STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

WWGHR LLC
WHEATLAND VILLAGE
1500 CATHERINE STREET
WALLA WALLA, WA 99362

RE: WHEATLAND VILLAGE License # 1640

Dear Administrator:

This letter addresses Compliance Determination(s) 72349 (Completion Date 02/03/2026) and 67996 (Completion Date 12/05/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/03/2026 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-2660-1, WAC 388-78A-2660-4, RCW 70.129.090.2, RCW 70.129.140.1, RCW 70.129.140.2.b, RCW 70.129.140.2.c

The Department staff who did the on-site verification:
Krista Connelly, Community Nurse Consultant

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: WHEATLAND VILLAGE
Provider Type: Assisted Living Facility
License/Cert.#: 1640
Compliance Determination #: 67996
Intake ID: 196557
Investigator: Krista Connelly
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/10/2025 through 12/05/2025
Complainant Contact Date(s):

Allegation(s):

1. The facility removed the Identified Resident's privately hired caregiver without their consent.
2. The facility put the Identified Resident on hourly safety checks during the night that caused confusion and distress.
3. The facility did not communicate with the identified residents Power of Attorney(POA) after request.
4. The Identified Resident missed evening medications.
5. Facility staff violated the Identified Resident's right to privacy.

Investigation Methods:

Sample:
Total residents:
Resident sample size: 4
Closed records sample size: 0

Observations:
Identified resident
Residents
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Identified staff
Residents
Family members
Outside care agency staff

Record Reviews:
Medical records
Hospital records
Incident investigation
Facility policies
Personnel files
Staff training records
Staff schedules
Resident Agreements

Investigation Summary:

1. Observation showed the Identified Resident was assigned a facility staff member to maintain a one to one caregiver during on-site investigations. Observation showed the facility staff watched TV with the Identified Resident in their apartment and cued them when it was time for meals. The Identified Resident stated there had been a change, could identify the facility staff as not the caregivers they hired and was not sure why. No failed practice was identified.
2. Observation showed the Identified Resident was able to walk using a walker and reported they did not require staff assistance with activities of daily living and did not need any assistance through the night. The Identified Resident stated they hired caregivers to stay with them during the day until they went to bed in the evening and did not want to be bothered during the night. The Identified Resident did not know why the facility staff started coming in their apartment during the night. Failed practice identified WAC 388-78A-2660.
3. The Identified Resident's POA reported neither they or the resident were included in the decision to deny the resident's private caregivers access to the resident. The resident's POA reported the facility was not responding to their emails, text messages and calls demanding the facility allow the private caregivers access to the Identified Resident. The facility administrator stated they were directed to not respond to the POAs requests. Failed practice identified WAC 388-78A-2660.
4. Observation showed the Identified Resident had a pill box filled weekly by their POA. In an Interview the POA stated the caregivers they hired cued the resident when it was time to take their medication and this did not occur the night the facility removed the caregivers. The Identified Resident's progress notes showed the facility staff were directed to cue them and ensure they took the medications as prescribed. Staff interviews showed the incident was isolated. Sampled residents stated they did not have any concerns that they were not getting their medications as ordered. No failed practice identified.
5. Observation did not reveal any private, protected information identifying the Identified Resident outside their apartment. Facility staff stated it is not their practice to leave private information outside of the resident's room. No failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: WHEATLAND VILLAGE
Provider Type: Assisted Living Facility
License/Cert.#: 1640
Compliance Determination #: 67996
Intake ID: 198757
Investigator: Krista Connelly
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/10/2025 through 12/05/2025
Complainant Contact Date(s):

Allegation(s):

1. The Identified Resident left the facility without staff awareness and was found near the street.
2. The Identified Resident left the facility without staff awareness on another occasion when the facility staff left them unattended.
3. The Identified Resident's POA arrived to visit and was visibly distressed.
4. The Identified Resident's phone does not get charged, it and their purse have gone missing.
5. Identified Resident left the facility without staff awareness.

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Identified staff Residents Family members Outside care agency staff
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Personnel files Staff training records Staff schedules Resident Agreements

Investigation Summary:

1. Interview with the Identified Resident stated they became confused in the evening and may have left the facility and not remember. The Identified Resident reported they hired private caregivers to stay with them until they go to bed. The Identified Resident stated they missed going outside facility. Staff interviews showed the resident liked to walk outside the facility and staff were directed to walk outside with them. Staff reported seeing the resident and following them out. No failed practice was identified.
2. Record Review of the Identified Resident's care plan showed the resident hired a private caregiver as a companion while they were awake. The Identified Resident's POA reported the facility did not ensure they had one caregiver assigned to them to cover the one on one companionship they used the private care agency for. POA reported finding the resident unattended, downstairs in the front lobby at approximately 6:30 in the evening. Staff interviews showed the facility did not always have facility staff available to work the entire time Resident 1 needed assistance for. No failed practice was identified.
3. Interviews with the Identified Resident showed the resident became more confused in the evening and they stated they needed supervision after the evening meal. The Identified Resident's care plan directed the staff to provide consistent care and allow them to make choices when they became confused. POA, facility staff interviews and observations showed the resident was aware of their private caregivers not were not allowed into the facility and she did not understand why. No failed practice was identified.
4. The Identified Resident did not recall losing their phone or purse, stated they kept each on their nightstand unless the phone was charging in the living room. Observation showed their purse on the nightstand near their bed and their phone charging in the living room area. No failed practice identified.
5. Interview with Identified Resident showed they did not remember leaving the facility. Interview with facility staff showed they had eyes on the resident at all times in the front lobby and then staff followed the resident out of the facility for safety. Record review of the care plan showed the staff were to follow the resident if the resident went outside of 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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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 10/10/2025 and 10/30/2025 of:

WHEATLAND VILLAGE
1500 CATHERINE STREET
WALLA WALLA, WA 99362

This document references the following complaint number(s): 196557, 198757

The following sample was selected for review during the unannounced on-site visit: 4 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Krista Connelly, Community Nurse Consultant

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Stasi Oilg, IDR PM for Laura Williams-Davis
Residential Care Services

January 16, 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.

Ann Adams
Administrator (or Representative)

1/28/2026
Date

RCW 70.129.090 Advocacy, access, and visitation rights.

(2) The facility must provide reasonable access to a resident by his or her representative or an entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

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 her individuality.

(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:

(b) Interact with members of the community both inside and outside the facility;

(c) Make choices about aspects of his or her life in the facility that are significant to the resident;

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(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 reviews, the assisted living facility (ALF) failed to promote dignity, respect and allow each resident to make choices regarding the care they received for 3 of 3 residents (Resident 1, 2 & 3.) This failure resulted in residents rights and choices being violated when the ALF denied and restricted privately hired caregivers for Resident 1, 2, and 3.

Findings included...

During an interview on 11/05/2025 at 12:06 PM, Collateral Contact 5 (CC5), Care Agency Owner, stated they owned a private caregiving agency that provided private caregiving for Residents 1,2 & 3. CC5 reported the evening of 10/07/2025 at 5:00 PM, ALF facility staff went to each privately hired caregiver working with Residents 1, 2 and 3 and escorted them out of the facility. CC5 stated the facility continued to deny access to the private caregivers for Resident 1, 2, and 3.

Resident 1

Review of Resident 1's Assisted Living Agreement, dated 07/17/2024, showed the resident had the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. The agreement showed Resident 1 had the right to choose activities, schedules and health care consistent with their interests, assessments, plans of care and to interact with members of the community both inside and outside the facility. The agreement was signed by Collateral Contact 3 (CC3), Power of Attorney for Resident 1, on 07/17/2024.

During an interview on 11/05/2025 at 12:06 PM, Collateral Contact 5 (CC5), Care Agency Owner, stated they owned a private caregiving agency that provided private caregiving for Residents 1,2 & 3. CC5 reported the evening of 10/07/2025 at 5:00 PM, ALF facility staff went to each privately hired caregiver working with Residents 1, 2 and 3 and escorted them out of the facility. CC5 stated the facility continued to deny access to the private caregivers for Resident 1, 2, and 3.

Review of Resident 1's care plan, dated 10/16/2025, showed the resident hired and received companionship from an outside care agency daily. The care plan showed the resident was at risk for isolation, had a history of wandering, a history of feeling a burden to others and making suicidal statements. The care plan showed Resident 1 needed a consistent routine, frequent redirection, validation of their feelings and the safety provided by their private caregivers from the time they woke up until they went to bed. The care plan showed the resident needed to have personal choices and encouraged independence.

In an interview on 10/30/2025 at 8:49 AM, CC3 reported Resident 1 had been unattended by facility staff on three occasions, was declining cognitively and emotionally without their hired caregivers. CC3 reported their concern that some of the facility staff were encouraging Resident 1 to stay in their room rather than allowing the resident to maintain the daily routine with their hired companion.

During an interview on 11/05/2025 at 12:06 PM, CC5 stated they had provided a private caregiver for Resident 1. CC5 stated Resident 1 had been using the caregiving agency

for several months.

As of 11/25/2025, the ALF facility had denied the caregivers access to Resident 1 since 10/07/2025 for a total of 49 days.

Resident 2

Review of Resident 2's Assisted Living Agreement, dated 06/24/2024, that showed the resident had the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. The agreement showed Resident 21 had the right to choose activities, schedules and health care consistent with their interests, assessments, plans of care and to interact with members of the community both inside and outside the facility. The agreement was signed by Resident 2 on 06/24/2024.

Review of Resident 2's care plan, dated 09/29/2025, showed the resident hired and received cares from an outside care agency daily. The care plan showed Resident 2 needed assistance from caregivers that were sensitive to their care needs, knew their care routines, gave them choices and encouraged independence.

In an interview on 09/30/2025 at 3:41 PM, Collateral Contact 2 (CC2), Power of Attorney, reported they were concerned about the facility denying the private caregivers access to the resident. They stated Resident 2 needed and enjoyed the time the caregivers were able to spend with them. CC2 reported their concern that the facility denied the caregivers access to Resident 2 for an unrelated incident involving another resident. CC2 stated they were unsure of the facility's intention by keeping the resident's hired caregivers away from them.

