-1-e, WAC 388-76-10315-1-f, WAC 388-76-10315-1-g, WAC 388-76-10315-2, WAC 388-76-10198, WAC 388-76-10198-1, WAC 388-76-10198-2, WAC 388-76-10198-2-a, WAC 388-76-10198-2-b, WAC 388-76-10198-2-c, WAC 388-76-10198-2-d, WAC 388-76-10198-3, WAC 388-76-10198-4, WAC 388-76-10960-11

The Department staff who did the on-site verification:
Priscilla Changa, Nursing Home Complaint Investigator

If you have any questions, please contact me at (360)664-8421.

Sincerely,

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

Jennifer LeMaster

Jennifer LeMaster, Community Nurse Field Manager
Region 3, Unit F
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

800 NE 136th Ave, Suite 200, Vancouver, WA 98684

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 an unannounced on-site complaint investigation on 05/04/2026 and 05/19/2026 of:

Rivercrest Adult Family Home
13013 SE Rivercrest Dr
Vancouver, WA 98683

This document references the following complaint number(s): 219534, 221913

The following sample was selected for review during the unannounced on-site visit: 4 of 4 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Priscilla Changa, Nursing Home Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit F
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

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.

Jennifer LeMaster
Residential Care Services

06/16/2026
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)

6/19/2026
Date

WAC 388-76-10330 Resident assessment. The adult family home must:

(1) Obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home;

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home failed to ensure an assessment was completed prior to admission for 1 of 4 sampled residents (Resident 3 [R3]). This failure placed R3 at risk of unmet care needs.

Findings included...

An unannounced on-site complaint investigation was conducted on 05/04/2026 at 11:00 AM.

Record review of R3's medical record showed R3 was admitted to the home on [redacted]/2025. The medical record did not show an assessment was done prior to admission.

During an interview on 05/04/2026 at 11:30 AM Staff C, Caregiver stated that they were unable to find R3's assessment and would check with the new provider.

During the interview on 05/06/2026 at 3:20 PM, Staff D, New Provider, stated that they would provide R3's assessment.

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Record review of an email received by the Department on 05/08/2026 at 7:40 PM showed Staff D sent an external healthcare record titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report," dated 04/26/2026 as R3's assessment.

Record review of an email sent to the Department on 05/12/2026 at 2:22 PM, showed Staff D indicated that they thought a hospice assessment was the required assessment.

During an interview on 05/19/2026 at 11:20 AM, Staff D stated that they assumed the hospice assessment was good enough for admission to the home.

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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) ~~8/3/2026~~ 7/18/26.

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

Provider (or Representative) — Date: 6/19/2026

WAC 388-76-10375 Negotiated care plan Signatures Required. The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:

(1) Resident; and

(2) Adult family home.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home failed to ensure negotiated care plans were agreed to, signed and dated by the resident/representative and the provider for 5 of 5 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4] and Resident 5 [R5]). This failure placed the residents/representatives at risk for not being involved in their care decisions and the services being provided.

Findings included...

An unannounced on-site complaint investigation was conducted on 05/04/2026 at 11:00

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

AM.

<Resident 1>
Record review of R1's medical record showed R1 was admitted to the home on [redacted]/2026. The record did not include R1's negotiated care plan.

Record review of an email sent to the Department on 05/12/2026 at 2:04 PM showed R1's negotiated care plan, dated 03/03/2026. The record did not show the provider's and the resident's/representative signatures and date.

<Resident 2>
Record review of R2's medical record showed R1 was admitted to the home on [redacted]/2024. The record did not include R2's negotiated care plan.

Record review of an email sent to the Department on 05/13/2026 at 4:17 PM showed R2's negotiated care plan, dated 09/03/2025. The record did not show the provider's and the resident's/representative signatures and date.

<Resident 3>
Record review of R3's medical record showed R3 was admitted to the home on [redacted]/2025.

Record review of R3's negotiated care plan, dated 04/28/2026 did not show the provider's and the resident's/representative signatures and date.

<Resident 4>
Record review of R4's medical record showed R4 was admitted to the home on [redacted]/2022. The record did not include R4's negotiated care plan.

Record review of an email sent to the Department on 05/13/2026 at 4:17 PM showed R4's negotiated care plan, dated 07/01/2024 did not show the provider's and the resident's/representative signatures and date. The record did not show it was reviewed annually.

<Resident 5>
Record review of R5's medical record showed R5 was admitted to the home on [redacted]/2025 and discharged on [redacted]/2026.

Record review of R5's unsigned negotiated care plan, dated 06/09/2025 did not show the provider's and the resident's/representative signatures and date.

