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

GRANDE MANOR CARE INC
Grand Manor Care, Inc
1718 W 9th Ave
Spokane, WA 99204

RE: Grand Manor Care, Inc License # 2658

Dear Administrator:

This letter addresses Compliance Determination(s) 82744 (Completion Date 08/26/2026) and 80289 (Completion Date 07/10/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/26/2026 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-2474-2-b, WAC 388-78A-2474-2-c, WAC 388-112A-0495-4, WAC 388-112A-0080-5

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.

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

Statement of Deficiencies	License #: 2658	Compliance Determination #80289
Plan of Correction	Grand Manor Care, Inc	Completion Date
Page 1 of 3	Licensee: GRANDE MANOR CARE INC	07/10/2026

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 07/10/2026 of:
Grand Manor Care, Inc
1718 W 9th Ave
Spokane, WA 99204

This document references the following SOD dated: 07/10/2026

The following sample was selected for review during the unannounced on-site visit: 5 of 5 current residents and 0 former residents.

The department staff that inspected 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 — 07/22/2026 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) — 7/10/2026 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 388-112A-0495 What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities? Adult family homes.

(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 demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training.

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:

(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:

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Based on interview and record review, the facility failed to ensure that staff who provided resident care, completed their basic training as required for 1 of 4 staff (Staff B). This failed practice placed residents at risk of receiving care from staff who had not completed required caregiver training.

Findings included...

Review of a facility as-worked schedule, dated July 2026, showed that Staff B, Caregiver, worked at the facility as a caregiver on 07/08/2026 and 07/09/2026.

On 07/10/2026, a request was made for documentation of Staff B's 70-hour basic training and no record showing completion was provided.

In an interview on 07/10/2026 at 10:26 AM, Staff A, Manager, stated that Staff B had not completed their 70-hour basic training. Staff A stated that Staff B was still on the schedule to provide care to residents.

This is an uncorrected deficiency previously cited on 05/13/2026 for WAC 388-112A-0080 and WAC 388-78A-2474 subsection (2) (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, Grand Manor Care, Inc is or will be in compliance with this law and / or regulation on (Date) 7/10/2026

Staff in Quest in was fired.

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

Administrator (or Representative)

7/10/2026
Date

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Grand Manor Care, Inc

Provider Type: Assisted Living Facility

License/Cert.#: 2658

Intake ID: 221691

Compliance Determination #: 76725

Region/Unit #: RCS Region 1 / Unit B

Investigator: Amy Wright

Investigation Date(s): 04/30/2026 through 05/13/2026

Complainant Contact Date(s): 04/29/2026, 05/12/2026

Allegation(s):

1. Multiple residents using illicit drugs.
2. Staff are verbally abusive to residents.
3. Staff transporting residents in personal vehicles without verified licenses or car insurance.
4. Staff are working without proper credentials.

Investigation Methods:

Sample:	Total residents: 6 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Kitchen Food preparation
Interviews:	Reporter Residents Alleged Perpetrator Manager Owner/Administrator Caregivers
Record Reviews:	*Hospital after-visit summaries *Resident care plans *Staff training records *Resident services agreement *Disclosure of Services *Characteristic roster *Staff roster *Drug and alcohol policy *Abuse and neglect policy *Staff background checks

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

*Incident investigation
*Progress notes
*Staff education
*Personnel policies
*Behavior intervention and crisis plan
*Resident face sheets
*Behavior support plan

Investigation Summary:

