STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

09/10/2026

RP Operations, LLC
Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

RE: Rose Pointe Assisted Living # 2452

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 83515 (Completion Date 09/10/2026) and 78484 (Completion Date 07/14/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/10/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

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

The Department staff who did the On Site verification:
Sandra Fast, Community Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: Rose Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2452
Intake ID: 226800
Compliance Determination #: 78484
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sandra Fast
Investigation Date(s): 06/04/2026 through 07/14/2026
Complainant Contact Date(s): 06/04/2026, 06/30/2026

Allegation(s):

1. A resident was allowed to be in severe pain without intervention.

2. A resident experienced unsanitary living conditions.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Housekeeping staff
Record Reviews:	Medical records Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:

1. The identified resident's medication administration records reviewed showed that the identified resident was not administered pain medication on a consistent basis. The identified resident observed showed signs of severe distress and pain. The medication technician observed did not administer medications to alleviate the resident's distress. A citation was issued regarding Washington Administrative Code

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(WAC) 388-78a-2210(1)(b)(2)(a)(b).

2. The identified resident's records reviewed showed that they needed assistance with maintaining sanitary living quarters. The resident's quarters observed showed unsanitary living conditions. Citations were issued regarding WAC 388-78a-2610(2)(e) and WAC 388-78a-3090(1)(a)(d). T

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Rose Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2452
Intake ID: 227019
Compliance Determination #: 78484
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sandra Fast
Investigation Date(s): 06/04/2026 through 07/14/2026
Complainant Contact Date(s): 06/04/2026

Allegation(s):

1. The identified resident was unable to call for staff assistance.

2. The identified resident's pain was not adequately addressed.

3. The identified resident was exposed to unsanitary living conditions.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Housekeeping staff
Record Reviews:	Medical records Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:

1. The identified resident's records reviewed showed that there were interventions in place to check on the resident in their room frequently. The facility staff observed

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were rounding on residents and assisting them as needed. The sampled residents observed were able to summon staff physically or verbally and showed no signs of distress. No failed facility practice was identified.

2. The identified resident's medication administration records reviewed showed that the identified resident was not administered as needed pain medication on a consistent basis. The identified resident observed showed signs of severe distress and pain. The medication technician observed did not administer medications to alleviate the resident's distress. A citation was issued regarding WAC 388-78a-2210(1)(b)(2)(a)(b).

3. The identified resident's records reviewed showed that they needed assistance with maintaining sanitary living quarters and laundry. The resident's quarters observed showed unsanitary living conditions. Citations were issued regarding WAC 388-78a-3090(1)(a)(d), and WAC 388-78a-2610(2)(e).

Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 06/04/2026 of:

Rose Pointe Assisted Living
13013 E Mission Ave
Spokane Valley, WA 99216

This document references the following complaint number(s): 226800, 227019

The following sample was selected for review during the unannounced on-site visit: 3 of 93 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

Residential Care Services — Date: 07/24/2026

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: 7/30/26

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to develop and implement safe medication service and to ensure residents received their medications as prescribed and when indicated for 1 of 3 residents (Resident 1). These failures resulted in the resident not receiving prescribed as needed pain medication despite showing signs of pain, placing them at risk for unmanaged pain and unnecessary suffering.

Findings included...

Review of the facility's house policy titled, "Medication Services," dated October of 2015, showed that qualified staff members would provide medication services to residents as determined by their assessments and evaluations. The policy showed that any special directions on a resident's Medication Administration Record (MAR) would be followed.

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Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement) showed that the resident had diagnoses of [redacted], and [redacted]. The NSP showed that Resident 1 was on hospice (end of life care).The NSP showed that the Resident 1 had long term pain and could not determine their own need for as needed (PRN) medications and that medications were to be given as ordered (prescribed). The NSP further showed that staff would maintain Resident 1's comfort at the "end of life."

In an interview on 06/04/2026 at 8:22 AM, Collateral Contact 1 (CC1), Hospice Social Worker, stated that on 06/02/2026, they visited Resident 1 at the facility. CC1 stated that Resident 1 was observed, "writhing in pain." CC1 stated that they alerted Staff B, Medication Technician (MT), at 10:15 AM on 06/02/2026, that the resident reported and showed signs of significant pain. CC1 stated that Staff B told them that Resident 1's PRN Morphine Sulfate (MS, controlled narcotic pain medication) was ordered to be given every 12 hours. CC1 stated that the resident's MS was not ordered every 12 hours and was ordered for every two hours PRN for pain. CC1 stated that at 10:35 AM Staff B had not yet provided Resident 1 with any pain medication.

In an interview on 06/04/2026 at 9:36 AM, Collateral Contact 2 (CC2), Hospice Registered Nurse, stated that Resident 1 was observed in a huge amount of pain on 06/03/2026 and that they alerted Staff B of the pain. CC2 stated that Staff B did not medicate the resident with their PRN pain medication.

Review of Resident 1's MAR for June of 2026, showed that the resident had PRN MS ordered every two hours for verbal and non-verbal indications of pain. The MAR documented the non-verbal signs of pain as groaning, crying, or rigidity in position. The MAR documented that when non-verbal signs and symptoms of pain were noted, the staff were to medicate per orders to ensure the resident's comfort. The MAR showed only one administration of the resident's PRN MS, on 06/02/2026, at 1:46 AM. Further review of the MAR showed that Resident 1 was not provided their ordered MS medication when notified by hospice of the resident's pain on 06/02/2026 and 06/03/2026.