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

During an interview on 05/19/2026 at 11:20 AM, Staff D, New Provider, stated that it was their understanding that only the power of attorney (POA) was required to sign the negotiated care plan. Staff D stated that they would have Staff A the provider sign the NCP. Staff D stated that for R1, their POA could not travel, hence unsigned NCP. Staff D stated that they will have the resident sign. Staff D stated that for R2 their POA lived out of state and they will ask POA to sign the NCP. Staff D stated that for R3, they were out of the country and R3's POA as well. Staff D stated they would ask R3's POA to sign. Staff D stated that for R4 they had not met with POA yet, they will ask POA to sign.

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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 8/31/2026. 7/18/26

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

Provider (or Representative) — Date: 6/19/2026

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(3) The care and services in a manner and in an environment that:

(a) Actively supports, maintains or improves each resident's quality of life;

(4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure residents received necessary care and services including nursing delegation services and oversight for 4 of 5 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 5 [R5]). This failure resulted in R1, R2, R3 and R5 receiving medication administration from caregiving staff that had not received the required nursing oversight or training and placed residents at risk for medication errors.

Findings included...

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Review of Washington Administrative Code (WAC) 248-840-930 showed Nurse Delegation is described as the transferring of a selected nursing task to Nursing Assistant Certified, a Home Care Aide, or a Registered Nursing assistant. Tasks that can be delegated include medication administration, application of ointments, and ostomy care. WAC 248-840-930(18) showed the registered nurse delegator ensures safe and effective services are provided. Re-evaluation and documentation occur at least every 90 days.

An unannounced on-site complaint investigation was conducted on 05/04/2026 at 11:00 AM. In an interview on 05/04/2026 at 11:05 AM, Staff C, Caregiver, stated that two of the three staff members were delegated for administration of oral, eye drops, ear drops, eye ointment, inhaler, topical and patch medications and blood sugar checks for two current residents, R2 and Resident 4. Staff C stated that two of the three AFH staff members were delegated for administration for oral, eye drop, topical and patch medications, and catheter flushing for one discharged resident - R5. Staff C stated that one current resident - R1 - had medications that required nurse delegation, to their knowledge no nurse delegator had evaluated the resident since admit on [redacted]/2026.

Record review of R1's medical record showed they were admitted to the home on [redacted]/2026. Record review of R1's assessment, dated 07/05/2025 showed R1 required nurse delegation services for topical medications. Record review of R1's negotiated care plan, dated 03/03/2026 showed the section for nurse delegation tasks was blank. Record review of R1's medical record did not show R1 had been evaluated by a nurse delegator since their admission to the home. Record review of R1's Medication Administration Record (MARs) from February 2026 through May 2026 showed staff administered the topical medications on some days but multiple days contained no staff initials, indicating the medications were not administered. The record showed from 03/01/2026 through 03/31/2026 there were no staff initials for the topical medication.

Record review of R2's nurse delegation paperwork showed R2 was delegated for administration of oral, topical, inhaler, eye drops, and ear drops medications. The record showed nurse delegation services were rescinded on 04/07/2026.

Record review of R4's nurse delegation paperwork showed R4 was delegated for administration of oral, topical, eye drop and eye ointment medications, and blood sugar checks. The record showed nurse delegation services were rescinded on 04/07/2026.

Record review of R5's nurse delegation paperwork showed R5 was delegated for administration of oral, eye drop, topical, and patch medications and catheter flushing. The record showed nursed delegation services were rescinded on 04/07/2026.

During an interview on 04/30/2026 at 2:44 PM, Collateral Contact 1 (CC1), Registered Nurse Delegator stated that they rescinded nurse delegation services at the home on 04/07/2026. CC1 stated that they had been working with the AFH staff and provider for

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a while, but the issues were not resolved. CC1 stated that the caregivers were unable to find orders when requested. CC1 stated that the MARs were not correct and/or updated per orders and staff initials were missing on multiple days. CC1 stated that the weekend staff (Staff D, New Provider) was not delegated due to a pending health care license and another caregiver's health care aide license had expired. CC1 stated that they were made aware the residents were not getting their medications over the weekend and the new provider asked the caregivers to initial on the MARs the days they did not work. CC1 stated that they were concerned for all the residents in the home.

During an interview on 05/04/2026 11:30 AM, Staff C, Caregiver stated that they worked Monday through Friday and they were delegated for R2, R4 and R5. Staff C stated that they were not delegated for R1. Staff C stated that they had been administering the medications to R1 each time they worked. Staff C stated that Staff D, New Provider, was not delegated and did not know how delegated medications were handled over the weekend.