1. Interview and record review showed that a facility resident had used illicit drugs for several months. Record review showed that the resident's negotiated service agreement failed to reflect their drug use and it failed to identify interventions to be used by staff when drug use was suspected or confirmed. Failed facility practice was identified and cited under WAC 388-78A-2130 Service agreement planning (3)(a)(b).
2. Interview and record review showed that staff had been aware of suspected verbal abuse of residents by staff though they never reported it to the department. Failed facility practice identified and cited under WAC 388-78A-2630 Reporting abuse and neglect (1)(a). Interview with facility residents showed that staff had treated them in a manner unlikely to maintain or enhance their dignity. Failed facility practice identified and cited under WAC 388-78A-2660 Resident rights (2).
3. Residents were interviewed, and they reported that they typically used public transportation for outings and shopping. Two staff were interviewed, and they denied being asked to transport residents in their personal vehicles. A third staff was interviewed, and they reported that they were the only staff to transport residents though it occurred on an infrequent basis. The staff verified that their license and insurance were checked by the facility. Facility management was interviewed. They reported that while the facility did not have a policy related to resident transportation, they discouraged the use of staff vehicles for transportation of residents while on shift. Staff were observed available to assist the residents with arranging transportation when needed. No failed facility practice.
4. Interview and record review showed that the facility continued to employ care staff who had not met training requirements. Failed facility practice identified and cited under WAC 388-78A-2474 Training and home care aide certification requirements (2)(b)(c), WAC 388-112A-0495 What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities (4), and WAC 388-112A-0080 Who is required to completed the seventy-hour long-term care worker basic training and by when (5).

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 04/30/2026 of:

Grand Manor Care, Inc
1718 W 9th Ave
Spokane, WA 99204

This document references the following complaint number(s): 221691

The following sample was selected for review during the unannounced on-site visit: 3 of 6 current residents and 0 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 — 05/20/2026 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) — 6/27/2026 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 388-112A-0495 What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities? Adult family homes.

(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 demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training.

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:

(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:

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Based on interview and record review, the facility failed to ensure that mental health specialty training occurred in the timeframe required for 1 of 2 staff (Staff C) and to ensure that basic training occurred in the timeframe required for 1 of 2 staff (Staff B). This failed practice placed residents at risk for inadequate care and decreased quality of life.

Findings included...

<Mental Health Specialty Training>

Review of an undated facility characteristic roster showed that the facility had six residents, all of whom had [redacted] diagnoses.

In an interview on 05/06/2026 at 11:04 AM, Staff A, Manager, stated that Staff C, Caregiver, was supposed to be working on their mental health specialty training. Staff A stated they were unsure when the mental health specialty training was due.

In an interview on 05/13/2026 at 11:24 AM, Staff E, Owner/Administrator, stated that Staff C's date of hire was 05/26/2025.

Review of Staff C's mental health specialty training certificate, dated 05/08/2026, showed that the training was not completed until that day, nearly one year from Staff C's date of hire.

<Basic Training>

In an interview on 05/06/2026 at 11:04 AM, Staff A stated they did not believe Staff B, Caregiver, had completed their basic training. Staff A stated they were unsure when the basic training was due. Staff A stated that Staff B's date of hire was in July 2025.

A request for record of Staff B's 75-hour basic training was made on 05/06/2026 at 12:10 PM and no record showing completion was provided.

In an email communication sent on 05/11/2026 at 1:48 PM, Staff A stated they spoke with Staff B and Staff B only had 54 hours of their 75-hour basic training done.

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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, Grand Manor Care, Inc is or will be in compliance with this law and / or regulation on (Date) 6/27/2026.

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

Administrator (or Representative) — Date: 6/27/2026

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update a resident's negotiated service agreement to include the resident's known use of illicit drugs for 1 of 1 resident (Resident 3). This failed practice placed Resident 3 at risk for inadequate supervision and response from staff when drug use occurred.

Findings included...

Per WAC 388-78A-2120, when incidents that were likely to adversely affect a resident's well-being were observed by or reported to staff persons, the resident was to be evaluated in order to determine if there was a need for further action. Appropriate action should be taken in response to each resident's changing needs.

Review of a progress note for Resident 3, dated 02/01/2026, showed that on that day, the resident told staff they had used methamphetamine (powerful, highly addictive synthetic stimulant that affects the central nervous system) for the previous two nights. The note showed that Resident 3 had been falling all over the place and was acting very strangely.

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Review of a progress note for Resident 3, dated 03/15/2026, showed that the resident had arrived home after being gone all night without checking in. The note showed that Resident 3 told staff they had used fentanyl (potent synthetic opioid) and methamphetamine the night before.

Review of a hospital after-visit summary for Resident 3, dated 03/27/2026, showed that the resident was seen at a hospital emergency department that day. Further review of the summary showed that Resident 3 was diagnosed with [redacted].

