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

02/09/2026

CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC
GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

RE: GUARDIAN ANGEL HOMES (THE COTTAGE) # 1513

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 72699 (Completion Date 02/09/2026) and 70155 (Completion Date 12/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/09/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

The Department staff who did the On Site verification:
Robin Barnes, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

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

Laura Williams-Davis, ALF Field Manager
Region 1, 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
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site follow-up on 12/16/2025 of:
GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

This document references the following SOD dated: 12/18/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 74 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Robin Barnes, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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

Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff that had a valid Washington state name and date of birth background check completed every two years for 1 of 4 staff (Staff A). This failure placed residents at risk of being cared for by staff with unknown background history.

Findings included…

Review of personnel file for Staff A, Caregiver, showed that they had been hired on 10/06/2021. Staff A's file showed that they had a Washington state name and date of birth background check on 12/08/2023 that had expired on 12/08/2025. Staff A's file showed that they did not have a valid Washington state name and date of birth background check for 8 days as of 12/16/2025.

In an interview on 12/16/2025 at 12:41 PM, Staff B, Administrator, stated that they had audited personnel files at the beginning of December 2025. Staff B stated that they did not know why Staff A did not have a current valid background check completed. Staff B also stated that Staff A had worked three shifts since their background check expired.

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

This is an uncorrected deficiency, written on the Statement of Deficiencies dated 10/27/2025 for Washington Administrative Code 388-78a-2466(1a).

Plan/Attestation Statement

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 10/13/2025, 10/14/2025, 10/15/2025 and 10/16/2025 of:
GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

The following sample was selected for review during the unannounced on-site visit: 9 of 79 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Elaine Lopez, Licensor
Robin Barnes, Assisted Living Facility Licensor
Anna Cairns, ALF Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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 | Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) | Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure resident medications were obtained when staff were responsible for ordering medications for 3 of 9 residents (Resident 5, 6 and 8). This failure resulted in the residents not receiving their prescribed medication and placed the residents at risk of complications with their health conditions.

Findings included…

<Resident 5>

Review of Resident 5's Negotiated Service Agreement (NSA), dated 03/18/2025, showed that the resident had a diagnosis of [redacted]. Additionally, Resident 5's NSA showed that the resident required staff assistance with medication ordering and self-administration of medication.

Review of Resident 5's physician orders, dated 08/07/2025, showed that the resident had an order for propranolol (used to treat tremors) to be given three times daily.

Review of Resident 5's August 2025 Medication Administration Record (MAR), showed

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that the resident did not receive 15 of 15 doses of the propranolol from 08/07/2025 through 08/11/2025.

In an interview on 10/22/2025 at 12:30 PM, Staff H, Licensed Practical Nurse/Health Services Director, stated that Resident 5's orders for their propranolol medication showed a start date of 08/07/2025 and that the facility did not receive the medication from the pharmacy until 08/11/2025.

<Resident 6>

Review of Resident 6's NSA, dated 01/16/2025, showed that the resident had a diagnosis of [redacted] and staff were to observe for skin changes. Resident 6's NSA showed that the resident required assistance with their medications.

Review of Resident 6's physician orders, dated 08/18/2025, showed that the resident had an order for nystatin powder (prescription antifungal medication for skin infections) to be applied two times a day in the stomach folds for a rash.

Review of Resident 6's September 2025 MAR showed that the resident had not been given their nystatin powder as prescribed for 20 of 20 doses from 09/01/2025 through 09/10/2025.

Review of Resident 6's progress note, dated 09/01/2025, showed that facility staff documented that the resident's nystatin powder was not available.

Review of Resident 6's progress note, dated 09/10/2025, showed that the nystatin powder was not available.

In an interview on 10/16/2025 at 1:05 PM, Staff H stated that Resident 6's nystatin powder was prescribed for abdominal yeast rashes. Staff H acknowledged that Resident 6 did not receive the medication for 10 days and that the resident would have discomfort from not having the medication available to them.

<Resident 8>

Review of Resident 8's NSA, dated 7/17/2025, showed that the resident had a diagnosis of [redacted] and [redacted]. Additionally, Resident 8's NSA showed that they required assistance for medications and that the facility was to use the contracted pharmacy for medication management.

