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

06/04/2025

Highgate Wenatchee LP
HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

RE: HIGHGATE SENIOR LIVING # 2225

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 60633 (Completion Date 06/04/2025) and 53343 (Completion Date 04/11/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/04/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(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;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

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

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

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

WAC 388-78A-2371 Investigations. The assisted living facility must:

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

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.

The Department staff who did the On Site verification:
Tracy Ramirez, Assisted Living Facility Licensor

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: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 53343
Investigator: Brittney Shull
Investigation Date(s): 01/21/2025 through 04/11/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 160132
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
There was a resident-to-resident altercation.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 2 Closed records sample size: 1
Observations:	Environment, Resident to resident interactions, Staff availability and responsiveness, Staff to resident interactions.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Resident Assessment, Negotiated Service Agreement, Progress Notes, Incident Report and Investigation, Police Report, Admission Agreement.

Investigation Summary:
Observations showed that staff were available and responsive to resident needs. Interview and record review showed that there was a resident to resident altercation. Interview and record review showed that the named resident had previous behaviors of aggression and there were no protective measures in place after the prior incident. The facility discharged one of the residents involved in the altercation a few hours after the incident. Interview and record review showed that the facility did not provide a written discharge notice to the discharged resident. Interview and record review showed that the facility staff did not cooperate with the Department during the course of the investigation. Failed practice identified, WAC 388-78A(2130), WAC 388-78A(2660), RCW 70.129(110), and WAC 388-78A(3170). Reference Statement of Deficiencies and Consultation dated 04/11/2025.

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: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 53343
Investigator: Brittney Shull
Investigation Date(s): 01/21/2025 through 04/11/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 161439
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
The named resident had a witnessed fall with injury.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 2 Closed records sample size: 1
Observations:	Environment, Resident to resident interactions, Staff availability and responsiveness, Staff to resident interactions.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Resident Assessment, Negotiated Service Agreement, Progress Notes, Incident Report and Investigation.

Investigation Summary:
Observations showed that staff were available and responsive to resident needs. Interview and record review showed that the named resident had a witnessed fall with injury. Interview and record review showed that the named resident had a significant change prior to the incident and their negotiated service agreement was not updated to reflect the significant change. Failed practice identified, WAC 388-78A(2371). Reference Statement of Deficiencies dated 04/11/2025.

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

Statement of Deficiencies	License #: 2225	Compliance Determination # 53343
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 1 of 14	Licensee: Highgate Wenatchee LP	04/11/2025

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 01/21/2025 and 02/26/2025 of:

HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

This document references the following complaint number(s): 160132, 161439

The following sample was selected for review during the unannounced on-site visit: 2 of 56 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, 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

Statement of Deficiencies	License #: 2225	Compliance Determination # 53343
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 2 of 14	Licensee: Highgate Wenatchee LP	04/11/2025

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

04/17/2025
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.

Administrator (or Representative)

4/25/25
Date

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(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;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to attempt a reasonable accommodation to avoid a discharge, issue a written discharge notice to the resident and their representative, and failed to provide sufficient preparation for a discharge for 1 of 1 resident (Resident 1). This failure resulted in a violation of resident rights for Resident 1.

Findings included...

Review of the facility policy titled, "Responding to Unexpected or Unpredictable Resident Behavior," dated August 2016, showed that the facility recognized that residents with dementia experienced significant

distress because of their disease process and might demonstrate unpredictable behavior as a way of communicating when they felt threatened or not understood. It also showed that residents moving into an unfamiliar environment might experience transfer trauma and then would settle in well once they were adjusted.

Review of the Resident Admission Agreement, dated February 2024, showed that if a resident was discharged due to the health or safety of individuals in the community, a discharge notice would be given as soon as possible.

Review of Resident 1's Facility Face Sheet showed that Resident 1 was admitted on [redacted]/2024.

Review of Resident 1's Negotiated Service Agreement, dated 12/04/2024 showed that Resident 1 had moved directly into memory care, had difficulty with transitions, and required frequent safety checks at night until they were adjusted to the new living situation.

Record review of a Resident 1's transferring facility Face Sheet showed that the new facility was unable to admit Resident 1 to another facility until [redacted]/2024.