Review of a hospital after-visit summary for Resident 3, dated 04/11/2026, showed that the resident was seen at the hospital emergency department that day. The summary showed that the resident was provided with information related to addiction recovery while there.

Review of a progress note for Resident 3, dated 04/25/2025, showed that on that day, the resident admitted to staff that they had smoked methamphetamine.

In an interview on 04/30/2026 at 12:34 PM, Staff A, Manager, stated that Resident 3 had been using methamphetamine since about January 2026. Staff A stated that Resident 3's care plan did not reflect their drug use.

In an interview on 05/06/2026 at 9:03 AM, Staff C, Caregiver, stated that Resident 3 just came home high on fentanyl that morning after leaving the hospital against medical advice. Staff C stated that Resident 3 had recently been doing methamphetamine and fentanyl. Staff C said there was no specific protocol that staff were supposed to use when dealing with resident drug use, rather they just go about it like a normal day.

Review of Resident 3's negotiated service agreement, dated 05/21/2025, showed that it failed to reflect the resident's use of illicit drugs and that it failed to identify interventions to be used by staff when drug use was suspected or confirmed.

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

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, Grand Manor Care, Inc is or will be in compliance with this law and / or regulation on (Date) 6/27/2026 .

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

Administrator (or Representative) 6/27/2026 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff made a report to the department's Complaint Resolution Unit hotline when reasonable cause to believe that verbal abuse of residents occurred for 1 of 1 staff (Staff C). This failed practice precluded the department from initiating a timely investigation which placed residents at prolonged risk for verbal abuse and decreased quality of life.

Findings included...

Review of a facility policy, titled, "Detection of Abuse/Neglect," last revised 12/2018, showed that all suspected abuse or neglect of a vulnerable adult should be reported to the appropriate authorities to prevent further abuse and to safeguard the resident.

In an interview on 04/30/2026 at 9:52 AM, Resident 1 stated that if the residents did not do the right thing because they did not understand what Staff D, Caregiver, was saying, Staff D got mad. Resident 1 stated that Staff D also got mad when residents asked for something later than they were supposed to. Resident 1 stated that when Staff D got mad, they swore, got a mad tone, and raised their voice. Resident 1 stated that they felt like "nothing" when Staff D talked to them that way.

In an interview on 04/30/2026 at 10:09 AM, CC1, Anonymous Reporter, stated that Staff

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D was a bully. CC1 stated that Staff D yelled and they would "chew you out from head to toe." CC1 stated that because of that, residents did not want to tell Staff D what they wanted or needed. CC1 stated that Staff D needed to calm down. CC1 stated that when Staff D chewed them out, it made them cringe.

In an interview on 04/30/2026 at 10:20 AM, Resident 2 stated that Staff D let their frustrations out and yelled sometimes.

In an interview on 04/30/2026 at 10:46 AM, Staff D stated they had worked at the facility for eight years.

In an interview on 05/06/2026 at 8:53 AM, Staff C, Caregiver, stated that Staff D had been very angry toward the residents and Staff D became very frustrated with the residents very quickly. Staff C stated that Staff D yelled at the residents and it had been going on since Staff D started working at the facility. Staff C stated that Staff D treated all the residents that way. Staff C stated that all the residents complained about Staff D.

In an interview on 05/11/2026 at 11:50 AM, when asked if they ever made a report to the state reporting hotline regarding their concerns about Staff D's treatment of the residents, Staff C stated, "I don't remember. No." Staff C stated they told the residents it would be better coming from them.

Review of the department's reporting database showed no reports made by Staff C regarding verbal abuse of residents by Staff D.

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, Grand Manor Care, Inc is or will be in compliance with this law and / or regulation on (Date) 6/27/2026.

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

Administrator (or Representative) — Date: 6/27/2026

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or

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her individuality.

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;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that care was provided to residents in a manner that maintained or enhanced the residents' dignity for 2 of 2 residents (Residents 1 and 2). This failed practice resulted in feelings of decreased self-worth for Resident 1 and placed facility residents at risk for psychosocial harm and decreased quality of life.

Findings included...