During an interview on 05/06/2026 at 3:20 PM, Staff D stated that they were in charge and oversaw the home's daily operations. Staff D stated that they "visit" the home Fridays, Saturday and Sundays and whenever caregivers needed assistance. Staff D stated that Staff C worked on the weekends "sometimes when asked" and Staff E (caregiver) worked Mondays through Saturday from 7 PM - 8 AM. Staff D stated that they worked over the weekend. Staff D stated that since they were not qualified yet, they asked the caregivers to "fix" all the residents' medications for them for the weekend by putting them in medicine cups for Staff D to pass later in the day. Staff D stated that they were not nurse delegated because their Department of Health (DOH) credential was still pending. Staff D stated that when they covered for the weekend and a resident needed a medication that required nurse delegation, they "face timed" (video called) Staff C or Staff E to walk them through medication administration since they were not delegated to administer medications. Staff D stated that nurse delegation services were rescinded on 04/07/2026 and the AFH did not have a nurse delegator currently. Staff D stated that they did not have new orders that required nurse delegation. Staff D stated that they were not initialing on the MARs when working and administering medications to residents, they asked the other caregivers to initial them since their DOH credential was still pending.

During an interview on 05/18/2026 at 12:19 PM, Collateral Contact 3 (CC3, Registered Nurse Delegator and owner of the delegation company that employs CC1) stated they did not receive a request from the facility for R1 to be evaluated for nurse delegation services.

During an interview on 05/19/2026 at 11:20 AM, Staff D stated that R1 was not evaluated for nursing delegation services since admission to the home.

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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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) ~~6/3/26~~ 7/18/26

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

Provider (or Representative) — Date 6/19/26

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 ;

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home failed to ensure a system was in place to meet medication needs of residents and keep accurate medication administration records for 5 of 5 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], and Resident 5 [R5]). This failure resulted in all residents having inaccurate medication logs and receiving medication adminsitration from staff who had not received nurse delegation training, and placed all residents at risk for harm.

Findings included...

An unannounced on-site complaint investigation was conducted on 05/04/2026 at 11:00 AM.

<Resident 1>
Record review of R1's medical record showed R1 was admitted to the home on [redacted]/2026. The record showed R1 had multiple diagnoses including [redacted]

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[redacted] and [redacted].

Record review of R1's assessment, dated 07/05/2025, documented R1 required assistance with medication and nurse delegation services.

Record review of R1's unsigned negotiated care plan, dated 03/03/2026 documented R1 required assistance with medication administration. The record instructed staff to assist with medication administration daily, document in the Medication Administration Record (MAR), follow doctor's orders and nurse delegator instructions.

Record review of R1's medical record did not show admitting orders. Staff were unable to provide admitting orders upon request during on site visit on 05/04/2026.

Record review showed the home had electronic and hard copy systems of MARs.

Record review of R1's April 2026 Medication Administration Records (MAR) showed R1 had medication orders for stool softener routinely twice daily and every day as needed, daily for cholesterol, daily for mood and behavior, daily supplements, twice daily for blood pressure, twice daily for skin ointments, daily pain medication, four times daily for loose stool, twice daily for acid reflux, once daily for seizures and or mood and behavior, daily for nerve pain and seizures, daily for stroke, four times daily eyedrops, and daily for sleep and four times daily as needed inhalers.

Record review of R1's MARs from February 2026 to April 2026 showed multiple days with no staff initials, indicating medications were not administered. The record showed May 2026 MARs were not created during the on-site investigation on 05/04/2026.

During an interview on 05/04/2026 at 1:50 PM, R1 stated that caregivers bring them medications, and they "believe" caregivers were giving them correct medications.

<Resident 2>
Record review of R2's medical record showed R2 was admitted to the home on [redacted]/2024. The record showed R2 had multiple diagnoses including [redacted] and [redacted].

Record review of R2's assessment, dated 05/13/2025 documented R2 required assistance with medication administration and nurse delegation services.

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Record review of R2's unsigned negotiated care plan, dated 09/03/2026 documented R2 required staff to administer medication. The record instructed staff to assist with medication administration daily, document in the MAR, follow doctor's orders and nurse delegator instructions.

Record review of R2's April 2026 MARs showed R2 had medication orders for daily blood pressure, stool softener, blood thinner, muscle relaxant, thyroid, allergies, supplements, antibiotic, bladder spasms, acid reflux, potassium supplement, sleep aid, three times a day pain and multiple additional medications as needed.

Record review of R2's electronic MARs from January 2026 to February 2026 showed multiple days with no staff initials, indicating medications were not administered.

Record review of R2's hard copy MARs from March 2026 to April 2026 showed multiple days with no staff initials, indicating medications were not administered. The record showed May 2026 MARs were blank with no staff initials indicating medication administration for any medications from 05/01/2026 - 05/04/2026.

Record review of R2's physician orders dated 04/09/2026 showed orders for mineral oil to both ears three times a week and for Levaquin (antibiotic) total of 750 milligrams (mg) daily. The record did not show orders for Macrobid 100 mg.

Record review of R2's April 2026 MARs showed Levaquin was not included on the MAR, indicating R2 did not receive the medication as ordered for a total of 21 days (from 04/09/2026 - 04/30/2026). The record showed staff initialed for Macrobid (antibiotic) 17 days out of 30, indicating staff administered a medication that was not currently ordered.