On 01/21/2025 at 11:43 AM, Staff A, Executive Director, stated that Resident 1 had an altercation with another resident, they believed Resident 1 needed a single occupancy room that was not available, and due to safety concerns, Resident 1 needed to discharge immediately. Staff A stated that they notified Resident 1's family on [redacted]/2024 (8 days after admission) over the telephone. Staff A stated that a written discharge notice was not given to Resident 1 or their representative.

Review of Resident 1's record on 01/21/2025 showed that there was no record of a written discharge notice.

Review of an Incident Report dated [redacted]/2025, showed that Resident 1 was involved in a resident-to-resident altercation at 5:00 AM. It also showed that that Resident 1 was discharged from the facility the same day, [redacted]/2025 at 10:00 AM.

On 01/30/2025 at 4:50 PM, Collateral Contact 1 (CC1), stated that they received a phone call at 6:15 AM on [redacted]/2025 and were told about the resident-to-resident incident and that Resident 1 would not be allowed to reside at the facility. CC1 stated that it was expressed to them that there was a zero-tolerance policy for the incident and Resident 1 could not stay another

night. CC1 stated that Resident 1 had only resided at the facility for 1 week and CC1 was not aware of Resident 1's rights as a long-term care resident. CC1 stated they did not receive a written discharge notice. CC1 lastly stated that Staff A told them that Resident 1 would be emergently transferred to another facility, but they received a call from the transferring facility's sale representative stating otherwise. CC1 stated that they packed up Resident 1's belongings to move them back to their previous assisted living with their spouse, but did not know that was not allowed, so Resident 1 had to stay with other family members unexpectantly. CC1 lastly stated that they did not have sufficient time to coordinate the discharge.

On 02/24/2025 at 1:44 PM, Staff A stated that they did not attempt to accommodate Resident 1 before they were discharged.

Statement of Deficiencies	License #: 2225	Compliance Determination # 53343
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 5 of 14	Licensee: Highgate Wenatchee LP	04/11/2025

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 5/9/25 .

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

Administrator (or Representative) — Date: 4/25/25

WAC 388-78A-2371 Investigations. The assisted living facility must:

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to protect a resident by not identifying and implementing measures to prevent future incidents for 1 of 3 residents (Resident 2). This failure placed residents at risk of not having preventative measures identified and implemented.

Findings included...

Review of the facility, "Incident/Accident Reporting Policy," dated 07/2022, showed that an incident or accident (unexpected or unintended) was an event that could cause a resident injury. The policy showed that an incident/accident report should be completed for falls, accidents, injuries, altercations, suspected abuse or neglect, or any other unusual event that affected the safety or welfare of a resident. It showed that incidents required to be investigated by state requirements should use the Investigation Summary Template.

Review of the "Incident Investigation Summary," template showed that summary of the incident would include updates to the service plan, and what could be done to prevent the incident from happening again.

Resident 1

Review of Resident 1's facility Assessment, dated 12/04/2024, did not show any behaviors of aggression or abuse (screaming, threatening, hitting others). It did not show any updates to their assessment after a resident-to-resident altercation on 12/19/2024.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 12/04/2024, did not show any interventions for behaviors of aggression or abuse. It did not show any updates to Resident 1's NSA after the resident-to-resident altercation on 12/19/2024.

Resident 2

Review of Resident 2's facility Assessment, dated 10/04/2024, showed that Resident 2 had started hospice care on 09/14/2024, spoke in word salad (mixed up words that do not form complete thoughts or sentences), was fully dependent upon staff for all activities of daily living (ADL, dressing, showers, mobility, transfers), and had to be pushed in a wheelchair by others.

Altercation 1

Record review on of the facility "FYI (For Your Information) Forms," for Resident 2 showed that:

On 12/14/2024, Resident 1 was found "messing" with Resident 2 at 1:00 AM rounds.

On 12/19/2024, Resident 1 was aggressive with Resident 2 and required facility staff to redirect Resident 1 out of the room for Resident 2's safety. It showed that Resident 1 had yanked Resident 2's blankets, attempting to get Resident 2 out of bed and Resident 1 told staff that they wanted Resident 2 out of their room.

On 03/28/2025 at 1:39 PM, Staff E, Care Partner, stated that on 12/19/2024, during rounds, Staff E saw that the door to Resident 1 and Resident 2's room was open, and Resident 1 was next to Resident 2 aggressively throwing pillows and sheets around attempting to hit Resident 2. Staff E stated that they had to remove Resident 1 from the room and redirect Resident 1. Staff E stated that Resident 2 seemed scared. Staff E stated that they told Staff A, Executive Director, about the incident on 12/20/2024.

