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

06/12/2025

CRH CHRISTOPHER HOUSE LLC
CHRISTOPHER HOUSE
100 S Cleveland Ave
Wenatchee, WA 98801

RE: CHRISTOPHER HOUSE # 2067

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 60231 (Completion Date 06/12/2025) and 56502 (Completion Date 04/02/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/12/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(2) All long-term care facilities shall fully disclose to potential residents or their legal representative the service capabilities of the facility prior to admission to the facility. If the care needs of the applicant who is medicaid eligible are in excess of the facility's service capabilities, the department shall identify other care settings or residential care options consistent with federal law.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(d) Include in the notice the items described in subsection (5) of this section.

(5) The written notice specified in subsection (3) of this section must include the following:

(f) For residents who are mentally ill, the mailing address and telephone number of the

agency responsible for the protection and advocacy of mentally ill individuals established under the protection and advocacy for mentally ill individuals act.

(6) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(7) A resident discharged in violation of this section has the right to be readmitted immediately upon the first availability of a gender-appropriate bed in the facility. [1997 c 392 205; 1994 c 214 12.] NOTES: Short title -- Findings -- Construction -- Conflict with federal requirements -- Part headings and captions not law -- 1997 c 392: See notes following RCW 74.39A.009 .

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

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

The Department staff who did the On Site verification:
Nicole Mcgraw, Community Complaint Investigator

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: CHRISTOPHER HOUSE **Provider Type:** Assisted Living Facility
License/Cert.#: 2067
Compliance Determination #: 56502 **Intake ID:** 169525
Investigator: Nicole Velazquez **Region/Unit #:** RCS Region 1 / Unit G
Investigation Date(s): 03/18/2025 through 04/02/2025
Complainant Contact Date(s):

Allegation(s):

1) Two residents were discriminated against.
2) A named resident was abused and financially exploited.
3) A named resident did not receive their medications for a week.
4) A named resident does not get food when they stay in bed.
5) The facility is prejudice against a named resident.
6) Residents are being left with little money from their disability checks.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 6 Closed records sample size: 1
Observations:	Environment, Cares, Resident to resident interactions, Staff to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident records, Facility policy, Facility incident report and investigation,

Investigation Summary:

1) Observations showed that staff to resident interactions were appropriate and respectful. Resident interviews showed that staff treated them with respect and declined being discriminated against. Staff interview and record review showed that the named resident had mental health issues that made it difficult for them to comprehend certain situations. No failed practice identified.
2) Observations showed staff to resident and resident to resident interactions were appropriate and respectful. Resident interviews showed that other residents and staff treated them with respect and they felt safe. Staff interview and record review showed that that the facility had investigated all allegations and ruled out abuse. No failed practice identified.
3) Interview and record review showed that the named resident missed medications for one week causing them a decline in their wellbeing. Failed Practice Identified, WAC 388-78A-2240 reference Statement of Deficiencies dated 03/26/2025.

4) Interview and record review showed that the named resident made a choice not to eat meals and stay in bed. Residents could request snacks if they were hungry between meals. No failed practice identified.
5) Observations showed that staff to resident interactions were appropriate and respectful. Staff were observed to treat all residents equally. Resident interviews showed that they did not feel like staff treated residents differently that others. Staff interviews and record review showed that a named resident had difficulty understanding that all residents have interventions put into place when facility rules were not followed. No failed practice identified.
6) Interview and record review showed that each resident receive their allotted amount of money determined by the state and the facility distributes that money each month. Resident interviews showed that a named resident had government mistrust with altered thought processes which made them believe situations were different than they were.

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: CHRISTOPHER HOUSE **Provider Type:** Assisted Living Facility
License/Cert.#: 2067
Compliance Determination #: 56502 **Intake ID:** 169937
Investigator: Nicole Velazquez **Region/Unit #:** RCS Region 1 / Unit G
Investigation Date(s): 03/18/2025 through 04/02/2025
Complainant Contact Date(s):

Allegation(s):
A resident to resident altercation.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 6 Closed records sample size: 1
Observations:	Environment, Cares, Resident to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident records, Facility policy, Facility incident report and investigation.

