Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 80836
Investigator: Joy Pipgras
Investigation Date(s): 07/21/2026 through 08/10/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 231637
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
Resident had an unexplained absence.

Investigation Methods:

Sample:	Total residents: 29 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Social services staff Executive Director
Record Reviews:	Resident records Incident investigation Facility policies

Investigation Summary:
Interviews with staff showed the immediate safety concerns were addressed appropriately by the facility. Staff were observed available to supervise resident safety and to assist with care when needed. Record review showed the facility did not complete an investigation or establish interventions to prevent future occurrence and deficient practice was identified and cited per WAC 388-78A-2371 (1)(3).

Conclusion / Action:

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

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☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
Provider Type: Assisted Living Facility
License/Cert.#: 2556
Intake ID: 230806
Compliance Determination #: 80836
Region/Unit #: RCS Region 1 / Unit B
Investigator: Joy Pipgras
Investigation Date(s): 07/21/2026 through 08/10/2026
Complainant Contact Date(s): 08/07/2026

Allegation(s):

1. Staff did not speak English around residents.
2. Staff did not wash their hands.
3. The facility ran out of gloves and briefs on weekends.
4. Medication technicians gave wrong medications to wrong residents.
5. Staff working while intoxicated.
6. Staff sleeping while on shifts providing care to residents that required one or two person monitoring at all times.

Investigation Methods:

Sample:	Total residents: 29 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Kitchen Food preparation
Interviews:	Nursing staff Residents Social services staff Kitchen staff Laundry staff Executive Director
Record Reviews:	Resident records State reporting log Incident investigation Facility policies Personnel files Staff training records

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Staff patterns

Investigation Summary:

1. Interviews with staff and residents showed staff spoke English around residents. Record review showed no concerns regarding using primarily other languages around residents. Observations showed staff speaking English around residents. No failed practice identified.
2. Interviews with nursing staff showed audits were completed on handwashing for infection control regularly. Record review showed no concerns regarding hand washing. Observations showed staff using safe and appropriate handwashing practices. No failed practice identified.
3. Interviews with staff and residents showed the facility had not had any issues with running out of gloves or briefs. Record review showed no concerns regarding running out of items. Observations showed sufficient stock of gloves and briefs on different days in the facility. No failed practice identified.
4. The facility's medication systems were reviewed and deficient practice was identified regarding unsafe medication practices. A citation was issued per WAC 388-78A-2210 (1)(b).
5. Interviews with the executive director showed there was one known incident over a year ago when a staff member appeared intoxicated while working and that staff member was terminated. Record review showed no concerns regarding intoxicated staff. Observations showed no concerns for intoxicated staff. Staff were observed available to supervise resident safety and to assist with care when needed. No failed practice identified.
6. Interviews with staff showed that there were specific rules around staff sleeping in the facility. Observations showed no staff sleeping. Record review showed no concerns for staff sleeping in the facility. No failed practice identified.

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 the unannounced on-site full inspection and complaint investigation on 07/21/2026, 07/23/2026 and 07/28/2026 of:

Sycamore Glen at Quail Hollow
506 N Ehorn Lane
Chewelah, WA 99109

This document references the following complaint numbers: 232632, 232325, 231637, 230806.

The following sample was selected for review during the unannounced on-site visit: 6 of 29 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Joy Pipgras, LTC Surveyor
Patricia Eddy, Community Licensor
Brian Zbylski, ALF Licensor

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.

Staci Oilg , IDR PM for Stepahnie Jenks
Residential Care Services

October 12, 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)

Date

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.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to implement safe medication services for 3 of 5 residents (Residents 1, 3, and 5). This failure placed the residents at risk of adverse health events.

Findings included...

<Resident 3 – Blood thinner medication>

Review of Resident 3's Negotiated Care Plan (the facility's titled negotiated service agreement), dated 05/09/2026, showed the resident had diagnoses of [redacted] and [redacted]. Further review showed the resident required extensive facility staff assistance with medication management.

Review of Resident 3's May 2026 Medication Administration Record (MAR) showed an order for blood thinner medication to be held (not given) on 05/13/2026, and to be given the next six days. Further review showed the medication was not given from 05/14/2026 through 05/18/2026, a total of five doses. The MAR did not contain any documentation to indicate why the medication was not given.

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In an interview on 07/27/2026 at 2:00 PM, Staff D, Licensed Practical Nurse (LPN), stated that Staff G, Registered Nurse, took care of Resident 3's blood thinner medication and that they did not know why Resident 3 missed five doses of the medication.

<Resident 3 – Blood sugar levels and units of insulin given>

Review of Resident 3's May 2026 MAR showed an order, dated 05/07/2026, to give sliding scale (system to determine the number of units to be given based on the resident's current blood sugar level) insulin injections three times daily with meals.