Review of Resident 8's record showed a doctor's order, dated 7/16/2025, for

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Alendronate (for osteoporosis) to be given once weekly on Friday.

Review of Resident 8's August 2025 MAR showed that the resident had not been given Alendronate on 08/15/2025, 08/22/2025, and 08/29/2025. The August 2025 MAR showed reasons the medication was not given as, "Medication not available" for the 08/15/2025 and 08/22/2025. The MAR showed that on 08/29/2025 the reason was left blank with no explanation.

Review of Resident 8's September 2025 MAR showed that the resident had not been given Alendronate on 09/05/2025, 09/12/2025 and 09/19/2025. The September MAR showed reasons the medication was not given on 09/05/2025 and 09/12/2025 as, "Medication not available." The MAR showed that on 09/19/2025 the reason was left blank with no explanation.

Review of Resident 8's progress notes for 08/15/2025 and 08/22/2025 showed staff documented, "medication not available" for the Alendronate. The progress notes showed that for 09/05/2025 and 09/12/2025, staff documented, "Not in cart."

In an interview on 10/16/2025 at 11:10 AM, Staff H stated that they were unaware of the Alendronate not being given. After investigating, Staff H stated that they found that when the resident moved in during the middle of the month, they were not put on automatic cycle fill with the pharmacy. Staff H stated that each of the medication technicians working did not request for the refill therefore the resident went without the medication.

Plan/Attestation Statement

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop systems to ensure that nursing services were provided as ordered for 2 of 2 residents (Resident 5 and 6). This failure contributed to Resident 5 not receiving blood sugar monitoring and Resident 6 not receiving wound care as ordered, which placed the residents at risk of health complications.

Findings included…

<Resident 5>

Review of Resident 5's Negotiated Service Agreement (NSA), dated 03/18/2025, showed that the resident had a diagnosis of [redacted] and was able to self-administer medications with caregiver assistance.

Review of Resident 5's physician orders, dated 08/16/2025, showed that the resident had orders to check blood sugars daily.

Review of Resident 5's progress note, dated 08/18/2025, showed that the resident was able to obtain their own blood sugar and that staff would document the reading.

Review of Resident 5's August 2025 Medication Administration Record (MAR), showed that the resident did not have their blood sugar reading obtained for four of seven days between 08/24/2025 and 08/31/2025.

Review of Resident 5's September 2025 MAR showed that the resident did not have their blood sugar reading obtained for nine of fourteen days between 09/05/2025 and 09/24/2025.

Review of Resident 5's October 2025 MAR showed that the resident did not have their blood sugar reading obtained for four of eight days between 10/06/2025 and 10/14/2025.

In an interview on 10/16/2025 at 9:44 AM, Staff H, Licensed Practical Nurse/Health Services Director, acknowledged that there were lapses in documentation of Resident 5's daily blood sugar checks in the resident's MAR from August 2025 through October 2025.

<Resident 6>

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

Review of Resident 6's NSA, dated 01/16/2025, showed that the resident had a diagnosis of [redacted] and staff were to observe for skin changes. Resident 6's NSA showed that the resident required staff assistance with their medications.

Review of Resident 6's physician visit summary and order, dated 04/10/2025, showed that Resident 6 had ongoing skin breakdown and a wound to their abdomen. The summary included an order for Resident 6 to have a medicated ointment and a dressing applied daily to the area.

Review of Resident 6's August 2025 MAR showed that the resident's wound care was to be performed by a licensed nurse daily. The MAR showed that Resident 6 did not receive their daily wound care for 10 days between 08/02/2025 and 08/31/2025.

Review of Resident 6's September 2025 MAR showed that the resident did not receive their daily wound care for 13 days between 09/11/2025 and 09/23/2025.

Review of Resident 6's progress note, dated 09/11/2025, showed that there were no wound care supplies at the facility to dress Resident 6's wound.

In an interview on 10/16/2025 at 1:00 PM, Staff H stated that Resident 6 did have orders for daily wound care to be done by a licensed nurse. Staff H acknowledged that Resident 6 did not receive wound care for 23 days from 08/02/2025 through 09/23/2025.