Investigation Summary:
Observations showed that resident to resident interactions were appropriate and respectful. Staff were observed to be available and responsive to resident's needs. Resident interviews showed that they did not have issues with others residents and that they felt safe. Staff interview and record review showed that staff intervened, separated the residents and followed their policy to investigate. All notifications were made. Care plans were reviewed and updated as needed. No failed practice identified.

Conclusion / Action:

- ☐ 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: CHRISTOPHER HOUSE **Provider Type:** Assisted Living Facility
License/Cert.#: 2067
Compliance Determination #: 56502 **Intake ID:** 170066
Investigator: Nicole Velazquez **Region/Unit #:** RCS Region 1 / Unit G
Investigation Date(s): 03/18/2025 through 04/02/2025
Complainant Contact Date(s):

Allegation(s):
A resident received an immediate discharge notice.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 6 Closed records sample size: 1
Observations:	Environment, Residents
Interviews:	Staff and others not associated with the facility
Record Reviews:	Characteristic roster, Resident record, facility policy, department records

Investigation Summary:
Observations showed that residents were appropriately dressed. Interview and record review showed that the named resident was discharged without appropriate medication assessment and was inappropriately discharged. Failed Practice Identified, WAC 388-78A-2660 reference Statement of Deficiencies dated 03/26/2025.

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: CHRISTOPHER HOUSE **Provider Type:** Assisted Living Facility
License/Cert.#: 2067
Compliance Determination #: 56502 **Intake ID:** 170576
Investigator: Nicole Velazquez **Region/Unit #:** RCS Region 1 / Unit G
Investigation Date(s): 03/18/2025 through 04/02/2025
Complainant Contact Date(s):

Allegation(s):
A named resident left the facility and did not return.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 6 Closed records sample size: 1
Observations:	Environment, Cares, Residents, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident records, Facility policy, Facility incident report and investigation.

Investigation Summary:
Observations showed that staff were observed to be available and responsive to resident's needs. The named resident was observed to be clean and groomed. Interview and record review showed that the named resident returned to the facility safe without incident. No failed practice identified.

Conclusion / Action:

- ☐ 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: CHRISTOPHER HOUSE **Provider Type:** Assisted Living Facility
License/Cert.#: 2067
Compliance Determination #: 56502 **Intake ID:** 170187
Investigator: Nicole Velazquez **Region/Unit #:** RCS Region 1 / Unit G
Investigation Date(s): 03/18/2025 through 04/02/2025
Complainant Contact Date(s):

Allegation(s):
A resident to resident altercation.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 6 Closed records sample size: 1
Observations:	Environment, Cares, Resident to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, staff and others not associated with the facility.
Record Reviews:	Characteristic roster, resident records, facility policy, facility incident reports and investigation.

Investigation Summary:
Observations showed that residents were appropriately dressed. Staff were observed to be available and responsive to resident's needs. Resident interviews showed that other residents treated them with respect and that they felt safe. Staff interview and record review showed that the facility responded immediately, separated the two residents and followed their policy. All notifications were made. Care plans were reviewed and updated as needed. No failed practice identified.

Conclusion / Action:

- ☐ 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: CHRISTOPHER HOUSE **Provider Type:** Assisted Living Facility
License/Cert.#: 2067
Compliance Determination #: 56502 **Intake ID:** 171546
Investigator: Nicole Velazquez **Region/Unit #:** RCS Region 1 / Unit G
Investigation Date(s): 03/18/2025 through 04/02/2025
Complainant Contact Date(s):

Allegation(s):
A resident to resident altercation.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 6 Closed records sample size: 1
Observations:	Environment, Cares, Resident to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, resident records, facility policy, facility incident report and investigaion.

