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

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

RE: HIGHGATE SENIOR LIVING License # 2225

Dear Administrator:

This letter addresses Compliance Determination(s) 62986 (Completion Date 07/24/2025) and 59834 (Completion Date 05/29/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/24/2025 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-2240

The Department staff who did the on-site verification:
Felicia Cantu, 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: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 59834
Investigator: Felicia Cantu
Investigation Date(s): 05/20/2025 through 05/29/2025
Complainant Contact Date(s): 05/29/2025

Provider Type: Assisted Living Facility

Intake ID: 176397
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
The facility did not give a named resident their ordered medication for several days.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Facility environment Resident to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Hospital records Resident records (face sheet, care plan, assessments, chart notes, medication administration records, doctor orders)

Investigation Summary:
Observations showed that staff to resident interactions were helpful, respectful, and safe. Interviews and record review showed that the named resident returned from the hospital and was not started on an ordered medication timely. Failed practice identified WAC 388-78A-2240. This is a repeated deficiency previously cited on 05/10/2023.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ]

Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Statement of Deficiencies	License #: 2225	Compliance Determination #:59834
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 1 of 4	Licensee: Highgate Wenatchee LP	05/29/2025

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 05/20/2025 of:

HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

This document references the following complaint number(s): 178397

The following sample was selected for review during the unannounced on-site visit: 3 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, 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

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HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

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Page 2 of 4	Licensee: Highgate Wenatchee LP	05/29/2025

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

06/06/2025
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)

6/12/25
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 (ALF) failed to obtain and administer ordered medications in a timely manner for 1 of 3 Residents (Resident 1). This failure resulted in Resident 1 missing 13 doses of medication for depression that contributed to the resident experiencing emotional and negative psychological outcomes.

Findings included...

Review of the ALF's policy titled "Medications Policy" dated 09/01/2018 showed that the Health and Wellness Director is responsible to see that all residents' medications are given.

Review of Resident 1's undated demographic sheet showed that they moved into the ALF on [redacted] 2023, with diagnoses of [redacted] and [redacted].

Review of Resident 1's medications orders showed that they were prescribed Paxil every morning since March 2024.

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 | Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) | Date

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Findings included…

Review of the ALF's policy titled "Medications Policy" dated 09/01/2018 showed that the Health and Wellness Director is responsible to see that all residents' medications are given.

Review of Resident 1's undated demographic sheet showed that they moved into the ALF on [redacted]/2023, with diagnoses of [redacted] and [redacted] ([redacted]).

Review of Resident 1's medications orders showed that they were prescribed Paxil every morning since March 2024.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 05/15/2025, showed that the facility provided medication assistance for Resident 1.

Review of Resident 1's hospital discharge instructions dated [redacted]2025, showed that Resident 1 was to continue taking Paxil 10 mg daily starting on [redacted]/2025.

Review of Resident 1's hospital follow-up visit note dated [redacted]/2025, showed that their medication discharge orders included Paxil. The document showed that the hospital staff discussed and reviewed medication changes with Staff A, Medication Technician. The document further showed that Staff A voiced no concerns or questions regarding the medication discharge orders.

Review of Resident 1's second follow-up visit note with their health care provider dated 03/06/2025 showed that facility staff reported that Resident 1 had been tearful, having constant anxiety, panic, hallucinations, delusions, not sleeping at night, and was drowsy during the day. "Due to a facility med error" [Resident 1] had not received Paxil since [Resident 1] returned to the facility on [redacted]2025. Additionally, the document showed that the missed medication could have caused Resident 1's increase in tearfulness, anxiety, panic, insomnia, hallucinations, and delusions.

Review of Resident 1's Medication Administration Records (MAR) for February 2025 through March 2025 showed that Resident 1 did not receive Paxil daily after they returned from the hospital from [redacted]2025 through [redacted]2025.

On 05/14/2025 at 10:00 AM, Collateral Contact 1 (CC1), Resident 1's Representative, confirmed that Resident 1 was discharged from the hospital on [redacted]2025. Additionally, CC1 explained that Resident 1 was supposed to continue their Paxil 10mg (medication that helps with depression and if stopped abruptly can cause nausea, dizziness, irritability, and anxiety). The facility staff notified them a week later that Resident 1 was showing signs of distress, not wanting to eat, and increased tearfulness.
On 05/29/2025 at 11:00 AM, Staff A confirmed that they spoke to hospital staff regarding Resident 1's medication orders. Staff A stated that they faxed the medication orders to the pharmacy upon Resident 1's return to the ALF.

