STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Pendo Homecare LLC
PENDO HOMECARE LLC
2128 W LAKESIDE DR
Moses Lake, WA 98837

RE: PENDO HOMECARE LLC License # 757465

Dear Provider:

This letter addresses Compliance Determination(s) 82278 (Completion Date 08/14/2026) and 80538 (Completion Date 07/23/2026).

The Department completed a follow-up inspection of your Adult Family Home on 08/14/2026 and found that you have corrected the violations listed in the Complaint report dated 07/23/2026. Your home is back in compliance as of 07/30/2026 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 388-76-10617-1, WAC 388-76-10617-2, WAC 388-76-10617-3, WAC 388-76-10617-4, WAC 388-76-10617-5-e-ii, WAC 388-76-10617-5-g-i, WAC 388-76-10617-5-g-ii, WAC 388-76-10617-5-g, WAC 388-76-10617-5-h-i, WAC 388-76-10617-5-h-iii, WAC 388-76-10617-5-h-iv, WAC 388-76-10617-5-h-ii, WAC 388-76-10617-5-h, WAC 388-76-10225-1-a-i, WAC 388-76-10225-1-a-ii

The Department staff who did the on-site verification:
Brittney Shull, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Ann Yarbrough

Michelle Yarbrough, Adult Family Home Field Manager
Region 1, Unit C

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Residential Care Services

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1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 757465	Compliance Determination # 80538
Plan of Correction	PENDO HOMECARE LLC	Completion Date
Page 1 of 7	Licensee: Pendo Homecare LLC	07/23/2026

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 07/16/2026 of:

PENDO HOMECARE LLC
2128 W LAKESIDE DR
Moses Lake, WA 98837

This document references the following complaint number(s): 228775, 228854

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit C
1200 Alder Street
Union Gap, WA 98903

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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.

Michelle Ann Garbrough
Residential Care Services

07/27/2026
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)

7/30/26
Date

WAC 388-76-10617 Resident rights Transfer and discharge notice Residents with medicaid as a payor. For residents with medicaid as a payor, in addition to the requirements in WAC 388-76-10616 , the adult family home must do the following when issuing a written notice of transfer or discharge:

(1) Include in the notice contact information provided by the department for the legal services agencies assigned to provide legal counsel;

(2) Clearly state in the notice that, subject to legislative appropriation, legal counsel at public expense is available to represent the resident's interests in the transfer or discharge process. This language must be substantially in the following form: "Subject to legislative appropriation you have a right to a free lawyer to help you respond to a notice of transfer or discharge. If you want a free lawyer to help you, please call the long-term care discharge defense screening line at (888) 437-0017.";

(3) Within three calendar days of issuing the notice, provide a copy of the notice to the resident's assigned department case manager;

(4) Within three calendar days of issuing the notice, provide a copy of the notice to the Washington state long-term care ombudsman program; and

(5) Issue the transfer and discharge notice in substantially the following form: Notice of transfer or discharge residents with medicaid as a payor:

(e) Location to where resident is transferred or discharged:

(ii) Address;

(g) Copy of notice given within three days to:

(i) Department case manager;

(ii) Washington state long-term care ombudsman program;

(h) Your rights and resources.

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(i) Legal counsel: Subject to legislative appropriation, you have a right to a free lawyer to help you respond to a notice of transfer or discharge. If you want a free lawyer to help you, please call the long-term care discharge defense screening line at (888) 437-0017.

(ii) Washington state ombuds: For assistance and information about this notice contact your long-term care ombuds toll free at 1- 800-562-6028 or by email at ltcop@mschelps.org. The Washington long-term care ombudsman program is located at 1200 South 336th St, Federal Way, WA 98003. You can find your local ombuds person on the Washington state long-term care ombudsman program website at www.waombudsman.org, under "Find an Ombuds".

(iii) Disability rights Washington: If you have a diagnosis of a mental illness or an intellectual disability, you may contact disability rights Washington 1-800-562 -2702 or (206) 324-1521. You may also make your request in writing by fax at (206) 957-0729, email at info@dr-wa.org or mail at Disability rights Washington, 315 5th Ave S, Suite 850, Seattle WA, 98104.