In an interview on 04/30/2026 at 9:52 AM, Resident 1 stated that Staff D, Caregiver, would get mad if the residents did not do the right thing because they did not understand what Staff D was saying. Resident 1 stated that Staff D got mad when residents asked for something later than they were supposed to. Resident 1 stated that when Staff D got mad, they swore, got a mad tone, and raised their voice. Resident 1 stated that they felt like "nothing" when Staff D talked to them that way. Resident 1 stated that they talked to Staff A, Manager, about how Staff D treated them about three to four days prior, and that Staff A just said that Staff D was having a bad day and needed some time to themselves.

In an interview on 04/30/2026 at 10:09 AM, CC1, Anonymous Reporter, stated that Staff D was a bully. CC1 stated that Staff D yelled and they would "chew you out from head to toe." CC1 stated that because of that, residents did not want to tell Staff D what they wanted or needed. CC1 stated that when Staff D chewed them out, it made them cringe.

In an interview on 04/30/2026 at 10:20 AM, Resident 2 stated that Staff D let their frustrations out and yelled sometimes.

In an interview on 04/30/2026 at 12:34 PM, when told there were allegations of verbal abuse of residents against Staff D, Staff A stated they had not heard any complaints about Staff D yelling or swearing. Staff A then said there was one day when Staff D was arguing on the phone with someone. Staff A stated that maybe that was what brought on the concerns about Staff D yelling.

Review of a facility investigation, dated 04/28/2026 (the facility denied knowledge of the verbal abuse allegations against Staff D until notified of them by the department on 04/30/2026), showed that when asked what their thoughts or concerns were about staff

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doing their jobs, two residents mentioned that Staff D was "loud." Review of the investigation showed that Staff A spoke with Staff D about trying to have a calmer tone and that it was okay to walk away for a few minutes then go back to the situation at hand.

A request was made for any written staff education that was completed with Staff D following the verbal abuse investigation. Review of documented staff education, dated 05/01/2026, showed that on that day, Staff D was educated that "personal" verbal abuse could be interpreted as "patient" verbal abuse. Review of the education showed that Staff D was directed not to take personal calls at work, or to go to a private place where they could not be overheard. Review of the education showed that Staff D was directed to take a minute, calm down, and call the person back. Review of the education showed that the focus of the education was not on Staff D's treatment of the residents, rather on Staff D's phone etiquette with others while at work.

In an interview on 05/06/2026 at 8:53 AM, Staff C, Caregiver, stated that Staff D had been very angry toward the residents and Staff D became very frustrated with the residents very quickly. Staff C stated that Staff D yelled at the residents and that it had been going on since Staff D started working at the facility. Staff C stated that Staff D treated all the residents that way. Staff C stated they talked to Staff A about it in the past and Staff A just said, "You know how [Staff D] is." Staff C stated that all the residents complained about Staff D.

In an interview on 05/11/2026 at 11:50 AM, Staff C stated that some of the residents were afraid of Staff D. Staff C stated that they told Staff A every time Staff D was mean to the residents. Staff C stated there had been no change in how Staff D treated the residents since Staff D was removed from the schedule for one day during the facility's abuse investigation.

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, Grand Manor Care, Inc is or will be in compliance with this law and / or regulation on (Date) 6/26/2026.

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

Administrator (or Representative) — Date: 6/27/2026

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

Grande Manor Care INC
1718 W 9th Ave
Spokane WA 99204

June 30, 2026

Plan of Correction For Inspection Finding on 04/30/26

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

Administer and Manager will begin training with a week of hire. Weekly checks will be conducted with new employee as part of employment orientation.

WAC 388-78A-2130. Service agreement planning. The assisted living facility must:

Adm. And Manager will update all Service plans to reflect residents [redacted] diagnosis and treatments plans to prevent escalation.

WAC 388-78A-2630 Reporting Abuse and neglect. Grande Manor Adm staff will review and add more emphasis on the importances of being a mandated reporter.

WAC 388-78A-2660

Grande Manor Adm conducted Inservice on proper communication towards residents, staff and visitors.

Grande Manor Adm and Clinical Director will continue to education and monitor monthly.

Thank you
Israel Rodriguez 509-989-1843

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