On 03/20/2025 at 4:42 PM, Staff A, Executive Director, stated that there was no incident report (or investigation) for Resident 1 or Resident 2 for the incident on 12/19/2024.

Altercation 2

Review of an Incident Report and attached Alert Note dated [redacted]/2024, showed that Staff C, Care Partner, responded to screaming in a resident room. Staff C found Resident 2 on the floor covering their face protecting themselves and Resident 1 screaming to Resident 2 to get out of the room. The Incident Report noted a rug burn to Resident 1's face. The Alert Note showed that video monitoring used for falls captured Resident 1 pulling Resident 2 out of bed.

Record review of a Police Report dated [redacted]/2024, showed that a staff member from the facility reported to Emergency Medical Systems (EMS) that Resident 1 urinated on Resident 2, hit them with a blanket and fists, strangled them, and pulled them out of bed. The police report noted that Law Enforcement reviewed video surveillance provided from a fall monitoring program and observed Resident 1 urinating on Resident 2's bed, pulled Resident 2 off their bed, and used a pillow and a sheet or blanket to strike Resident 1. The police report also noted that Resident 1 yelled at Resident 2 and pointed towards the door which they believed was Resident 1 telling Resident 2 to leave the room.

Record review of the facility FYIs for Resident 2 on showed that:

-On [redacted]/2024, Resident 2 screamed, which alerted staff to respond. Resident 1 was "uncontrollable," yelling to get Resident 2 out of the room. The incident required all 3-night shift staff to respond and redirect Resident 1 out of the room and calm Resident 1 down. It further showed that facility staff reviewed the fall video surveillance footage, and that Resident 1 had "assaulted" Resident 2.

-On [redacted]2024, Resident 2 had bruising to their right wrist.

Review of Resident 2's Hospice Notes showed:

-On 12/22/2024, Resident 2 had discoloration to their right wrist and both lower legs after the altercation with their roommate.

On 01/21/2025 at 11:43AM with Staff A, Executive Director, and Staff B, Healthcare Director, Staff B stated that they did not investigate the altercation between Resident 1 and Resident 2. Staff B stated that they did not implement a temporary care plan or make any updates to either resident's NSA.

On 01/21/2025 at 12:49 PM, Resident 2 was observed sitting in a tilt in space wheelchair (specialized wheelchair that reclines for people who do not have core strength to sit upright). Resident 2 did not awaken to voice or touch. Resident 2 was thin, had visible bony prominences, sunken cheeks, and appeared frail. Staff I, Care Partner, stated that Resident 2 had been alert enough to eat lunch, but was very fatigued. Staff I stated that Resident 2 would not be able to defend themselves in an altercation. Staff I stated that Resident 2 required full care (staff assistance with every activity of daily living).

On 2/11/2025 at 1:37 PM, Staff A stated that the Incident Report was the entire investigation for the incident on [redacted]/2025.

On 02/19/2025 at 12:18 PM, Staff C stated that they responded to the resident-to-resident altercation on [redacted]/2024 and completed the Incident Report. Staff C stated that they summoned additional staff to assist via radio during the altercation because Resident 1 was very upset, and they had to intervene to stop Resident 1 from hitting Resident 2. Staff C stated that Staff D, Medication Assistant, responded to the event, had viewed the video monitoring of the altercation and summoned Emergency Medical Services (EMS) and Police. Staff C lastly stated that Resident 2 still does not sleep well and startles easily at night. Staff C stated that they believed Resident 2 had post-traumatic stress from the altercation.

On 02/25/2025 at 4:36PM, Collateral Contact 2 (CC2) stated that from the beginning, Resident 1 and Resident 2 did not make a good pair for roommates. CC2 stated that Resident 1 did not like having Resident 1 as a roommate and it was not safe for Resident 1. CC2 stated that multiple staff reported their concerns to administrators and wrote their concerns on FYI forms. CC2 stated that Resident 1 tried to pull Resident 2 out of bed multiple times before the incident on [redacted]/2024. CC2 stated that 1 on 1 supervision was not provided to Resident 1, because the facility was unable to provide staff to accommodate it. CC2 finally stated that Resident 2 had pain to their ribs after the incident.