Record review of R2's nurse delegation supervisory visit, dated 04/07/2026, documented R2 required nurse delegation services for oral, topical, inhaler, eye drops and ear drops medications. The record documented no physician orders were found, there were medication discrepancies identified between facility MARs and pharmacy MARs and facility MARs were not signed consistently. The record showed nurse delegation services were rescinded on 04/07/2026.

During an interview on 05/04/2026 at 2:00 PM, R2 stated that they received medications "as far as I know," they do not keep track of what medications they were getting.

<Resident 3>
Record review of R3's medical record showed R3 was admitted to the home on [redacted]/2025. The record showed R3 had multiple diagnoses including [redacted]

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[redacted] and [redacted].

Record review of R3's medical record did not show an assessment was done prior to admission.

Record review of R3's unsigned negotiated care plan dated 04/28/2026 documented R3 required assistance with medication administration. The record instructed staff to assist with medication administration daily, document in the MAR, to follow doctor's orders and nurse delegator instructions.

Record review of R3's April 2026 MARs showed R3 had medication orders for daily for urinary, muscle relaxant, urinary urgency and blood pressure, pain and anxiety medications as needed medications.

Record review of R3's electronic MARs from January 2026 to February 2026 showed multiple days with no staff initials, indicating medications were not administered.

Record review of R3's hard copy MARs from March 2026 to April 2026 showed multiple days with no staff initials, indicating medications were not administered. The record showed May 2026 MARs were blank during on-site investigation on 05/04/2026.

During an interview on 05/04/2026 at 2:05 PM, R3 stated that they received medications they do not know exactly what they were.

<Resident 4>
Record review of R4's medical record showed R4 was admitted to the home on [redacted]/2022. The record showed R4 had multiple diagnoses including [redacted] and [redacted].

Record review of R4's assessment, 07/15/2025 showed R4 required staff assistance with medication administration and nurse delegation.

Record review of R4's unsigned negotiated care plan, dated 07/01/2024 documented R4 required staff to administer medication. The record instructed staff to assist with medication administration daily, document in the MAR, follow doctor's orders and nurse delegator instructions.

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Record review of R4's April 2026 MARs showed R4 had medication orders for four times daily for pain, daily for blood pressure, blood thinner, cholesterol, cognition, supplements, diabetes, thyroid, twice daily as needed for cramping, three times daily eye drops and nerve pain, twice daily for depression and twice daily blood sugar checks.

Record review of R4's electronic MARs from January 2026 to February 2026 showed multiple days with no staff initials, indicating medications were not administered.

Record review of R4's hard copy MARs showed from March 2026 to April 2026 showed multiple days with no staff initials, indicating medications were not administered.

Record review of R4's March 2026 MARs showed medications for blood pressure, diabetes, blood thinner, skin infections, thyroid, depression and iron supplement were not initialed for the entire month, indicating medications were not administered for 31 days. During on-site investigation on 05/04/2026 at 11:05 AM, R4's May 2026 MARs were blank.

During an interview on 05/04/2026 at 2:10 PM, R4 stated that they received medications and relied on caregivers to bring correct medications at the right time.

<Resident 5>
Record review of R5's medical record showed R5 was admitted to the home on [redacted]/2025 and discharged on [redacted]/2026. The record showed R5 had multiple diagnoses including [redacted] and [redacted].

Record review of R5's unsigned negotiated care plan, dated 06/09/2025 documented R5 required staff assistance with medication administration and required nurse delegation. The record showed staff were to follow Registered Nurse Delegator instructions and to document in the MARs.

Record review of R5's April 2026 MARs dated showed R5 had medications once daily for blood pressure, cholesterol, blood thinner, supplements, enlarged prostate diabetes, HIV infection, sleeping, heartburn, stool softener, depression and twice daily stool softener, blood sugar checks.

Record review of R5's electronic MARs from January 2026 to February 2026 showed multiple days with no staff initials, indicating medications were not administered.

Record review of R5s hard copy for April 2026 showed multiple days with no staff initials, indicating medications were not administered.

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Record review of R5's medical record, electronic and hard copy did not show MARs for March 2026 were created. Staff did not provide March 2026 records when requested by department staff.

During an interview on 04/30/2026 at 2:44 PM, Collateral Contact 1 (CC1, Registered Nurse Delegator) stated that they rescinded nurse delegation services at the home on 04/07/2026. CC1 stated that they had been working with the staff and provider for a while, but the issues were not resolved. CC1 stated that the caregivers were unable to find orders when requested. CC1 stated that the MARs were not correct and/or updated per orders and staff initials were missing on multiple days. CC1 stated that caregivers relied on their memory of what medications had changed because the MARs were not updated. CC1 stated that the weekend staff (Staff D, New Provider) was not delegated due to a pending health care license and was made aware that Staff D asked other caregivers to initial on the MARs the days the caregivers were not working. CC1 stated that they were made aware that residents were not getting their medications over the weekends.