Plan/Attestation Statement

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

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WAC 388-78A-2371 Investigations. The assisted living facility must:

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to investigate and document investigative actions, determine the circumstances of resident to resident and fall incidents, and implement preventative measures, for 2 of 3 residents (Residents 2 and 5). This failure contributed to Resident 2 having a fall and placed residents at risk of further falls and incidents.

Findings included…

Review of a facility policy titled, "Incident/Accident Reporting," dated 2008, showed that all accidents and incidents were to be investigated promptly to identify the cause of the event. The policy also showed that the Health Services Director was responsible to investigate the incident and implement preventative measures when needed.

In an interview on 10/13/2025 at 10:08 AM, Staff A, Administrator, stated that their system for monitoring residents when needed was their Short Term Monitoring (STM) forms.

<Resident 2>

Observation on 10/13/2025 at 11:49 AM showed that Resident 2 had extensive discoloration to their entire face and forehead, spreading down to the bottom of their neck. The discoloration ranged from dark purple to yellowish green. There were two large raised lumps on Resident 2's forehead.

In an interview on 10/13/2025 at 11:50 AM, Collateral Contact 1 (CC1), family member, stated that Resident 2 had sustained a couple of falls. CC1 stated that they were concerned that staff were not monitoring Resident 2 often enough.

Review of Resident 2's Negotiated Service Agreement (NSA), dated 07/07/2025, showed that the resident had a history of falls and a diagnosis of [redacted].
The NSA showed that Resident 2 walked with assistance using a walker, and required alarms to be placed on their bed and chair to prevent falls. The NSA also showed that Resident 2 took aspirin (a blood thinning medication which increases the risk of bleeding and bruising).

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Review of a progress note in Resident 2's record, dated 10/01/2025, showed that Resident 2 had fallen overnight. The progress note did not include any details about the fall, how or where it had happened, or that the circumstances of the fall had been investigated. The progress note did not indicate that any fall prevention measures had been implemented.

Review of a STM form in Resident 2's record, dated 10/01/2025, showed that the resident was being monitored for injuries due to falling out of bed on 10/01/2025. The form did not show that any investigation data was documented, nor did the form include any fall prevention precautions.

Review of another progress note in Resident 2's record, dated 10/03/2025, showed that Resident 2 had fallen overnight again and was sent to the hospital. The progress note showed that Resident 2 had sustained an open wound to their head. The progress note did not include any details about the fall, how or where it had happened, or that the circumstances of the fall had been investigated.

Review of the next progress note in Resident 2's record, dated 10/03/2025, showed that Resident 2 had returned from the hospital with stitches to their head.

Review of an additional progress note in Resident 2's record, dated 10/03/2025, showed that the resident had walked to the door unassisted when they fell and hit their head on the nightstand. The note showed that Resident 2's fall was unwitnessed, however fall precautions had been in place at the time of the fall. The note did not show that the fall had been further investigated.

Review of a STM form in Resident 2's record, dated 10/03/2025, showed that the resident had fallen and had stitches placed in a cut on their forehead. The form showed that Resident 2 was to be monitored for any complications from their injuries. The form did not show any investigation data was documented, nor did the form include any fall prevention precautions.

Review of progress note, dated 10/08/2025, showed that Resident 2 was seen by their primary care provider. The note showed that Resident 2 had eight stitches placed on their forehead and that they had been sent to the emergency room on 10/04/2025 due to excessive bleeding from the wound. The note also showed that Resident 2 had significant bruising to their face and forehead, with swelling and pain.

Review of Resident 2's record did not show that an investigation had been documented for their falls on 10/01/2025 and 10/03/2025. The record did not show that any additional preventative measures were put into place to prevent Resident 2 from having further falls.

In an interview on 10/16/2025 at 9:41 AM, Staff H, Licensed Practical Nurse/Health

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Services Director, stated that there were not any incident investigations documented for Resident 2's falls that had occurred on 10/01/2025 and 10/03/2025. Staff H stated that they did not know why the investigations had not been completed for Resident 2's falls.