On 05/29/2025 at 4:06 PM Staff B, Administrator acknowledged that Resident 1 missed several doses of their medication and would be working on a plan of correction for the failure.

This is a repeated deficiency previously cited on 05/10/2023.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 05/15/2025, showed that the facility provided medication assistance for Resident 1.

Review of Resident 1's hospital discharge instructions dated [redacted]/2025, showed that Resident 1 was to continue taking Paxil 10 mg daily starting on [redacted]/2025.

Review of Resident 1's hospital follow-up visit note dated [redacted]/2025, showed that their medication discharge orders included Paxil. The document showed that the hospital staff discussed and reviewed medication changes with Staff A, Medication Technician. The document further showed that Staff A voiced no concerns or questions regarding the medication discharge orders.

Review of Resident 1's second follow-up visit note with their health care provider dated 03/06/2025 showed that facility staff reported that Resident 1 had been tearful, having constant anxiety, panic, hallucinations, delusions, not sleeping at night, and was drowsy during the day. "Due to a facility med error" [Resident 1] had not received Paxil since [Resident 1] returned to the facility on [redacted]/2025. Additionally, the document showed that the missed medication could have caused Resident 1's increase in tearfulness, anxiety, panic, insomnia, hallucinations, and delusions.

Review of Resident 1's Medication Administration Records (MAR) for February 2025 through March 2025 showed that Resident 1 did not receive Paxil daily after they returned from the hospital from [redacted]/2025 through [redacted]/2025.

On 05/14/2025 at 10:00 AM, Collateral Contact 1 (CC1), Resident 1's Representative, confirmed that Resident 1 was discharged from the hospital on [redacted]/2025. Additionally, CC1 explained that Resident 1 was supposed to continue their Paxil 10mg (medication that helps with depression and if stopped abruptly can cause nausea, dizziness, irritability, and anxiety). The facility staff notified them a week later that Resident 1 was showing signs of distress, not wanting to eat, and increased tearfulness.
On 05/29/2025 at 11:00 AM, Staff A confirmed that they spoke to hospital staff regarding Resident 1's medication orders. Staff A stated that they faxed the medication orders to the pharmacy upon Resident 1's return to the ALF.

On 05/29/2025 at 4:08 PM Staff B, Administrator acknowledged that Resident 1 missed several doses of their medication and would be working on a plan of correction for the failure.

This is a repeated deficiency previously cited on 05/10/2023.

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Page 4 of 4	Licensee: Highgate Wenatchee LP	05/29/2025

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) 6/20/25 .

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

Administrator (or Representative) — Date: 6/12/25

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)_____ .

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

_____ _____

Administrator (or Representative) Date

Service Agreement WAC 365-78A-2240 Non-Availability of Medications

a. Executive Director met with Health Care Director on 6/9/25 and reviewed the WAC for Non-Availability of Medications and Highgate Senior Living's policies and procedures to ensure resident returning from the hospital have medications entered correctly in the EMAR and that medication is available in the timely manner.
b. The Health Care Director will provide additional training at the Monthly Medication Aide meeting scheduled for 6/19/25. Training will include: processing orders for residents returning from the hospital, Healthcare Director will confirm orders from the hospital physician are entered correctly, contacting the pharmacy to request a STAT order, and notifying the Healthcare Director or Executive Director if the pharmacy is unable to deliver the medication so that an alternate plan can be made to initiate medication delivery. The Healthcare Director will also review Medication Rights of Administration that Medication Aides need to follow.
c. A monthly audit will be completed by the Healthcare Director or Medication Aide Designee for residents who recently returned from a hospital stay to verify the EMAR orders are still accurate. The Executive Director will follow-up with the Health Care Director if there are any concerns following completion of the audit.

Resident #1 is no longer residing at the community and Medication Aide #A is no longer employed at Highgate Senior Living.