On 02/26/2025 at 2:31 PM, Staff B stated that they had provided all documentation of the investigation of the altercation between Resident 1 and Resident 2 and did not have any documentation of any interviews preformed. Staff B stated that abuse had been substantiated but was unable to explain how that determination was made. Staff B stated that they were aware of the incident that occurred between Resident 1 and Resident 2 on 12/19/2025, and thought, "No harm. No foul." When asked if there were any interventions put in place to protect Resident 2 from Resident 1's aggressive behavior after 12/19/2025, Staff B stated that they were unable to find any documentation of any interventions or notifications. Staff B stated that Resident 2 was not ambulatory and bed bound, had limited to movement in their arms, was nonverbal except making noises, and could not determine if they would be able to protect themselves during an altercation.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 5/9/25 .

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

Administrator (or Representative) [signature], BD Date 4/25/25

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 Assisted Living Facility (ALF) failed to update the negotiated service agreement within a reasonable time after a resident experienced multiple changes of conditions for 1 of 3 residents (Resident 3). This failure placed Resident 3 at risk for unrecognized needs and services.

Findings included...

Review of a facility, "Falls Policy," dated 01/2017, showed that in the event of a fall, an Incident Report and Fall Assessment Report would be completed, and the resident's Negotiated Service Agreement (NSA) would be updated as needed.

Review of Resident 3's Facility Assessment, dated 11/04/2024, showed that Resident 3 was independent with mobility, transfers, and ambulated independently without an assistive device, was at risk for falls, and had a skin problem of edema (tissue swelling due to excess fluid).

Resident 3's Negotiated Service Agreement, dated 11/04/2024, showed that Resident 3, "Did not have a walker but probably should." It showed statements that Resident 3 was both independent with walking/mobility and in need of assistance.

Review of Resident 3's Face Sheet showed that Resident 3 moved into the facility on [redacted]/2024.

Review of Resident 3's facility FYI (for your information) Forms, a document care staff use to communicate with administrative staff, progress notes and incident report showed that:
-On 11/26/2024, Progress note showed Resident 3 fell out of their recliner.
-On 11/27/2024, Resident 3 fell out of their recliner after leaning on their chair, was not wearing their call pendant, had to yell to get staff's attention, and had a bruise to their shoulder.
-On 11/27/2024, Resident 3 had an increase in edema to their legs with pain, Staff elevated their legs.
-On 11/29/2024, Resident 3's legs were noted legs as "pretty big," and Staff elevated their legs.
-On 12/01/2024, Staff elevated Resident 3's legs.
-On 12/08/2024, Resident 3's legs were noted as "still" bleeding with spots noted on the carpet, and bloody tissues thrown on the carpet. Progress note showed Resident's 3's legs began to blister.
-On 12/09/2024, Resident 3's legs were noted to "still"

be leaking fluid, and the medication technicians were asked multiple times to place a dressing or wrap on the legs, but no dressing was placed.
-On 12/26/2024, Resident 3's legs were bleeding again. Progress note showed home health saw Resident 3 for wound care, and Resident 3 was picking at their wounds, which caused them to bleed.
-On 01/01/2025, Resident 3 fell in the hallway and was sent out. Incident report showed that Resident 3 fell in the presence of a staff member and an ambulance was called for hip pain. Progress note showed resident was transported to the hospital.

Review of Resident 3's Progress Notes from ancillary services, showed that on 12/15/2024, home health was started to preform wound care treatment of a venous stasis ulcer (an open wound caused by poor blood circulation in the veins) of the right lower leg that measured 2 centimeters (cm) by 0.5 cm and weeping edema to both lower legs. It also showed that physical therapy began working with Resident 3 on 12/23/2024. The physical therapy note showed that Resident 3 initially refused to work an exercise program with physical therapy but was agreeable to ambulate and fatigued easily.

As of 02/26/2025, Resident 3's NSA had not been updated with the facilities documentation of FYI's and progress notes showing changes of conditions since the most current NSA on 11/04/2024 for:
-Updated fall prevention measures and fall interventions after Resident 3 fell on 11/26/2024.
-Designated responsibilities for wound care and related infection control prevention from bodily fluids.
-Interventions for leg edema.