During an interview on 04/30/2026 at 3:41 PM, Collateral Contact 2 (CC2, Hospice Nurse) stated that they completed medication reconciliation for R5 and they identified two doses of antiviral medications that were not given. CC2 stated that there were no staff initials for the whole week for the scheduled medications when they visited R5 on 04/27/2026. CC2 stated that it was unclear if the resident was getting their scheduled medications when staff were questioned. CC2 stated that they were concerned the staff did not know medication documentation.

During an interview on 05/04/2026 at 11:30 AM Staff C, Caregiver stated that they worked Monday through Friday from 7 AM - 7 PM. Staff C said it was their first day back to work and they were creating May 2026 MARs as no one started them at the first of month. Staff C said that it was not their responsibility to create MARs. Staff C said it was Staff D's responsibility to create MARs at the beginning of the month, and review and update MARs as orders came in. Staff C stated that they were supposed to use electronic MARs but had stopped using them because the medications were not being updated and they were not matching with current doctors' orders. Staff C said Staff D was responsible for updating the electronic MARs and had asked Staff D to update them on multiple occasions with no action. Staff C stated that they had texted Staff A, Current Provider, concerns that the MARs "are a mess" and was told it was Staff D's job and to reach out to them. Staff C said they called the pharmacy to send paper MARs to enable them to make changes as doctors' orders came in and to ensure accuracy of the medications. Staff C said Staff D oversaw daily operations and they reported to them. Staff C said Staff D worked on the weekends and when Staff C returned to work on Mondays, they found resident medications that were not popped out of the bubble packs (pharmacy-provided medication organizer with individual sealed doses). Staff C said they notified Staff D that the hospice nurse had visited R5 and their medication count was off. Staff C stated that Staff D told them not to worry about it because R5 did not need the medications and "state" (the Department) was not going to find out. Staff C stated that they had boxed all previous medications including multiple bubble packs

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that were not popped. Staff C stated that they were unable to find the box and stated that Staff D had taken the box out of the home. Staff C stated that Staff D was the only staff on duty from Friday at 7 PM through Monday at 8 AM.

During an interview on 05/05/2026 at 12:58 PM, Collateral Contact 3 (CC3, Registered Nurse Delegator) stated that they had reached out to Staff A, the Provider and they were directed to address the issues with Staff D, the new provider.

During an interview on 05/06/2026 at 3:20 PM, Staff D stated that they oversaw the home's daily operations. Staff D stated that they "visited" the home Fridays, Saturday and Sundays and whenever caregivers needed assistance. Staff D stated that Staff C worked on the weekends "sometimes when asked" and Staff E worked Mondays through Saturday from 7 PM - 8 AM. Staff D stated that they ask the caregivers to "fix" all the residents' medications for them by putting them in medicine cups for Staff D to pass later in the day. Staff D stated that Staff C "forgot" to create May MARs for the residents and they were "sorry" the MARs were not done. Staff D stated that they were not nurse delegated because their Department of Health (DOH) credentials were in pending status. Staff D stated that when they covered for the weekend and a resident needed an as-needed medication, they "face timed" (video called) Staff C to walk them through since they were not delegated to administered medications. Staff D stated that nurse delegation services were rescinded on 04/07/2026 because they were requesting doctors' orders and there was a delay from the doctor's office. Staff D stated that they do not have a nurse delegator for the AFH currently. Staff D stated that they were aware the caregivers missed initialing on MARs when medications were administered. Staff D stated that caregivers had a "long day" and were "exhausted" and they missed initialing the MARs. Staff D stated that they were not initialing on MARs when they were working, they asked other caregivers to initial since their DOH credentials were pending. Staff D stated that they have both electronic and hard copy systems of MARs. Staff D stated that when they input signatures in the electronic system the initials were not showing up and sometimes, they were unable to update the electronic MARs. Staff D stated that it was expected for staff to initial each time they administered the medications.

During an interview on 05/07/2026 at 9:29 AM, Staff C stated that they do not pre-pour medications for Staff D to administer them and they do not face time/video call to assist with as-needed medications over the weekend. Staff C stated that they rarely worked on weekends and if they did, they initialed the MARs when they administered the medications. Staff C stated that Staff D mainly works on the weekends from Friday 7 PM to Monday 8 AM.