During an interview on 11/05/2025 at 12:06 PM, CC5 stated they had provided a private caregiver for Resident 2. CC5 stated Resident 2 had been using the caregiving agency for two years.

As of 11/25/2025, the ALF facility had denied the caregivers access to Resident 2 since 10/07/2025 for a total of 49 days.

Resident 3

Review of Resident 3's Assisted Living Agreement, dated 12/11/2023, that showed the resident had the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. The agreement showed Resident 1 had the right to choose activities, schedules and health care consistent with their interests, assessments, plans of care and to interact with members

of the community both inside and outside the facility. The agreement was signed by Resident 3 on 12/11/2023.

Review of Resident 3's care plan, dated 04/09/2025, showed the resident was alert, oriented and had a multisystem degeneration of their autonomic nervous system (a rare progressive disease that impairs bodily functions like blood pressure, heart rate, ability to move their muscles, speaking, swallowing and digesting food.) The care plan showed Resident 3 used a typing communication keyboard and needed physical assistance to perform all activities of daily living. The care plan showed Resident 3 was a vegetarian and needed physical assistance to eat lunch and dinner.

During an interview on 10/10/2025 at 2:10 PM, Resident 3 reported their condition was one that would continue to decline, and they needed more physical help from the facility staff than they were able to provide. The resident reported that the facility told their power of attorney they had to hire an outside agency caregiver to assist them with meals and prevent them from choking. Resident 3 knew the caregivers they hired from an outside caregiving agency were not allowed in the facility anymore and they were not aware of the reason why.

During an interview on 10/14/2025 at 12:56 PM, Collateral Contact 4 (CC4), Power of Attorney for Resident 3, reported the resident's ability to use their fine motor skills (small muscles in the hands and fingers to perform precise movements) continued to decline. CC4 stated this impaired the resident's ability to communicate and feed themselves. CC4 reported a year ago that the facility told them Resident 3 needed more physical assistance during meals and they could not provide this level of assistance using their facility staff. CC4 stated the facility gave them three options, move the resident into the secured memory unit, move out of the facility into another facility or hire a private caregiver to provide the resident with the assistance they needed at meals. CC4 reported Resident 3 did not have any memory problems, was not confused and did not want to move from their apartment so they hired a private caregiver for lunch and dinner. CC4 stated the caregiver had cared for the resident for almost a year, Resident 3 was comfortable with them and enjoyed their company. CC4 reported they felt the facility had a falling out with the care agency which resulted in the caregiver not being allowed to visit the resident. CC4 expressed concern that the facility staff could not give Resident 3 the time and assistance they needed as their condition continued to decline.

During an interview on 11/05/2025 at 12:06 PM, CC5 stated they had provided a private caregiver for Resident 3. CC5 stated Resident 3 had been using the caregiving agency for a year.

As of 11/25/2025, the ALF facility had denied the caregivers access to Resident 2 since 10/07/2025 for a total of 49 days.

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, WHEATLAND VILLAGE is or will be in compliance with this law and / or regulation on (Date) 1/14/2026 .

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

Ann Adams

Administrator (or Representative)

1/27/2026

Date

Laura Williams-Davis
State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
1200 Alder Street
Union Gap, WA 98903

January 27, 2026

Re: Wheatland Village License #1640

Dear Laura Williams-Davis,

I am reaching out on behalf of Wheatland Village about our recently amended Statement of Deficiencies. We are grateful we were given the opportunity to present in more depth our experience in dealing with Sparrowcore, an unlicensed service provider providing services to our residents beyond the scope of companion care in our community. We appreciate the work that you, Staci Dilig and Krista Connelly put into your review and findings.

We had intended to request removal of 197557 and 198757 as well but honestly it was an oversight on our end to include those. We would like to request your reconsideration to remove those as well. Both situations were consistent with the challenges we were being presented by Sparrowcore misrepresenting themselves as providing services they are unlicensed to provide. Our resident safety is our top priority. Our numerous attempts to strike the proper balance were constantly challenged.

Regarding RCW 70.129.090 Advocacy, access, and visitation rights.

We will continue to allow essential support personnel as chosen by the Resident/POA. We agree to follow reasonable conditions. Services provided by their essential support personnel should be mutually agreed upon with clarity of their role and responsibilities. We will remain committed to open communication, honoring resident safety, rights and quality of life. Ongoing collaboration with service providers is key to promoting continuity of care and best practices for delivering the quality of care we are committed to providing.

Regarding RCW 70.129.140 Quality of Life Rights

We are fully committed to always providing all residents with dignity and respect. We continue to encourage residents to advocate for their personal choices and keep open communication to honor their wishes. We are proud of the services, choices and resources we provide to help our residents live their lives to the fullest possible.

Most Sincerely,

Ann Adrian
Sr Ex. Director
Wheatland Village
aadrian@generationsllc.com
509-524-4002