In an interview on 06/04/2026 at 1:46 PM, Staff B stated that part of their role as an MT was to assess residents for pain, including non-verbal pain. Staff B further stated that there was an medication error regarding Resident 1's MS pain medication. Staff B stated they believed the MS was scheduled as routine and not as a PRN.

Observation on 06/04/2026 at 10:48 AM showed that Resident 1 spoke in a strained manner, was grimacing and moaning. Further observation showed that the resident was restless and held their muscles in a tensed (stretched tight and rigid) manner. The resident was unable to verbally state whether they were in pain. Further observation

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showed Staff B, Medication Technician, entered Resident 1's room and observed the resident for about 30 seconds, then left the room. Staff B did not provide Resident 1 with their PRN MS.

In an interview on 07/14/2026 at 9:02 AM, Staff A, Executive Director, was asked what the facility had done to correct administration of PRN medications. Staff A stated that discussions were held with MTs and caregivers to ensure when a resident was seen in pain or showing non-verbal pain indicators, the residents would be medicated if indicated. Staff A further stated that Staff B received additional training from the facility nurse regarding PRN medications. Staff A stated that the training included looking at residents' body signs and expressions (non-verbal pain indicators) and ensuring that the residents received the PRN medications every two hours.

This is a recurring deficiency previously cited on 02/08/2026 for subsection (1) (b) and 12/10/2025 for subsection (1) (b).

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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8/24/26 .

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

Administrator (or Representative) [signature] Date 7/30/26

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that residents' quarters were maintained in a safe and sanitary condition for 3 of 3 residents (Resident 1, 2, and 3). This failure resulted in unhygienic living conditions for the residents, and placed the residents at risk for harm and decreased quality of life.

Findings included...

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<Resident 1>

Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 04/23/2026, showed that staff were to provide the resident with a safe environment. Further review showed staff were to anticipate the resident's wants and needs to maintain their dignity, safety and comfort.

Observation on 06/04/2026 at 11:05 AM showed that urine soaked linen and a urine soaked brief were left in Resident 1's apartment. A strong lingering odor of urine was detected. Further observation showed an unfastened clear trash bag containing soaked sheets and bedding on the floor of Resident 1's closet area.

Observation on 06/04/2026 at 11:08 AM, showed a pillow without a pillowcase sitting on Resident 1's closet floor area. A yellow stain with brown edges covered half the pillow.

In an interview on 06/04/2026 at 8:22 AM, Collateral Contact 1 (CC1), Hospice Social Worker, stated that Resident 1's room smelled of urine and there was a soiled brief on the floor, next to the resident's bed. CC1 further stated that they notified Staff B, Medication Technician, and they were told that the resident did that.

In an interview on 06/04/2026 at 9:17 AM, Collateral Contact 2 (CC2), Hospice Registered Nurse, stated that on 06/03/2026 at 1:30 PM, they observed Resident 1 in a bed and that their bedding was soaked in urine. CC2 further stated they observed urine running off the resident's bed onto the floor. CC2 stated that a soiled brief was observed on the floor next to the resident's bed. CC2 stated that this was the second time they had observed these things in two days. CC2 stated that when Staff B was notified, they did not intervene. CC2 stated that the decision was made to relocate the resident to a hospice (end of life) facility due to concerns for the resident's comfort and safety.

In an interview on 06/24/2026 at 1:57 PM, Collateral Contact 3, Representative, stated that they had come to the facility unannounced two times and both times the resident's room was filthy and, "looked like a hurricane had come through."

<Resident 2>

Review of Resident 2's NSP, dated 12/23/2026, showed that the resident had diagnoses of [redacted]. Further review showed that staff were to maintain the resident's room in an acceptable manner, bagging soiled linen and transporting it from the resident's apartment.

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Observation on 06/04/2026 at 11:56 AM showed a strong lingering odor of urine detected in Resident 2's apartment.

Observation on 06/04/2026, at 11:59 AM showed a brownish, wet liquid on the right sided base of Resident 2's toilet, and sticky matter covering the surface of their bathroom's flooring tiles. Observation of the resident's closet space showed unfolded clothing overflowing the resident's laundry basket. A soiled bedding pad was observed on the floor of the resident's closet area.

<Resident 3>

Review of Resident 3's NSP, dated 12/29/2025, showed a diagnosis of a [redacted]. The NSP further showed that staff were to assist the resident to keep their laundry clean and free of odor/soiling. The NSP showed that soiled laundry, when found, was to be bagged and transported from the apartment.

Observation on 06/04/2026 at 12:04 PM showed that the flooring tiles at the front of Resident 3's toilet were separated from each other. A brown substance was observed in the spaces between the separated tiles and between the front of the toilet base and the tiles.

Observation on 06/04/2026 at 12:08 PM of Resident 3's apartment, showed an overflowing dirty laundry basket. An unbagged soiled bed pad was observed in the basket.

This is a recurring deficiency previously cited on 12/10/2025 for subsection (1) (a), 08/19/2025 for subsection (1) (d), 06/17/2025 for subsection (1) (a), 12/27/2024 for subsection (1) (a), and 06/18/2024 for subsection (1) (a).

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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, Rose Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8/24/26 .

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

Administrator (or Representative) [signature] Date 7/30/26

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