During an interview on 05/07/2026 at 3:19 PM, Staff E, Caregiver stated that they worked Monday through Friday 7 PM - 8 AM. Staff E said they were responsible for evening and before breakfast medication pass before they leave on Saturday. Staff E said that they document on the MARs after administering medications to a resident. Staff E said "sometimes" they do forget to initial on the MARs. Staff E said they were not responsible for creating MARs and indicated that Staff D was responsible for creating and making changes to MARs as needed. Staff E stated that about 3-4 months ago they

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and Staff C decided to use hard copy MARs because the electronic MARs were not updated and were not matching the residents' orders. Staff E said it was Staff D's responsibility to ensure that the electronic MAR was updated as they do not have access to make changes to electronic MARs. Staff E stated that they had notified Staff D on multiple occasions to update the electronic MARs with no success. Staff E stated that Staff D told them they had no full access to the electronic MARs. Staff E said that Staff D has been overseeing the home's daily operations for "months." Staff E said that Staff D worked mainly on weekends. Staff E stated that Staff D asked them to pre-pour medications for all residents before leaving on Saturday mornings for Staff D to pass them the rest of the day and Staff D had previously documented Staff E's initials on the MARs. Staff E stated that they do not initial the MAR when they pre-pour the medications. Staff E stated they do not know what happens if a resident need as-needed medications. Staff E stated that they, Staff C and Staff D were the only caregivers in the home.

During an interview on 05/08/2026 at 1:38 PM, Staff B, Provider Representative/Designee, stated that Staff D took over the business and was the point person and oversaw daily operations.

During an interview on 05/18/2026 at 3:22 PM, Collateral Contact 4 (CC4, R5's family member) stated that Staff D was the new provider since September 2025 and they worked weekends. CC4 stated that the hospice nurse notified them the concerns of R5 not getting their medications. CC4 stated that it had been a long-standing problem with medications and when they asked for R5's MARs, staff did not provide them. CC4 stated that they believe R5 was not getting their medications because there was a time when R5 had orders for an antibiotic and the medication bottle was never delivered to the home and R5 had gone for one week without the antibiotic.

In an email sent to the department on 05/21/2026 at 7:34 AM, Staff C stated that Staff D had signed residents' May 2026 MARs using their (Staff C's) initials on the dates Staff D had worked. Staff C stated this was "not okay".

Record review of documentation faxed to the department by Staff C on 05/21/2026 included a record titled "date that we do not work" and showed Staff C did not work on the following dates; 05/02/2026, 05/03/2026, 05/09/2026, 05/10/2026, 05/16/2026, 05/17/2026 and 05/20/2026. The record further showed Staff E did not work on the following dates; 05/01/2026, 05/02/2026, 05/03/2026, 05/08/2026, 05/09/2026, 05/10/2026, 05/15/2026, 05/16/2026, 05/17/2026 and 05/19/2026. The faxed documentation further contained May 2026 MARs for R1, R2, R3 and R4. The MARs for R1, R2, R3, and R4 showed the initials of Staff C and Staff E from 05/01/2026 through 05/20/2026 on multiple dates they had not worked.

Record review of an email sent to the department on 05/21/2026 at 10:30 AM from Staff C showed an image of text messages between Staff C and Staff D. In the text messages, Staff C asked Staff D why they used their initials on the MARs on the dates that Staff D worked. The record showed Staff D responded, "To fill up the Gap, DSHS [Department of Social and Health Services] might flag again without.. you can change it if you're not

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happy about it.. it's fine.."

During an interview on 05/21/2026 at 11:10 AM, Staff C confirmed that they did not work the dates that showed their initials and that Staff D had documented their initials on the MARs. Staff C stated that they questioned Staff D in a text message why they were documenting the caregivers initials and Staff D responded that they will be flagged by DSHS if the MARS were not signed. Staff C confirmed the text message exchange between them and Staff D occurred 05/21/2026.

During an interview on 05/22/2026 at 8:35 AM, Staff E confirmed that they did not work the dates in May 2026 that showed their initials and stated that Staff D had documented their initials on the MARs.

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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 7/18/26

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

Provider (or Representative) — Date: 6/19/26

WAC 388-76-10015 License Adult family home Compliance required.

(1) The licensed adult family home must comply with all the requirements established in chapters 70.128 , 70.129, 74.34 RCW, this chapter and other applicable laws and regulations including chapter 74.39A RCW; and

(2) The provider is ultimately responsible for the day-to-day operation of each licensed home.

(3) The provider must promote the health, safety, and well-being of each resident residing in each licensed adult family home.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) provider failed to maintain day-to-day operation of the AFH and promote the health, safety and well-being for 5 of 5 residents (Residents 1, 2, 3, 4, and 5). This failure resulted in all residents living in an AFH without provider oversight.

Findings included...

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Review of department records showed the AFH was licensed on 03/29/2023. Staff A (Provider) and Staff B (Provider Representative/Designee) were listed as co-providers. Staff A was listed as the entity representative effective 10/19/2022 and Staff F was listed as the Resident Manager effective 05/01/2023. There had been no change of ownership (CHOW) applications received since the facility was licensed on 03/29/2023.