Investigation Summary:
Observations showed that resident to resident interactions were appropriate and respectful. Staff were observed to be available and responsive to resident's needs. Resident interviews showed that that they felt safe and staff would respond when there were issues between residents. Staff interview and record review showed that staff intervened, separated the residents and followed their policy to investigate and made all notifications. Care plans were reviewed and updated as needed. No failed practice identified.

Conclusion / Action:

- ☐ 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

Statement of Deficiencies	License #: 2067	Compliance Determination #56502
Plan of Correction	CHRISTOPHER HOUSE	Completion Date
Page 1 of 6	Licensee: CRH CHRISTOPHER HOUSE LLC	04/02/2025

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 03/18/2025 of:

CHRISTOPHER HOUSE
100 S Cleveland Ave
Wenatchee, WA 98801

This document references the following complaint number(s): 169525, 169937, 170066, 170187, 170576, 171546

The following sample was selected for review during the unannounced on-site visit: 6 of 71 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, Community Complaint Investigator

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.

Laura Williams-Davis
Residential Care Services

04/11/2025
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.

Karina Valencia
Administrator (or Representative)

4/21/2025
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure that a resident received their medications timely and as prescribed for 1 of 1 resident (Resident 2). This failure resulted in Resident 2 not receiving their medications as prescribed and contributed to their mental health decline and hospital admission.

Findings included...

Resident 2's facility assessment showed that the resident had [redacted] diagnoses including [redacted]. The resident required assistance with taking their medications.

Review of resident 2's 12/07/2024 physician orders showed that the resident was to received Clozapine (a medication used to reduce the risk of suicidal behaviors in adults with schizophrenia). The resident was to be administered per physician's orders, Clozapine 100 mg, three tablets in the morning and Clozapine 200mg, two tablets at bedtime.

Review of Resident 2's January 2025, Medication Administration Record (MAR), showed that Resident 2, missed 10 doses (01/02/2025-01/07/2025) of Clozapine.

Review of Resident 2's 01/02/2025 to 01/07/2025 progress note, did not show any documentation by the facility staff to obtain the Clozapine in a timely manner.

Resident 2's 01/08/2025 progress note, showed that the resident was sent to the hospital and told the hospital staff that they did not feel like they could keep themselves safe if they returned to the facility. The resident further stated that they were having suicidal ideations and was admitted to [redacted] for [redacted].

During an interview on 03/21/2025 at 11:17 AM, Staff B, Wellness Director stated that Resident 2 should have been sent to the hospital to get a medication refill for the Clozapine that they had missed 10 doses.

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, CHRISTOPHER HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~4/30/2025~~ 05/17/2025 .

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

Karina Valencia — Administrator (or Representative)

4/21/2025 — Date

Per facility ED, Karina Valencia, via telephone on 04/25/2025, the BIC date has changed to 05/17/2025. ME

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(2) All long-term care facilities shall fully disclose to potential residents or their legal representative the service capabilities of the facility prior to admission to the facility. If the care needs of the applicant who is medicaid eligible are in excess of the facility's service capabilities, the department shall identify other care settings or residential care options consistent with federal law.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(d) Include in the notice the items described in subsection (5) of this section.

(5) The written notice specified in subsection (3) of this section must include the following:

(f) For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the protection and advocacy for mentally ill individuals act.

(6) A facility must provide sufficient preparation and orientation to residents to ensure

safe and orderly transfer or discharge from the facility.

(7) A resident discharged in violation of this section has the right to be readmitted immediately upon the first availability of a gender-appropriate bed in the facility. [1997 c 392 205; 1994 c 214 12.] NOTES: Short title -- Findings -- Construction -- Conflict with federal requirements -- Part headings and captions not law -- 1997 c 392: See notes following RCW 74.39A.009 .

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

(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 Assisted Living Facility failed to ensure reasonable accommodations were made to avoid an unsafe discharge and failed to provide a resident with a discharge notice within the required timeframe that included a mental health agency's contact information and failed to readmit for 1 or 1 resident (Resident 1). These failures resulted in an unsafe discharge and the resident not having housing.