<Resident 6>

Review of Resident 6's NSA, dated 01/16/2025, showed that the resident had a diagnosis of [redacted], and that they used a walker for mobility. Additionally, Resident 6's NSA showed that the resident had a history of restlessness and agitation and had behavioral and emotional disorders.

Review of Resident 6's progress note, dated 08/03/2025, showed that the resident was on STM for a resident-to-resident incident that resulted in a bruise to their upper right arm.

Review of a STM form in Resident 6's record, dated 08/03/2025, showed that the resident had a resident-to-resident altercation and were to be monitored for pain, bruising, bleeding, and fear of other residents or cares.

Review of Resident 6's record did not show that an investigation had been documented for their altercation with another resident on an unknown date. The record did not show that any preventative measures were put into place to prevent Resident 6 from further altercations.

Review of Resident 6's progress note, dated 09/01/2025, showed that the resident had a fall on 08/31/2025. The progress note did not show that the circumstances causing Resident 6's fall had been further investigated, nor were any preventative precautions implemented.

Review of a STM form in Resident 6's record, dated 08/31/2025, showed that the resident had a fall that resulted in a bruise to their right upper thigh. Resident 6's STM showed that the resident was to be monitored for latent injuries, pain, discomfort, or changes in ambulation. The form did not show any investigation data was documented nor did the form include any fall prevention precautions.

Review of a STM form in Resident 6's record, dated 10/03/2025, showed that the resident was sent out from, "Another fall," and was off their baseline. The form did not show any investigation data was documented, nor did the form include any fall prevention precautions.

Review of Resident 6's progress note, dated 10/04/2025, showed that a nurse had assessed the resident after their fall. The note showed that Resident 6 had increased

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swelling in their legs and increased pain.

Review of Resident 6's record did not show that an investigation had been documented for their falls on 08/31/2025 and 10/03/2025. The record did not show that any preventative measures were put into place to prevent Resident 6 from having further falls.

In an interview on 10/16/2025 at 12:25 PM, Staff H stated that there were not any incident investigations documented for Resident 6's altercation with another resident, or for the falls that had occurred on 08/31/2025 and 10/03/2025.

Plan/Attestation Statement

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a Washington state name and date of birth background check was submitted every two years for staff that had worked in the facility for more than two years for 2 of 3 staff (Staff E and F). This failure placed residents at risk of being cared for by disqualified staff.

Findings included…

Review of personnel file for Staff E, Caregiver, showed that they had been hired on 08/05/2022. Staff E's file showed that their previous Washington state name and date of

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birth background check had expired on 08/05/2024. Staff E's file did not include a valid Washington state name and date of birth background check after their previous one had expired.

Review of personnel file for Staff F, Medication Technician, showed that they had been hired on 01/03/2023. Staff F's file showed that their previous Washington state name and date of birth background check had expired on 10/06/2025. Staff F's file did not include a valid Washington state name and date of birth background check after their previous one had expired.

In an interview on 10/16/2025 at 12:48 PM, Staff G, Business Office Manager, stated that Staff E and Staff F did not have current Washington state name and date of birth background checks in their personnel files.

Plan/Attestation Statement

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-112A-0080 Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC 388-112A-0090 : Adult family homes.

(5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training. Enhanced services facilities.

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

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(b) Basic;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff who worked as long-term care workers, had their Home Care Aide application submitted to the department within 14 days for 1 of 4 staff (Staff D) and that staff completed the required 70 hour basic training within 120 days of their date of hire for 1 of 4 staff (Staff F). Additionally, the facility failed to ensure that staff had completed their orientation and safety training for 1 of 4 staff (Staff D) and specialty training when providing care and services to a resident with a primary [redacted] diagnosis, for 6 of 6 staff (Staff A, B, C, D, E and F) and impact 1 of 1 residents (Resident 1). These failures placed residents at risk of receiving care from untrained staff.

Findings included…

Review of Washington Administrative Code (WAC) 246.980.030 showed that a Long-Term Care Worker (LTCW) must submit an application for a Home Care Aid (HCA) certification within 14 days of hire. The WAC also showed that LTCW training must be completed within 120 days of hire, and the certification must be obtained within 200 days of hire.

