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

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

RE: Rose Pointe Assisted Living License # 2452

Dear Administrator:

This letter addresses Compliance Determination(s) 84110 (Completion Date 09/22/2026) and 80261 (Completion Date 07/27/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/22/2026 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-2170-1

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

If you have any questions, please contact me at (509)323-7315.

Sincerely,

JSalquist

Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2452
Intake ID: 231464
Compliance Determination #: 80261
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 07/09/2026 through 07/27/2026
Complainant Contact Date(s):

Allegation(s):

1. Memory care resident suffered sunburn and heat stroke.
2. Resident unable to return to the facility timely because no one at the facility was available to assist with readmission.
3. Family not notified of resident's hospitalization.

Investigation Methods:

Sample:
Total residents: 89
Resident sample size: 2
Closed records sample size: 1

Observations:
Alleged Victim
Residents
Activities
Dining
Resident care equipment
Staff to resident interactions
Resident to resident interactions

Interviews:
Executive Director
Alleged Victim
Medication Technician
Resident Representative
Alleged Victim's Representative

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plans
*Staff certifications
*Hospital after-visit summary
*Progress notes
*Incident investigation
*Staff schedule
*Staff in-service education
*Unexpected Death Policy

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*Resident POLST form

Investigation Summary:

1. Interview, record review, and observation confirmed that the Alleged Victim had sustained sunburn and heatstroke while in the facility's care. Failed facility practice identified and cited under WAC 388-78A-2170 Required assisted living facility services (1).
2. Record review showed that the Alleged Victim readmitted to the facility the day following facility notification that the resident could return. Interview with facility management showed there had been no delay in readmitting the Alleged Victim. Interview with facility management showed that the facility had a process in place for coordinating resident readmissions. The Alleged Victim's Representative was interviewed, and no concerns were voiced about the resident's return to the facility. Staff were observed available to coordinate resident care when needed. No failed facility practice.
3. Interview with facility management showed that the Alleged Victim's family had been notified of the resident's hospitalization. Record review confirmed that family notification had occurred. The Alleged Victim's Representative was interviewed, and they reported that facility staff had called them to notify them of their loved one's hospitalization. The Alleged Victim's Representative reported that the facility had consistently notified them when concerns involving their loved one occurred. Staff were observed available for communication with families when needed. No failed facility practice.

Conclusion / Action:

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

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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 07/09/2026 of:

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

This document references the following complaint number(s): 231464, 231348

The following sample was selected for review during the unannounced on-site visit: 2 of 89 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain 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

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 — 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) — 8/7/24 Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure supervision and safety checks were completed, thereby failing to assume general responsibility for the well-being of 1 of 1 memory care resident (Resident 1) who remained outdoors for an extended period during hot weather. This failed practice resulted in sunburn, heatstroke, and hospitalization for Resident 1.

Findings included...

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 12/17/2025, showed that the resident had Alzheimer's disease (a progressive, irreversible brain disorder characterized by memory loss and confusion). Further review of the NSA showed that Resident 1 required routine checks for safety.

An online search on 07/14/2026 showed that on 07/06/2026, the high temperature at the location of the facility was 86 degrees Fahrenheit.

In an interview on 07/14/2026 at 10:07 AM, Collateral Contact 1 (CC1), Resident Representative, stated that they had lunch outside with Resident 1 on 07/06/2026. CC1 stated that facility staff had not applied any sunscreen to Resident 1. CC1 stated that Resident 1 had been wearing a shirt, a sweater, and cropped length pants that day. CC1

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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 _____

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-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure supervision and safety checks were completed, thereby failing to assume general responsibility for the well-being of 1 of 1 memory care resident (Resident 1) who remained outdoors for an extended period during hot weather. This failed practice resulted in sunburn, heatstroke, and hospitalization for Resident 1.

Findings included…

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 12/17/2025, showed that the resident had [redacted]. Further review of the NSA showed that Resident 1 required routine checks for safety.

An online search on 07/14/2026 showed that on [redacted]/2026, the high temperature at the location of the facility was 90 degrees Fahrenheit.

In an interview on 07/14/2026 at 10:07 AM, Collateral Contact 1 (CC1), Resident Representative, stated that they had lunch outside with Resident 1 on [redacted]/2026. CC1 stated that facility staff had not applied any sunscreen to Resident 1. CC1 stated that Resident 1 had been wearing a shirt, a sweater, and cropped length pants that day. CC1

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stated that after lunch, they left Resident 1 on the patio and let everyone know they were leaving and that Resident 1 was still outside. CC1 stated that Resident 1 sustained a sunburn to the areas above and below their knees. CC1 stated that the sunburn blistered and that it had been really bad in some spots.

In an interview on 07/09/2026 at 11:37 AM, Staff B, Medication Technician, stated that on [redacted]2026, Resident 1 had gone outside around 12:30 to 12:45 PM. Staff B stated they heard Resident 1 had been left outside until 4:30 PM, for approximately four hours.
Review of a hospital after-visit summary for Resident 1, dated [redacted]/2026, showed that the resident had been admitted to the hospital from [redacted]/2026 through [redacted]/2026. Further review of the summary showed that Resident 1 had been treated for heatstroke (a life-threatening medical emergency where the body's temperature regulation fails).

Review of a progress note for Resident 1, dated 07/07/2026 at 5:52 AM, showed that per hospital staff, the resident was initially non-responsive upon arrival to the hospital. The note showed that Resident 1 was found to be dehydrated.

In an interview on 07/09/2026 at 10:48 AM, Staff A, Executive Director, stated that Resident 1's sunburn and heatstroke were the result of a big oversight. Staff A stated that staff were supposed to check on the memory care residents who were outside. Staff A stated they were unsure if sunscreen had been applied to Resident 1 the day they obtained the sunburn. Staff A stated that Resident 1 had memory issues and they did not think Resident 1 would have been oriented to how long they had been outside.

Observation on 07/09/2026 at 12:40 PM showed that Resident 1 had red areas consistent with sunburn to the areas above both knees and on both of their shins.

In an interview on 07/31/2026 at 11:30 AM, Staff C, Resident Care Coordinator, was asked what staff were instructed regarding any resident NSA that documented that staff were to routinely check on residents. Staff C stated that routine checks were supposed to occur every two hours.

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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) 9/9/2026

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

Administrator (or Representative) — Date: 8/7/2026

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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)_____ .

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

_____ _____

Administrator (or Representative) Date

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