(iv) DSHS home and community living administration (HCLA): You have the right to make a complaint to the complaint resolution unit (CRU/complaint hotline) 1-800-562 -6078.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure that all required parties received a complete discharge notice for 1 of 1 resident (Resident 1). This failure resulted in a violation of Resident 1's rights and placed Resident 1 at risk of unknown resources for discharge.

Findings included...

388-76-10616
Resident rights—Transfer and discharge notice.
(1) Before a home transfers or discharges a resident, the home must give the resident and the resident's representative a written thirty day notification informing them of the transfer or discharge. The home must also make a reasonable effort to notify, if known, any interested family member. The written notification must be in a language and manner the resident understands and include the following:
(a) The reason for transfer or discharge;
(b) The effective date of transfer or discharge;
(c) The location where the resident is transferred or discharged if known at the time of the thirty-day discharge notice;
(d) The name, address, and telephone number of the state long-term care ombuds;
(e) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with a developmental disability; and
(f) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness.
(2) The home may make the notice as soon as practicable before transfer or discharge when:
(a) The safety and health of the individuals in the home would be endangered;
(b) An immediate transfer or discharge is required by the resident's urgent medical

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needs; or
(c) The resident has been absent from the home for thirty or more days.
(3) A copy of the written notification must be in the resident's records.

Review of Resident 1's record showed Resident 1:
-Was admitted to the facility on [redacted]/2025.
-Had a diagnosis of [redacted].

Record review on 07/16/2026 of Resident 1's discharge notice dated 06/16/2026:
-Did not show a physical address of transfer.
-Did not show the second page of the discharge notice, which should have included contact information for Washington state ombuds, Disability rights Washington, the Department complaint reporting unit, notice of legal counsel, and which Department case manager was notified.

On 07/16/2026 at 10:48am, Staff A, Resident Manager, stated they had given Resident 1 a 30-day discharge notice on 05/22/2026 as Resident 1 was going to lose [redacted] services and would not be able to pay for services. Staff A stated they did not have a record of the discharge notice dated 05/22/2026. Staff A stated they did not notify the Department Case Manager of Resident 1's anticipated discharge. Staff A stated that an immediate discharge notice was issued on 06/16/2026 when Resident 1 engaged in a physical altercation with Resident 2 and Resident 2's safety was endangered. Staff A stated that the notice dated 06/16/2026 was given to Resident 1 to sign. Staff A stated the discharge notice dated 06/16/2026 was not given to the ombuds. Staff A stated they verbally notified the Department case manager of Resident 1's discharge notice when they arrived at the facility to assess another resident. When requesting the second page for the discharge notice dated 06/16/2026, Staff A stated they did not have it and printed a blank second page.

On 07/21/2026 at 11:11am, Collateral Contact 1 (CC1), Department Case Manager, stated they did not receive verbal or written notice of Resident 1's 30-day discharge notice dated 05/22/2026. CC1 stated that Resident 1 told them they did not receive a copy of the immediate discharge notice dated 06/16/2026. CC1 stated they were not notified of any plans for Resident 1's discharge until 06/17/2026. CC1 stated that Resident 1 had received written correspondence of service changes, and Resident 1 was still eligible for [redacted] services under a different program.

On 07/21/2026 at 11:32am, Resident 1 stated they were not given a copy of any written discharge notice. Resident 1 stated they were required to sign the discharge notice to collect their medications and leave. Resident 1 stated they were living in their car.

Record review of Resident 1's 30-day discharge notice dated 05/22/2026 was not provided to the Department until 07/23/2026. Review of the discharge notice:
-Showed the discharge was issued due to room and care services through the Department being discontinued and payments had stopped.
-Did not show a location in which Resident 1 would be transferred to.
-Did not show contact information for the right to legal counsel.
-Did not show the disability rights Washington contact information.
-Did not show the notice was forwarded to anyone.

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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, PENDO HOMECARE LLC is or will be in compliance with this law and / or regulation on (Date) 7/30/26.