Findings included...

Review of 02/01/2021 facility policy titled, "Discharging Residents," showed that the facility would provide sufficient preparation to assure a discharge would be safe and orderly.

Review of 02/11/2025 Department's Comprehensive Assessment Reporting Evaluation, noted that Resident 1 required assistance with medication management. Resident 1 was not able to recall doses and types of medication they were prescribed. The document further stated that the resident needed reminders as they would forget to take their medications. The resident had multiple stays at a [redacted] when they would stop taking their medications. Furthermore, the resident required supervision of medication administration due to history of holding pills in their cheek and not swallowing them.

Resident 1's 02/25/2025 preadmission assessment completed by Staff D, Social Worker, noted that the resident was aware that they were on medications but was not aware of what their medications were.

Review of facility record showed that Resident 1 was admitted to the facility on [redacted]/2025.

Review of Resident 1's progress note dated 02/27/2025 at 6:44 PM, showed that Staff C, Medication technician, noted that they had to check the resident's mouth after giving

the resident their pills to make sure they swallowed all their pills.
Review of Resident 1's 03/03/2025 Negotiated Service Agreement, (NSA) showed the resident had diagnoses of [redacted] and [redacted]. The NSA did not have the resident's mental health disorders nor behavior interventions listed on the NSA to provide staff with guidance. The document further showed that they required medication supervision, including that facility staff were to set out the medications to prevent the resident from having confusion.

Review of Resident 1's facility record showed that they discharged from the facility on [redacted]/2025 (5 days after admission).

Review of Resident 1's discharge notice dated [redacted]/2025, showed that the reason for immediate discharge was due to the residents' needs not being able to be met in the facility and "Due to the Department of Social and Health Services Error in their service code facility is unable to meet clients care needs." The document did not have the agency's contact information that was responsible for the protection and advocacy of the resident's mental illnesses.

Interview on 03/18/2025 at 11:58 AM, Staff A, Executive Director, stated that Resident 1 was provided an immediate discharge notice from the facility because Resident 1 could become unstable and unpredictable and "no one could guarantee that they would not put other residents at risk of harm". Staff A further stated that when they realized the [redacted] daily rate was going to change from $354.00 to $109.00, that they needed to discharge the resident and that their Corporate Office would not want the facility to keep Resident 1 because of the significant decreased in the daily rate.

Interview on 03/18/2025 at 11:19 PM, Staff A stated there were no concerns regarding behaviors that would put Resident 1 or others at risk. Staff A stated that Resident 1 did need supervision, and that the facility was able to provide the resident with medication management and routine supervision. Staff A confirmed that no attempt for reasonable accommodations were made and Resident 1's discharge was unsafe as they had planned to discharge the resident to a homeless shelter or motel with their medications. A medication assessment was not done to assure the resident was safe taking their medications on their own without supervision.

During an interview on 03/20/2025 at 5:23 PM, Staff A had stated that despite the facility's responsibility under Revised Code of Washington (RCW) 70.129.110 section 7 to readmit Resident 1 when the resident's discharge was in violation of the RCW, they were not going to readmit the resident to their facility.

During an interview on 03/21/2025 at 8:23 AM Collateral Contact 1 (CC1), Case Manager, stated that Resident 1 was living on the streets, and Resident 1 was not taking their medications as prescribed.

Interview on 3/28/2025 at 12:19 PM, CC1 stated that they had sent a referral for Resident 1 to be considered for readmission to the facility. Staff A responded to the referral saying that they would not consider the resident for readmission until Resident 1 was approved for the $354.00 daily rate.

On 04/02/2025 at 9:48 AM, Staff A stated they do have male bed availability at the facility.

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, CHRISTOPHER HOUSE is or will be in compliance with this law and / or regulation on (Date) ~~4/30/2025~~ 05/17/2025 .

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

Karina Valencia — Administrator (or Representative)

4/21/2025 — Date

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