On 02/26/2025 at 11:27 AM Staff B confirmed that Resident 3 had a significant change of their leg edema requiring wound care dressing changes by home health and the resident's NSA had not been updated to reflect the changes. Staff B stated that the facility had not hired a Residential Care Coordinator to assist them with making changes to NSAs in a timely manner.

On 02/26/2025 at 2:20 PM, Staff G, Care Partner, stated that Resident 3 was very weak, and they did not know why they were still walking Resident 3 down to the dining room, despite their weakness, without an assistive device. Staff G stated that Resident 3 was known for refusing care,

which they knew they had to respect. Staff G stated that Resident 3 would state that they could do tasks themselves and Staff G did not think that was safe. Staff G stated that they had documented their concerns on the facility "FYIs" and did not think that the concerns had been addressed.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 5/9/25 .

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

Administrator (or Representative) 4/25/25 Date

Highgate at Wenatchee
1320 South Miller Street
Wenatchee, WA 98801

T 509-665-6695
F 509-662-7827

HIGHGATE
SENIOR LIVING

4/24/2025

Laura Williams-Davis , ALF Field Manager
Residential Care Services
Region 1, Unit G
1200 Alder Street
Union Gap, WA. 98903

Regarding: Highgate Senior Living License #2225

Dear Laura,

Please see the attached signed and dated Statement of Deficiencies for Highgate Senior Livings . We began correcting the deficiency immediately and will be in full compliance as of 5/9/2025.

If you have any questions, please contact me directly at 509-665-6695.

Sincerely,

Jean F. Lehman, Executive Director
Highgate Senior Living (Wenatchee)

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

a. Director of Operations reviewed with the Executive Director the RCW on disclosure, transfer, and discharge requirement as well as Highgate's Residency Agreement which outlines the requirement to provide written discharge notification as soon as possible if a resident is being discharged due to health and safety.
b. Moving forward if there is a need for an emergent discharge due to a resident's health and safety the Executive Director will prepare a written notice of discharge.
c. Highgate Senior Living will call to set-up a meeting with the responsible party to review the written discharge notification, discuss options to keep the resident safe while residing at Highgate, and plan for physical moving resident out of the community.
d. Highgate Senior Living will continue to work with the responsible party to help create a smooth transfer for the resident who is discharging.

WAC 388-78A-2371 Investigations.

a. Executive Director reviewed with Health Care Director Highgate Senior Living policy and procedure for investigations. Highgate's Resident Services Specialist provided additional investigation training to the Health Care Director during a site visit April 1-3rd, 2025.
b. Care partners will review Highgate's policy and procedure for Incident Reporting and Alert Charting during 5/6/25 Monthly Care Partner meeting. The importance of notifying the Health Care Director right away of any significant incident will also be reviewed.
c. The Manor and Cottage FYI binders will be brought to the department head stand-up meeting held at 9:00 a.m. from Monday thru Friday. FYI's will be reviewed during the meeting and a discussion will take place regarding next steps to prevent a reoccurrence of the incident.
d. Health Care Director and Resident Care Coordinator will be responsible for updating the resident Service Plan to reflect any changes needed following the conclusion of an investigation.
e. Investigations will be reviewed monthly by the Resident Services Specialist to verify policy and procedures continue to be followed. The Investigation Summary Template will be completed by the Health Care Director when appropriate and it will identify any updates to the resident Service Plan which could help prevent an incident from reoccurring.

WAC 388-78A-2130 Service Agreement Planning

a. Health Care Director reviewed the WAC for Service Agreement Planning and Highgate Senior Livings policy and procedure regarding Service Plan updates when a resident has a change of condition. Highgate's Resident Service Specialist provided additional training regarding the Service Plan process during a site visit April 1-3rd, 2025.
b. Resident #1 is no longer resides at Highgate Senior Living due to safety concerns. Resident #2 Service Plan was updated on 10/4/2024 which specified current resident needs and services provided. Resident #3's Service Plan was updated on 2/28/25 to reflect resident changes including mobility, fall prevention measures and interventions, with no outside services being provided at this time.
c. Health Care Director will complete a nursing assessment for pre-admission, within fourteen days, with change of condition, and every six months. The Service Plan will be reviewed, updated, and a meeting set-up with responsible party when appropriate.
d. Each month the Executive Director will audit the Monthly Revenue Report to confirm that required assessments and Service Plans are current. The Executive Director will follow-up with the Health Care Director if there are any concerns following completion of the audit so that the Service Plans are updated promptly.