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

Provider (or Representative) Isaac Mgugi Date 7/30/26

WAC 388-76-10225 Reporting requirement.

(1) The adult family home must ensure all staff:

(a) Report suspected abuse, neglect, exploitation, or abandonment of a resident:

(i) As required by chapter 74.34 RCW;

(ii) To the department by calling the complaint toll-free hotline number or completing an online report; and

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure abuse was reported to the Department for 1 of 1 resident (Resident 3). This failure delayed the Department's investigation of an allegation of abuse and placed all residents at risk of harm.

Findings included...

Review of the facility policy titled, "Abuse, Neglect, Abandonment and/or Exploitation," undated, showed abuse was defined as intentionally causing pain, suffering, and/or injury to a resident. The policy showed that staff were mandated reporters and were required to report abuse to the Department, as well as law enforcement if physical assault had occurred.

Review of Resident 1's Negotiated Care Plan (NCP) dated 01/31/2026 showed Resident 1:
-Was independent with ambulation and mobility.
-Had a diagnosis of [redacted].
-Had behaviors of aggression and intimidation, specifically towards Resident 2, threatening to physically assault Resident 2, Resident 1's roommate.
-Had behaviors of foul or offensive language, yelling, and verbal aggression towards others.
-Had behaviors of being violent to others outside the home and physically aggressive towards other residents.

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Review of Resident 3's NCP dated 03/16/2026 showed Resident 3:
-Had left sided weakness due to a stroke (brain injury) requiring use of a wheelchair.
-Had behaviors of yelling, cursing, insulting others, using foul language, hitting staff and throwing items.

Review of Resident 1 and Resident 3's progress notes dated 05/13/2026 showed that Resident 1 had pushed Resident 3 while in their wheelchair which caused Resident 3 and their wheelchair to tip over onto the ground after Resident 1 and Resident 3 had an escalating verbal altercation. The notes showed law enforcement was notified. The notes did not show that the Department was notified.

Review of an Incident Report dated 06/16/2026 showed Resident 1 and Resident 2 had an altercation in which Resident 1 strangled Resident 2 and grabbed Resident 2's genitals.

On 07/16/2026 at 10:48am, Staff A, Resident Manager stated Resident 1 did not like anyone at the home and had to eat meals at other times than the rest of the residents. Staff A stated Resident 1 had an altercation with Resident 3 on 05/13/2026 that required notification to law enforcement. Staff A stated that Resident 3 had an episode of psychosis, (the inability to distinguish what is real and not real), was screaming and banging doors, and Resident 1 became upset due to lack of sleep from the noise. Staff A stated that Resident 3 was verbally aggressive and Resident 1 pushed Resident 3 in their wheelchair which tipped over and fell. Staff A stated they did not think they reported the incident to the Department and did not know why. Staff A stated another incident occurred after that on 06/16/2026, when Resident 1 choked Resident 2 and squeezed their genitals stating that they would kill Resident 2 before they left.

On 07/16/2026 at 12:23pm, Resident 2 stated they did not get along with their roommate, Resident 1. Resident 2 stated Resident 1 had gotten into an altercation about one month ago and Resident 1 pushed Resident 2, kicked them, and pulled their hair.

On 7/16/2026 at 12:38pm, Resident 3 stated they did not feel safe when Resident 1 lived at the home, and Resident 1 had pushed them out of their wheelchair a couple months ago.

On 07/21/2026 at 11:32am, Resident 1 stated they had an altercation with Resident 2. Resident 1 stated that Resident 2 constantly nagged Resident 1 and they could not control themselves from acting physically. Resident 1 stated that they "warned" Resident 2 multiple times that if they didn't stop nagging Resident 1, Resident 1 would "punch their face so hard, they wouldn't wake up."

Review of Department records on 07/27/2026 showed the resident-to-resident altercation on 05/13/2026 between Resident 3 and Resident 1 had not been reported to the Department.

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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, PENDO HOMECARE LLC is or will be in compliance with this law and / or regulation on (Date) 7/30/26 .

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

Provider (or Representative) Isaac Ngugi Date 7/30/26

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