During an interview on 05/04/2026 at 11:30 AM Staff C (caregiver) stated that Staff D (New Provider) oversaw daily operations and they reported to them. Staff C stated that they had texted Staff A, Current Provider, concerns that residents' medication administration records "are a mess" and was told it was Staff D's job and to reach out to them.

During an interview on 05/05/2026 at 12:58 PM, Collateral Contact 3 (CC3, Registered Nurse Delegator) stated that they had reached out to Staff A and they were directed to address the issues with Staff D, the new provider.

During an interview on 05/06/2026 at 3:20 PM, Staff D stated that they were in charge and oversaw the home's daily operations.

During an interview on 05/07/2026 at 3:19 PM, Staff E, Caregiver stated that Staff D had been overseeing the home's daily operations for "months."

During an interview on 05/18/2026 at 3:22 PM, Collateral Contact 4 (CC4, R5's family member) stated that Staff D was the new provider since September 2025.

During an interview on 05/08/2026 at 1:38 PM, Staff B, Provider Representative/Designee, stated that Staff D took over the business and was the point person and oversaw daily operations.

Refer to WAC 388-76-10400, 388-76-10430, and 388-76-10960.

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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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 8/3/26 7/18/26.

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

Provider (or Representative) — Date 6/19/26

WAC 388-76-10315 Resident record Required. The adult family home must:

(1) Create, maintain, and keep records for residents in the home where the resident lives and ensure that the records:

(a) Contain enough information so home can provide the needed care and services to each resident;

(b) Be in a format useful to the home;

(c) Be kept confidential so that only authorized persons see their contents;

(d) Are only released to the following persons:

(i) A health care institution;

(ii) When requested by the law;

(iii) To department representatives; and

(iv) To the resident;

(e) Be protected to prevent loss, alteration or destruction and unauthorized use;

(f) Be kept for three years after the resident leaves the home or death of the resident;

(g) Be available so that department staff may review them when requested; and

(2) Ensure staff has access to the parts of residents' records needed by staff to provide care and services; and

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home failed to ensure resident records were available for 4 of 5 residents (Resident 1 [1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4]). This failure placed R1, R2, R3 and R4 at risk for unmet care needs.

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Findings included...

An unannounced on-site complaint investigation was conducted on 05/04/2026 at 11:00 AM.

Record review of R1's medical record showed R1 was admitted to the home on [redacted]/2026. The medical record did not have R1's assessment, negotiated care plan or doctors' orders during onsite visit on 05/04/2026.

Record review of R2's medical record showed R1 was admitted to the home on [redacted]/2024. The medical record did not have R2's negotiated care plan.

Record review of R3's medical record showed R3 was admitted to the home on [redacted]/2025. The medical record did not have R3's assessment and negotiated care plan.

Record review of R4's medical record showed R4 was admitted to the home on [redacted]/2022. The medical record did not have R4's negotiated care plan.

During an interview on 05/04/2026 at 2:55 PM, Staff C (caregiver) stated that they would notify Staff D, New Provider, of the Department's request to send the requested documents (assessments, negotiated care plans, doctors' orders) to the department within 24 hours.

Review of department records showed no documents were received by 05/06/2026 at 3:00 PM.

During an interview on 05/06/2026 at 3:20 PM, Staff D, New Provider, stated that they would send the documents (assessments, negotiated care plans, doctors' orders) to the Department within 24 hours as requested.

As of 05/07/2026, the Department had not received the requested documentation.

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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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) ~~6/3/26~~ 7/8/26 JH.

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

Provider (or Representative) — Date: 6/19/26

WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(1) Staff information such as address and contact information.

(2) Staff orientation and training records pertinent to duties, including, but not limited to:

(a) Training required by chapter 388-112A WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;

(b) Cardiopulmonary resuscitation;

(c) First aid; and

(d) HIV/AIDS training.

(3) Tuberculosis testing results.

(4) Criminal history disclosure and background check results as required.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home failed to ensure Department staff had access to 3 of 3 sampled personnel files (Staff C, Staff D and Staff E). This failure resulted in R1, R2, R3, and R4 receiving care from staff whose qualifications and criminal histories could not be determined.

Findings included...

An unannounced on-site complaint investigation was conducted on 05/04/2026 at 11:00

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AM.

Record review showed there were no staff personnel files available on site for Staff C, Staff D, or Staff E.

During an interview on 05/04/2026 at 2:55 PM, Staff C (caregiver) stated that they would notify Staff D, New Provider, of the Department's request to send the personnel files to the department within 24 hours.

Review of department records showed no documents were received by 05/06/2026 at 3:00 PM.

During an interview on 05/06/2026 at 3:20 PM, Staff D, New Provider, stated that they would send the personnel files to the Department within 24 hours as requested.

As of 05/07/2026, the Department had not received the requested documentation.

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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) ~~6/3/26~~ 7/16/26.

