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

NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC
Avamere at Wenatchee
1550 CHERRY STREET
WENATCHEE, WA 98801

RE: Avamere at Wenatchee License # 2415

Dear Administrator:

This letter addresses Compliance Determination(s) 56070 (Completion Date 03/10/2025) and 51862 (Completion Date 01/15/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/10/2025 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-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b

The Department staff who did the on-site verification:
Jessica Clapp, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)225-2823.

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:** Avamere at Wenatchee
**Provider Type:** Assisted Living Facility

**License/Cert.#:** 2415
**Intake ID:** 158606
**Compliance Determination #:** 51862
**Region/Unit #:** RCS Region 1 / Unit G
**Investigator:** Laura Williams-Davis
**Investigation Date(s):** 12/19/2024 through 01/15/2025
**Complainant Contact Date(s):** 01/27/2025, 12/18/2024

**Allegation(s):**
Pain medication used for pain not related to prescribed reason.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 79<br>Resident sample size: 2<br>Closed records sample size: 1 |
| **Observations:** | Identified resident<br>Residents<br>Activities<br>Dining<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Nursing staff<br>Identified staff<br>Residents<br>Family members<br>Business office manager<br>Administrator<br>Health Service Director |
| **Record Reviews:** | Medical records (face sheet, assessment, care plan, progress notes, medication administration record)<br>Incident investigation<br>Resident sign out log<br>Facility policies |

**Investigation Summary:**
Record review showed that the named resident had a fall, that the incident was investigated, and that the provider was not notified when the named resident had a significant change of condition. Interview showed that provider was notified of the

resident's change of condition after they transferred to the hospital. Failed practice was identified. Refer to Washington Administrative Code (WAC) 388-78A-2640(1)(a)(b).

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**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:** Avamere at Wenatchee
**Provider Type:** Assisted Living Facility

**License/Cert.#:** 2415
**Intake ID:** 158458
**Compliance Determination #:** 51862
**Region/Unit #:** RCS Region 1 / Unit G
**Investigator:** Laura Williams-Davis
**Investigation Date(s):** 12/19/2024 through 01/15/2025
**Complainant Contact Date(s):** 01/27/2025, 12/19/2024

**Allegation(s):**
Resident had a fall with injury.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 79<br>Resident sample size: 2<br>Closed records sample size: 1 |
| **Observations:** | Identified resident<br>Residents<br>Activities<br>Dining<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Identified staff<br>Nursing staff<br>Residents<br>Family members<br>Administrator<br>Health Services Director |
| **Record Reviews:** | Medical records (face sheet, assessment, care plan, medication administration record, progress notes)<br>Incident investigation<br>Facility policies |

**Investigation Summary:**
Record review showed that the named resident had a fall, that the facility investigated, and that the facility failed to notify the provider of the named residents change of condition when their pain significantly increased. Interview showed that the named resident had a witnessed fall and that the provider was notified of the resident's change of condition after they transferred to the hospital.

Failed practice was identified. Refer to Washington Administrative Code (WAC) 388-78A-2640(1)(a)(b).

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**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:** Avamere at Wenatchee
**Provider Type:** Assisted Living Facility

**License/Cert.#:** 2415
**Intake ID:** 157438
**Compliance Determination #:** 51862
**Region/Unit #:** RCS Region 1 / Unit G
**Investigator:** Laura Williams-Davis
**Investigation Date(s):** 12/19/2024 through 01/15/2025
**Complainant Contact Date(s):** 01/27/2025, 12/19/2024

**Allegation(s):**
Residents medications left on the counter to be taken at a later time.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 79<br>Resident sample size: 2<br>Closed records sample size: 1 |
| **Observations:** | Identified resident<br>Residents<br>Activities<br>Dining<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Identified staff<br>Nursing staff<br>Residents<br>Family members<br>Administrator<br>Health Services Director |
| **Record Reviews:** | Medical records (face sheet, assessment, care plan, medication administration record, progress notes)<br>Incident investigation<br>Facility policies |

**Investigation Summary:**
Record review showed that the named resident went out of the facility with their representative for the day and that the resident was marked as having been given then medication as prescribed while they were away. Interview showed that facility staff had left medications on the counter in residents' apartments for them to take later. Failed practice was identified. Refer to Washington Administrative Code (WAC)

388-78A-2210(1)(a)(b).

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**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 12/18/2024 and 12/19/2024 of:

Avamere at Wenatchee
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 158606, 158458, 157438, 159455, 159222

The following sample was selected for review during the unannounced on-site visit: 2 of 79 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Jessica Clapp, Assisted Living Facility Licensor
Laura Williams-Davis, ALF Field Manager

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

01/29/2025
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)

2-3-25
Date

**WAC 388-78A-2210 Medication services.**

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

**This requirement was not met as evidenced by:**

Based on interview and record review the facility failed to provide safe medication services for 1 of 2 residents (Resident 1). This failure placed the resident at risk of a medication error.

Findings included...

Review of the facility's medication management policy, revised in 03/2022, showed that when a resident could not administer their own medications safely, the facility staff would administer them as ordered by the physician. The document showed that medications used as needed would have specific instructions that included why and when the medication was used.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 11/18/2024, showed that the resident required staff assistance with medication administration.

Review of the facility's resident sign-out sheet for November 2024, showed that

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

01/29/2025
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)

Date

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(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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**This requirement was not met as evidenced by:**

Based on interview and record review the facility failed to provide safe medication services for 1 of 2 residents (Resident 1). This failure placed the resident at risk of a medication error.