Review of Resident 3's May 2026 MAR showed that the sliding scale insulin was given on 05/07/2026 and 05/11/2026. The MAR showed no documentation on those dates, of the resident's blood sugar level or of how many units of insulin were administered.

Review of Resident 3's May 2026 MAR showed that the sliding scale insulin was given on 14 occasions that month. The MAR did not contain documentation to show how many units of insulin were administered.

Review of Resident 3's June 2026 MAR showed that the sliding scale insulin was given on 23 occasions that month. The MAR did not contain documentation to show how many units of insulin were administered.

Review of Resident 3's July 2026 MAR showed that the sliding scale insulin was given one time on 07/06/2026. The MAR showed no documentation on that date, of the resident's blood sugar level or of how many units of insulin were administered.

In an interview on 07/27/2026 at 2:00 PM, Staff D stated that staff should have documented blood sugar levels and the number of insulin units being given.

<Resident 1 – Blood sugar levels and units of insulin given>

Review of Resident 1's Negotiated Care Plan, dated 05/20/2026, showed the resident was diagnosed with [redacted] and required facility staff assistance with medication management.

Review of Resident 1's June 2026 MAR showed an order, dated 06/24/2026, to give sliding scale insulin injections with meals and as needed, with a maximum of 36 units per day.

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Review of Resident 1's June 2026 MAR showed that the sliding scale insulin was given on three occasions that month. The MAR did not contain documentation to show how many units of insulin were administered.

Review of Resident 1's July 2026 MAR showed that on three occasions, when sliding scale insulin was given, the MAR did not contain documentation of the resident's blood sugar level or of how many units of insulin were administered.

Review of Resident 1's July 2026 MAR showed that on 22 occasions, when sliding scale insulin was given, the MAR did not contain documentation to show how many units of insulin were administered.

In an interview on 07/23/2026 at 10:20 AM, Staff D stated that they were not aware that the Medication Technicians (MTs) had not documented the units of insulin given for Resident 1.

In an interview on 07/23/2026 at 11:42 AM, Staff H, MT, stated that they did not have a place in the MARs to document how many units of insulin were given.

<Resident 5>

Review of Resident 5's Negotiated Care Plan, dated 04/20/2026, showed the resident was diagnosed with [redacted]. Further review showed the resident required facility staff assistance with medication management.

Review of Resident 5's May 2026 MAR showed an order, dated 05/11/2026 through 05/18/2026, for olanzapine (medication to treat schizoaffective disorder) 10 milligrams (mg) to be given in the morning and at noon, and a separate order, dated 05/12/2026 through 05/17/2026 for 10 mg at bedtime. Further review showed that from 05/13/2026 through 05/16/2026, the resident received four doses each day, instead of thre doses as ordered.

Review of Resident 5's May 2026 MAR showed an order, dated 05/20/2026 through 06/02/2026, for olanzapine 10 mg to be given at bedtime. Further review showed that from 05/21/2026 through 05/25/2026 and 05/27/2026 through 05/31/2026, the resident received the medication at 8:00 AM, 12:00 PM, and 7:00 PM, three times daily instead of one dose as ordered.

In an interview on 07/23/2026 at 3:30 PM, Staff G stated they were not aware of any issues with Resident 5's MARs or any medication changes. Staff G further stated they were not sure why there were multiple prescriptions with various start and end dates and various administration times.

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Review of Resident 5's July 2026 MAR showed an order for a monthly injection of a medication to be administered on 07/10/2026. The MAR showed it had not been administered in the month of July. Further review showed the MAR did not contain documentation to indicate why the medication was not given.

In an interview on 07/28/2026 at 9:05 AM, Staff A, Executive Director, confirmed Resident 5 did not receive their injection in July.

This is a recurring citation previously cited on 10/30/2023.

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, Sycamore Glen at Quail Hollow 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-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain copies of signed health care provider orders for medication prescriptions for 1 of 5 residents (Resident 5). This failure resulted in an inability to verify provider orders and placed the residents at risk of medication errors.

Findings included...

Review of Resident 5's Negotiated Care Plan, dated 04/20/2026, showed the resident had a diagnosis of [redacted] and required facility staff

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assistance with medication management.

Review of Resident 5's admission orders, dated 04/13/2026, showed an order of olanzapine (medication used to treat schizophrenia) 10 mg to be taken three times daily.

Review of Resident 5's May 2026 MAR showed multiple entries for olanzapine.

In an interview on 07/23/2026 at 12:05 PM, Staff G, Registered Nurse, stated that the contracted pharmacy added medications to the MARs and that the facility had a recurring issue with the pharmacy re-adding medications that had been previously discontinued by a resident's provider.