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

Provider (or Representative) — Date: 6/9/26

WAC 388-76-10960 Remedies Department may impose remedies. The department may impose a remedy or remedies if the department finds any person listed in WAC 388-76-10950 :

(11) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a license or any data attached to the application, or in any matter involving the department;

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home failed to ensure staff did not falsify medication administration records for 4 of 5 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]). This failure resulted in R1, R2,

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R3, and R4 having falsified medication administration records and placed them at risk for medication errors.

Findings included...

An unannounced on-site complaint investigation was conducted on 05/04/2026 at 11:00 AM.

During an interview on 05/04/2026 11:30 AM, Staff C, Caregiver stated that they worked Monday through Friday from 7 AM - 7 PM and they were nurse delegated to provide medication adminsitration for R2, R4 and R5. Staff C stated that Staff D was the only staff on duty from Friday at 7 PM through Monday at 8 AM. Staff C stated that Staff D, New Provider, was not nurse delegated and did not know how delegated medications were handled over the weekend.

During an interview on 05/06/2026 at 3:20 PM, Staff D stated that they oversaw the home's daily operations. Staff D stated that they "visited" the home Fridays, Saturday and Sundays and whenever caregivers needed assistance. Staff D stated that Staff C worked on the weekends "sometimes when asked" and Staff E worked Mondays through Saturday from 7 PM - 8 AM. Staff D stated that they ask the caregivers to "fix" all the residents' medications for them by putting them in medicine cups for Staff D to pass later in the day. Staff D stated that they were not nurse delegated because their Department of Health (DOH) credentials were in pending status. Staff D stated that when they covered for the weekend and a resident needed an as-needed medication, they "face timed" (video called) Staff C to walk them through since they were not delegated to administered medications. Staff D stated that they were not initialing on MARs when they were working, they asked other caregivers to initial since their DOH credentials were pending.

During an interview on 05/07/2026 at 9:29 AM, Staff C stated that they do not pre-pour medications for Staff D to administer them and they do not face time/video call to assist with as-needed medications over the weekend. Staff C stated that they rarely worked on weekends and if they did, they initialed the MARs when they administered the medications.

During an interview on 05/07/2026 at 3:19 PM, Staff E, Caregiver stated that they worked Monday through Friday 7 PM - 8 AM. Staff E said they were responsible for evening and before breakfast medication pass before they leave on Saturday. Staff E said that Staff D worked mainly on weekends. Staff E stated that Staff D asked them to pre-pour medications for all residents before leaving on Saturday mornings for Staff D to pass them the rest of the day and Staff D had previously documented Staff E's initials on the MARs. Staff E stated that they do not initial the MAR when they pre-pour the medications. Staff E stated they do not know what happens if a resident need as-needed medications. Staff E stated that they, Staff C and Staff D were the only caregivers in the home.

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In an email sent to the department on 05/21/2026 at 7:34 AM, Staff C stated that Staff D had signed residents' May 2026 MARs using their (Staff C's) initials on the dates Staff D had worked. Staff C stated this was "not okay".

Record review of documentation faxed to the department by Staff C on 05/21/2026 included a record titled "date that we do not work" and showed Staff C did not work on the following dates; 05/02/2026, 05/03/2026, 05/09/2026, 05/10/2026, 05/16/2026, 05/17/2026 and 05/20/2026. The record further showed Staff E did not work on the following dates; 05/01/2026, 05/02/2026, 05/03/2026, 05/08/2026, 05/09/2026, 05/10/2026, 05/15/2026, 05/16/2026, 05/17/2026 and 05/19/2026. The faxed documentation further contained May 2026 MARs for R1, R2, R3 and R4. The MARs for R1, R2, R3, and R4 showed the initials of Staff C and Staff E from 05/01/2026 through 05/20/2026 on multiple dates they had not worked.

Record review of an email sent to the department on 05/21/2026 at 10:30 AM from Staff C showed an image of text messages between Staff C and Staff D. In the text messages, Staff C asked Staff D why they used their initials on the MARs on the dates that Staff D worked. The record showed Staff D responded, "To fill up the Gap, DSHS [Department of Social and Health Services] might flag again without.. you can change it if you're not happy about it.. it's fine.."

During an interview on 05/21/2026 at 11:10 AM, Staff C confirmed that they did not work the dates that showed their initials and that Staff D had documented their initials on the MARs. Staff C stated that they questioned Staff D why they were documenting the caregivers initials and Staff D responded that they will be flagged by DSHS if the MARS were not signed. Staff C confirmed the electronic communication occurred 05/21/2026.

During an interview on 05/22/2026 at 8:35 AM, Staff E confirmed that they did not work the dates in May 2026 that showed their initials and stated that Staff D had documented their initials on the MARs.

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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, Rivercrest Adult Family Home is or will be in compliance with this law and / or regulation on (Date) ~~8/3/26~~ 7/18/26.

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

Provider (or Representative) — Date: 6/19/26

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