<Home Care Aide application and training>

Review of the personnel file for Staff D, Caregiver, showed that they were hired on 06/18/2025. Staff D's file showed that their HCA application was sent to the department on 09/26/2025, 100 days after their date of hire.

Review of the personnel file for Staff F, Medication Technician, showed that they were hired on 01/03/2023. Staff F's file showed that their 70-hour basic training was completed on 01/27/2024, 389 days after their date of hire.

In an interview on 10/15/2025 at 10:40 AM, Staff G, Business Office Manager, acknowledged that Staff D's HCA application was sent to the department late. Staff G stated that they did not know the reason for Staff F not having their 70-hour basic training completed within the required timeline.

<Orientation and Safety training>

Review of the personnel file for Staff D, showed that they did have their orientation and

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safety training completed.

In an interview on 10/16/2025 at 9:30 AM, Staff G stated that Staff D did not have a completed orientation and safety training in their personnel file.

<Specialty Developmental Disability training>

Review of Resident 1's Negotiated Service Agreement, dated 12/23/2024, showed that the resident had primary diagnoses of [redacted] and [redacted].

In an interview on 10/13/2025 at 10:15 AM Staff A, Administrator, stated that the facility admitted and provided services for residents with developmental disabilities. Staff A stated that Resident 1 had a diagnosis of a [redacted]. Staff A also stated that they thought that the developmental disability specialty training was included in their HCA basic training curriculum.

Review of the personnel file for Staff A showed that they were hired on 02/16/2022. Staff A's file did not show that they had received developmental disability specialty training.

Review of the personnel file for Staff B, Registered Nurse, showed that they were hired on 01/03/2024. Staff B's file did not show that they had received developmental disability specialty training.

Review of the personnel file for Staff C, Medication Technician, showed that they were hired on 06/23/2025. Staff B's file did not show that they had received developmental disability specialty training.

Review of the personnel file for Staff D showed that they were hired on 06/18/2025. Staff D's file did not show that they had received developmental disability specialty training.

Review of the personnel file for Staff E, Caregiver, showed that they were hired on 08/05/2022. Staff E's file did not show that they had received developmental disability specialty training.

Review of the personnel file for Staff F showed that they were hired on 01/03/2023. Staff F's file did not show that they had received developmental disability specialty training.

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In an interview on 10/15/2025 at 10:21 AM, Staff G acknowledged that staff at the facility did not have the developmental disability specialty training and that Staff A, B, C, D, E and F did not have it documented in their personnel files.

Plan/Attestation Statement

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that the animals living at the facility had current record of regular examinations and immunizations by a veterinarian and were certified to be free of diseases transmittable to humans for 1 of 2 resident pets (Pet 2). This failure placed residents at risk of contracting transmittable diseases.

Findings included…

Review of the facility pet policy, undated, showed that the facility required residents' pets living at the facility to have proof of current immunizations in the form of a veterinarian certification.

In an interview on 10/13/2025 at 10:17 AM, Staff A, Administrator, stated that there were two cats that lived at the facility.

Review of Pet 2's record showed that they did not have current immunizations or proof

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of an examination on file at the facility.

In an interview on 10/15/2025 at 11:27 AM, Staff A stated that they were unable to provide documentation of Pet 2's immunizations or exam.

Plan/Attestation Statement

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC
GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

RE: GUARDIAN ANGEL HOMES (THE COTTAGE) # 1513

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/27/2025 and found that your facility does not meet the Assisted Living Facility 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 your program 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:

Laura Williams-Davis, ALF Field Manager
Residential Care Services
Region 1, Unit G
Preferred methods:

eFax: (509) 454-4160
Email: rcsregion1email@dshs.wa.gov
Optional method:
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, 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 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

The facility failed to keep the furniture and carpets clean and in good condition. The facility corrected the deficiency by cleaning and shampooing the furniture and carpets during the full 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:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o You can make an IDR request and find directions on the IDR web page at:
    https://www.dshs.wa.gov/altsa/idr

If You Have Any Questions:
• Please contact me at (509)208-5231.

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

Sincerely,

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Enclosure

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