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

CHP Yelm-Rosemont WA Tenant Corp
Prestige Senior Living Rosemont
215 Killion Rd NW
Yelm, WA 98597

RE: Prestige Senior Living Rosemont License # 2236

Dear Administrator:

This letter addresses Compliance Determination(s) 82981 (Completion Date 08/28/2026) and 80544 (Completion Date 07/31/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/28/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2260-2-d, WAC 388-78A-2260-2

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit E
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Prestige Senior Living Rosemont
License/Cert.#: 2236
Compliance Determination #: 80544
Investigator: Pamela Horlick
Investigation Date(s): 07/16/2026 through 07/31/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 230896
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Misappropriation of Property: Report of facility nurse giving a caregiver a deceased residents medication.
2. Resident/Patient/Client Neglect: Report of staff not following the plan of care when transferring 2 person assist residents.

Investigation Methods:

Sample:	Total residents: 59 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Health Services Director Executive director Resident Care Coordinator
Record Reviews:	State reporting log Incident investigation Facility policies Personnel files Staff training records Medication Administration Record Medication delivery slips Medication destruction logs Progress notes Pictures

Investigation Summary:

1. Misappropriation of Property: Facility staff failed to follow facility policy by ensuring medication room door is locked at all times. Failed practice identified.

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

2. Resident/Patient/Client Neglect: Facility staff and residents interviewed stated there is a process in place when providing care to residents who require 2 person assist with care. Unable to substantiate failed practice.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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 Ste 200, Vancouver, WA 98684

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 complaint investigation on 07/16/2026 of:

Prestige Senior Living Rosemont
215 Killion Rd NW
Yelm, WA 98597

This document references the following complaint number(s): 230896

The following sample was selected for review during the unannounced on-site visit: 2 of 59 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

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

Statement of Deficiencies	License #: 2236	Compliance Determination # 80544
Plan of Correction	Prestige Senior Living Rosemont	Completion Date
Page 2 of 4	Licensee: CHP Yelm-Rosemont WA Tenant Corp	07/31/2026

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Cory Cisneros
Residential Care Services

08/04/2026
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)

8/5/2026
Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure all medications were stored and locked in a secure manner. This failure to secure medications for 1 of 1 medication rooms resulted in a medication being removed from the facility by staff and placed other residents medications at risk for tampering with or misuse of medications by staff.

Findings included...

Record review of facility policy, titled, "Medication Ordering, Receiving and Storing," dated April 2021, showed it was policy to order, receive, and store medications in a timely, safe, secure, and proper manner, following manufacturer or pharmacy recommendations and in accordance with federal and state regulations. Medications centrally stored were to be stored in the medication room, under lock, accessible only by authorized personnel.

In an interview on 07/07/2026 at 4:10 PM, Staff C, former caregiver, reported that they were in possession of a deceased residents medication that was given to them by Staff B, Health Services Director and provided pictures of the package containing the residents medication including the label with the residents name, prescribing doctor, and date it was filled.

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

In an interview on 07/16/2026 at 2:16 PM, Staff B denied giving the medication to Staff C and stated it was destroyed.

Record review of facility provided investigation "Questions for Staff," dated 07/17/2026, showed Staff D, caregiver, stated they had witnessed the medication room door opened without a Med Tech (medication technician), ED (executive director), SHSD (Senior Health Services Director) or RCC (resident care coordinator) present. Staff D stated they had also witnessed a non med tech enter the medication room without a Med tech, ED, SHSD or RCC present.

Record review of facility provided investigation "Questions for Staff," dated 07/16/2026, showed Staff E, caregiver, stated they had witnessed the medication room door opened without a Med Tech, ED, SHSD, or RCC present.

Record review of facility provided investigation "Questions for Staff," dated 07/16/2026, showed Staff F, caregiver, stated they had witnessed the medication room door opened without a Med tech, ED, SHSD, or RCC present. Staff F stated they have also witnessed a non med tech enter the medication room without a Med tech, ED, SHSD or RCC present.

Record review of facility provided investigation "Questions for Staff," dated 07/16/2026, showed Staff G, caregiver, stated they had witnessed the medication room door opened without a Med, ED, SHSD, or RCC present. Staff F stated they had also witnessed a non med tech enter the medication room without a Med tech, ED, SHSD or RCC present.

In an interview on 07/17/2026 at 12:37 PM, Staff C stated they had witnessed the medication room door either propped open or not fully closed while no one who was authorized to enter it was present. Staff C stated they had also been in the HSD's office with the med techs after hours and had seen medications, including narcotics, on the desk of the Health Services Director (HSD).

In an interview on 07/31/2026 12:29 PM, Staff A, Executive Director, stated the door to the medication room should not ever be left open and staff did not follow facility policy to ensure the medication room was locked at all times.

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

Statement of Deficiencies	License #: 2236	Compliance Determination # 80544
Plan of Correction	Prestige Senior Living Rosemont	Completion Date
Page 4 of 4	Licensee: CHP Yelm-Rosemont WA Tenant Corp	07/31/2026

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, Prestige Senior Living Rosemont is or will be in compliance with this law and / or regulation on (Date) 8/5/2026 .

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

Administrator (or Representative) [signature] Date 8/5/2026

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