In an interview on 07/23/2026 at 3:30 PM, Staff G confirmed the facility did not have any copies of current provider orders for Residents 5.

In an interview on 07/27/2026 at 2:20 PM, Staff D, Licensed Practical Nurse, confirmed the facility did not obtain copies of current provider orders to reconcile (ensure that medication orders are correct) against the MARs.

In an interview on 08/10/2026 at 4:36 PM, Staff A, Executive Director, stated it was unclear which order was correct for Resident 5 because the facility did not have a provider order to verify.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

RCW 70.129.020 Exercise of rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident and assist the resident which include:

(2) The resident has the right to be free of interference, coercion, discrimination, and

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reprisal from the facility in exercising his or her rights.

RCW 70.129.100 Personal property -- Storage space.

(1) The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure resident rights were protected for 1 of 5 residents (Resident 4) who had their personal property taken away by facility staff and who was denied breakfast. These failures resulted in emotional distress related to the removal of the resident's personal phone and the withholding of food as forms of punishment, and placed the resident at risk of a decreased quality of life.

Findings included...

<Resident 4>

Review of Resident 4's Negotiated Care Plan (the facility's titled negotiated service agreement), dated 01/10/2026, showed the resident had diagnoses of [redacted] and [redacted]. Further review showed the resident required facility staff assistance with medication management, required occasional physical bathing assistance, and preferred to make their own decisions on when to bathe.

Review of Resident 4's Department of Social and Health Services (DSHS) assessment, dated 11/12/2025, showed that the resident's phone was important to them and losing phone privileges was not an effective support intervention. Further review showed the resident preferred to wake up around 10:00 AM and needed encouragement to complete hygiene tasks.

Review of Resident 4's facility observation notes showed the following:

05/05/2026 – Staff D, Licensed Practical Nurse, stated the resident was told they could have their phone removed from their possession if they did not take their medications between 7:00 AM and 9:00 AM.

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05/05/2026 – Staff F, Behavior Support Specialist, stated attempts to utilize the resident's phone as a motivational tool resulted in the resident being argumentative and resistant.

05/20/2026 – Staff G, Registered Nurse, stated the resident's phone was taken away until they completed their shower.

05/31/2026 – Staff D stated the resident had their phone and iPad taken away due to a "petulant [moody or childlike]" attitude and disrespect towards staff.

In an interview on 07/22/2026 at 2:15 PM, Resident 4 stated that they had to wake up at 8:00 AM every day to shower, go to the medication room to take their medications, and get breakfast. Resident 4 stated that if they did not get up at 8:00 AM, they would not be able to get breakfast, and staff would tell them that their phone would be taken away if they did not shower. Resident 4 stated they had asked for help showering often due to chronic pain and had frequently been told no. The resident stated that having their phone taken away made them upset and they did not think it was fair. Resident 4 stated if they did not go to the dining room to get breakfast by 9:00 AM, they were told by kitchen staff that they would have to wait for snack time.

In an interview on 07/22/2026 at 4:00 PM, Staff A, Executive Director, stated that they were unaware that Resident 4 had their phone taken away and that residents should not have their personal property taken away.

In an interview on 07/23/2026 at 10:15 AM, Staff F stated they had developed rules for Resident 4 that required them to get up at 8:00 AM, shower, go to the medication room to take medications, and eat breakfast daily. Staff F further stated the consequences of not following the rules would be to have their phone taken away.

In an interview on 07/28/2026 at 9:40 AM, Resident 4 stated that kitchen staff told them that they were not allowed to eat breakfast that day because it was past 9:00 AM.

In an interview on 07/28/2026 at 9:45 AM, Staff I, Kitchen Staff, stated they were told that Resident 4 could not eat meals an hour after mealtime.

In an interview on 07/28/2026 at 9:55 AM, Staff A stated they were unaware that kitchen staff were not providing food at times to Resident 4 and that the resident should be allowed to have food at any time.

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Plan/Attestation Statement

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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;

(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 interview and record review, the facility failed to investigate and document their findings after 1 of 5 Residents (Resident 5) left the facility without an approved plan . This failure resulted in the facility not determining if measures needed to be implemented to prevent future occurrences and placed the resident at risk of harm.

Findings included...

Review of the facility's policy titled, "Incident Reporting and Investigation", dated 01/09/2026, showed the facility was to investigate incidents that included unexplained absences.

Review of Resident 5's Negotiated Care Plan (the facility's titled negotiated service agreement), dated 04/20/2026, showed the resident was diagnosed with [redacted]. Further review showed the resident had memory impairment, poor decision making, and required assistance with medication management.