Findings included…

Review of the facility's medication management policy, revised in 03/2022, showed that when a resident could not administer their own medications safely, the facility staff would administer them as ordered by the physician. The document showed that medications used as needed would have specific instructions that included why and when the medication was used.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 11/18/2024, showed that the resident required staff assistance with medication administration.

Review of the facility's resident sign-out sheet for November 2024, showed that

Resident 1 went out of the facility with their family at 12:40 PM and returned to the facility at 9:00 PM.

Review of Resident 1's Medication Administration Record (MAR) for November 2024 showed that the resident received medications for their thyroid problems, pain, allergies and seizures. The MAR showed that on 11/28/2024, Resident 1 was given their morning medications prior to their leaving the facility. The MAR showed that Resident 1 was administered their pain medication between 1:00 PM and 2:00 PM and their seizure medication at 6:30 PM while they were out of the facility.

In an interview on 12/19/2024 at 12:33 PM, Collateral Contact 3 (CC3) stated that they assisted Resident 1 with an outing on 11/28/2024 and that they received the resident's medications to give to the resident that evening. CC3 stated that when they brought Resident 1 back to the facility there was a cup of medications sitting on the resident's counter in their room. CC3 stated he asked the staff about the medications as they left the facility and was told that they did not know Resident 1 had been out of the facility.

In an interview on 01/02/2025 at 4:36 PM, Staff B, Medication Technician, stated they would leave a resident's medication in their room for the resident to take later if they were not present. Staff B stated that they have left medications on the counter in Resident 1's room when the resident was not present.

In an interview on 01/02/2025 at 5:54 PM, Staff A stated that leaving medications at the resident's bedside was not the facility's policy. Staff A said that the facility can send medications with a resident's representative when they go out of 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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 2-27-25 .

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

Administrator (or Representative) [signature] Date 2-3-25

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as

Resident 1 went out of the facility with their family at 12:40 PM and returned to the facility at 9:00 PM.

Review of Resident 1's Medication Administration Record (MAR) for November 2024 showed that the resident received medications for their thyroid problems, pain, allergies and seizures. The MAR showed that on 11/28/2024, Resident 1 was given their morning medications prior to their leaving the facility. The MAR showed that Resident 1 was administered their pain medication between 1:00 PM and 2:00 PM and their seizure medication at 6:30 PM while they were out of the facility.

In an interview on 12/19/2024 at 12:33 PM, Collateral Contact 3 (CC3) stated that they assisted Resident 1 with an outing on 11/28/2024 and that they received the resident's medications to give to the resident that evening. CC3 stated that when they brought Resident 1 back to the facility there was a cup of medications sitting on the resident's counter in their room. CC3 stated he asked the staff about the medications as they left the facility and was told that they did not know Resident 1 had been out of the facility.

In an interview on 01/02/2025 at 4:36 PM, Staff B, Medication Technician, stated they would leave a resident's medication in their room for the resident to take later if they were not present. Staff B stated that they have left medications on the counter in Resident 1's room when the resident was not present.

In an interview on 01/02/2025 at 5:54 PM, Staff A stated that leaving medications at the resident's bedside was not the facility's policy. Staff A said that the facility can send medications with a resident's representative when they go out of 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, Avamere at Wenatchee 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

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as

possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

**This requirement was not met as evidenced by:**

Based on interview and record review the facility failed to make notify the physician when a additional fall occurred with injury and increased pain occurred for 1 of 3 residents (Resident 1). This failure placed the resident at risk of unmet care needs.

Findings included…

Review of Resident 1's incident report, dated 12/04/2024, showed that the resident had a fall in their room. The document showed that Resident 1 reported little pain, that they were able to walk and that they declined the need for transfer to the local hospital for evaluation. The document showed that the physician was notified of the fall at that time.

Review of Resident 1's progress note, dated 12/04/2024, showed that the resident had a fall in their room and that they reported no pain.

Review of Resident 1's progress note, dated 12/06/2024, showed that the resident complained, "about a lot of pain." An additional progress note, dated 12/06/2024, showed that Resident 1 was given their Oxycodone (medication used for moderate to severe pain) for pain from a previous arm injury. The document did not show that Resident 1's physician was notified of the resident's change of condition.

Review of Resident 1's progress note, dated 12/07/2024, showed that the resident was in a lot of pain, was screaming and upset in their room. The document showed that Resident 1 was given their Oxycodone after staff talked with the resident's representative. The document did not show that Resident 1's physician was notified of the resident's change of condition.

In an interview on 12/19/2024 at 8:37 AM, Collateral Contact 2 (CC2) stated they had received a call on 12/07/2024 from staff about Resident 1's increased pain. CC2 stated they thought Resident 1's pain was related to a past arm fracture and didn't know the reported pain was in a different area. CC2 stated Resident 1 could not move, that the resident was transferred to a local hospital by the family's private vehicle and that a sacrum (triangle shaped bone at the base of the spine) fracture was found.

In an interview on 12/19/2024 at 9:30 AM, Staff A stated Resident 1 had a fall in their room on 12/04/2024 and that the resident's pain increased on 12/06/2024. Staff A

stated that on 12/07/2024, Resident 1 had trouble walking and standing due to the pain. Staff A stated that Resident 1 was transferred to the hospital and a sacral fracture was identified.

**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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 2-27-25 .

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

Administrator (or Representative) 2-3-25 Date

stated that on 12/07/2024, Resident 1 had trouble walking and standing due to the pain. Staff A stated that Resident 1 was transferred to the hospital and a sacral fracture was identified.

**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, Avamere at Wenatchee 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