Review of Resident 5's observation notes, dated 07/09/2026, showed staff reported that the resident had informed them that morning that they were moving out, was later observed leaving in a vehicle with two individuals, then was returned to the facility that evening by law enforcement and a crisis responder.

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In an interview on 7/28/2026 at 10:00 AM, Staff A, Executive Director, stated the facility had not completed an investigation for the incident involving Resident 5 and that an investigation should have been completed. Staff A stated that they were unaware of any interventions that were implemented to prevent future occurrences.

In an interview on 07/28/2026 at 10:55 AM, Staff F, Behavior Support Specialist, stated they did not complete an investigation for the incident involving Resident 5 and did not think an investigation was required due to the resident returning the same day. Staff F stated they did not implement any interventions to prevent future occurrences.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure tuberculosis screenings were conducted within three days of employment for 2 of 5 staff (Staff B and C).This failure placed residents at risk of exposure to a communicable disease.

Findings included...

<Staff B>

Review of Staff B's, Home Care Aide, personnel file showed that they were hired on 05/27/2025. The file showed that Staff B's first step Tuberculosis (TB, contagious respiratory illness) test was completed on 06/04/2025, eight days after hire.

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<Staff C>

Review of Staff C's, Nurse Assistant Certified, personnel file showed that they were hired on 09/22/2025. The files showed that Staff C's first step TB test was completed on 09/26/2025, four days after hire.

In an interview on 07/27/2026 at 3:15 PM, Staff A, Executive Director, confirmed that the TB testing for Staff B and Staff C had not been completed by the facility within three days of hire.

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, Sycamore Glen at Quail Hollow 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-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a one-step tuberculosis screening was conducted for 1 of 5 staff (Staff D).This failure placed residents at risk of exposure to a communicable disease.

Findings included...

Review of Staff D's, Licensed Practical Nurse, personnel file showed that they were hired on 12/18/2025. Further review showed a two-step Tuberculosis (TB, contagious respiratory illness) test was completed within 12 months prior to Staff D's hire, and that

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a one-step had not been completed by the facility after hire.

In an interview on 07/27/2026 at 3:15 PM, Staff A, Executive Director, confirmed that testing for TB had not been completed by the facility for Staff D after they were hired.

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, Sycamore Glen at Quail Hollow 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-2474 Training and home care aide certification requirements.

(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:

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

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that continuing education had been completed by 1 of 6 staff (Staff E), that developmental disabilities specialty training had been completed within 120 days of hire for 2 of 6 staff (Staff C and D), that mental health specialty training had been completed within 120 days of hire for 1 of 6 staff (Staff F), and that dementia special training had been completed within 120 days of hire for 2 of 6 staff (Staff C and F). These failures placed residents at risk of care from staff that had not completed all their required trainings.

Findings included...

Per WAC 388-78A-0495 (4), If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstration competency in specialty training within 120 days of hire.

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Review of the facility's Characteristic Roster showed that 15 residents had a [redacted] diagnosis, seven residents had a diagnosis of [redacted], and that five residents had a developmental disability.

<Staff C>

Review of Staff C's, Nursing Assistant Certified, personnel file showed that they were hired on 09/22/2025. Further review showed they completed their dementia specialty training on 04/17/2026 and developmental disabilities specialty training on 06/02/2026.

In an interview on 07/27/2026 at 3:15 PM, Staff A, Executive Director, confirmed that Staff C had not completed specialized training for dementia and developmental disabilities prior to the 120-day deadline.

<Staff D>

Review of Staff D's, Licensed Practical Nurse, personnel file showed that they were hired on 12/18/2025. Further review showed that their developmental disabilities specialty training was completed on 06/02/2026.

In an interview on 07/27/2026 at 3:15 PM, Staff A confirmed that Staff D had not completed specialized training for developmental disabilities prior to the 120-day deadline.

<Staff E>

Review of Staff E's, Medication Technician/Lead, personnel file showed that they were hired on 08/30/2023. Further review showed that they had not completed 12 hours of annual continuing education requirements.

In an interview on 07/27/2026 at 3:15 PM, Staff A stated that Staff E had not completed all 12 hours of continuing education.

<Staff F>

Review of Staff F's, Behavior Support Specialist, personnel file showed that they were hired on 11/06/2023. Further review showed that their mental health specialty training was completed on 07/09/2025 and dementia specialty training was completed on 07/15/2025.

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In an interview on 07/28/2026 at 3:15 PM, Staff A confirmed that Staff C had not completed specialized training for mental health and dementia prior to the 120-day deadline.

This is a recurring citation previously cited on 05/15/2025 for subsection (2) (c), on 03/28/2025 for subsection (2) (c), and on 02/06/2025.

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, Sycamore Glen at Quail Hollow 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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