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

07/30/2025

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

RE: Avamere at Wenatchee # 2415

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 63261 (Completion Date 07/30/2025) and 59632 (Completion Date 06/05/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/30/2025 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.

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: Avamere at Wenatchee

Provider Type: Assisted Living Facility

License/Cert.#: 2415

Intake ID: 177828

Compliance Determination #: 59632

Region/Unit #: RCS Region 1 / Unit G

Investigator: Nicole Mcgraw

Investigation Date(s): 05/15/2025 through 06/05/2025

Complainant Contact Date(s): 05/15/2025

Allegation(s):

A named resident did not receive their medications as ordered by physician.

Investigation Methods:

Sample:	Total residents: 75 Resident sample size: 13 Closed records sample size: 0
Observations:	Environment, Medications
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic Roster, Resident Records, Facility Policy, Facility incident report and investigations.

Investigation Summary:

Observation interview and record review showed that the facility failed to have resident medications available to administer to residents. Failed Practice Identified, WAC 388-78A-2240 reference Statement of Deficiencies dated 06/05/2025.

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 #: 2415	Compliance Determination # 59632
Plan of Correction	Avamere at Wenatchee	Completion Date
Page 1 of 4	Licensee: NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC	06/05/2025

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 05/15/2025 of:

Avamere at Wenatchee
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 177828

The following sample was selected for review during the unannounced on-site visit: 13 of 75 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Mcgraw, 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

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)

6-10-25
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 failed to ensure that a resident received their prescribed medications 2 of 9 residents (Resident 1 and 2). This failure contributed to Resident 1 not receiving the mental health medications and experiencing a decline in mental health and placed residents at risk of not receiving medication timely.

Findings included...

<Resident 1>

Resident 1's facility assessment, dated 01/15/5025, showed that the resident had multiple [redacted] diagnoses and required assistance with medication administration including ordering of medications.

Review of Resident 1's April 2025, Medication Administration Record (MAR), showed that Resident 1 had a physician's order to take clonazepam (Klonopin) (a medication used to treat mental health disorder) twice daily and had missed 5 doses (04/16/2025, 04/17/2025, and 04/18/2025) of the medication.

Review of Resident 1's 04/16/2025 to 04/29/2025 progress notes did not show any

documentation by the facility staff to obtain the clonazepam in a timely manner.

During an interview on 05/15/2025 at 12:40 PM, Resident 1 stated that the days they went without their clonazepam they felt out of control, scared that they were going to destroy things, hurt themselves or someone else. Resident 1 stated that when they did not receive their Klonopin, they had to address their [redacted] concerns with their [redacted]. They further stated that they had times when they felt physically ill (feeling sick and having headaches) from not having their medications.

Record review of an American Addiction Centers article, titled "Dangers of Quitting Klonopin by Yourself," dated 03/17/2023, showed that when Klonopin is suddenly stopped, the first day of missing the medication, it can cause severe side effects such as irrational feelings, delusions, hallucinations, nausea and vomiting, return of anxiety symptoms in addition to physical withdrawal symptoms. (https://americanaddictioncenters.org/klonopin-treatment/dangers-of-quitting-alone)

During an interview on 05/15/2025 at 1:32 PM, Staff A, Resident Care Coordinator, stated that the Klonopin ran out because staff do not reorder it. The resident medications were received from pharmacy and restarted in the evening of 04/18/2025.

<Resident 2>

Review of Resident 2's 12/02/2024 assessment, showed that the resident had a diagnoses of [redacted], and [redacted]. The document showed that facility staff were responsible for making sure Resident 2's medication were obtained for staff to administer.

Review of Resident 2's March 2025 MAR, showed that Resident 2 had physician orders to take Januvia (medication to treat abnormal blood sugars) once daily and Senna (bowel medication) once daily. The MAR showed staff documented with a code of "9" (not administered, see progress notes) for Januvia from 03/22/2025 through 03/31/2025 and for Senna from 03/22/2025 through 03/28/2025. Resident 2 missed 10 doses of Januvia and 7 doses of Senna.

Review of Resident 2's progress notes dated 03/22/2025 through 03/31/2025, did not show any documentation by the facility staff that they had attempted to obtain the resident's Januvia in a timely manner. Further review of the progress notes dated 03/22/2025 through 03/28/2025, did not show documentation by facility staff that they had attempted to obtain the resident's Senna in a timely manner.

During an interview on 05/15/2025 at 1:32 PM, Staff A, Resident Care Coordinator , stated that residents medications run out because the facility staff just do not reorder them.

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) 6-30-25 .

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

Gilbert Foot — Administrator (or Representative)

6-10-25 — Date

Plan of Correction for WAC 388-78A-2240 – Medication Services

Facility Name: Avamere at Wenatchee

Date of Deficiency: 6-5-25

Surveyor: Nicole Mcgraw Community Complaint Investigator

WAC Reference: WAC 388-78A-2240

Date PoC Submitted: 6-10-25

Deficiency Summary:

The facility was found to be noncompliant with WAC 388-78A-2240, specifically regarding Non availability of medications for resident consumption. Med Errors not addressed in a timely manner.

1. Corrective Action Taken for Residents Found to be Affected

- Immediate corrective measures were taken for the residents affected.
- Medications were reviewed and reconciled against physician orders.
- Affected residents were assessed for any adverse effects.
- The responsible staff members were re-trained on medication administration procedures.

2. Identification of Other Residents Who May Be Affected

- A full audit of all resident MARs (Medication Administration Records) was conducted to identify any other discrepancies.
- Pharmacy and physician orders were cross-verified for all residents.
- Any additional discrepancies found were corrected immediately and appropriate follow-up was completed.

3. Measures and Systemic Changes to Prevent Reoccurrence

- All medication staff have received re-training on WAC 388-78A-2240 requirements and company medication protocols.
- Monthly medication audits have been implemented to ensure compliance and accuracy.
- A new checklist has been developed for all medication passes, including documentation of PRN effectiveness and double-checks of physician orders.

- Supervisory medication pass observations will now be conducted weekly for 60 days, then monthly thereafter.

4. Monitoring to Ensure Ongoing Compliance

- The Director of Nursing or designee will perform random MAR audits weekly for the next 90 days.
- Medication pass audits will continue on a monthly basis thereafter.
- Any discrepancies found will be addressed immediately, and results will be documented and reported in the facility's Quality Assurance Performance Improvement (QAPI) meetings.

5. Completion Date of Corrective Actions

All corrective actions will be completed by: 6-30-25

Responsible Person(s):

Executive Director: Gilbert Lutes
Director of Nursing: Regional Nurse Mary Miller
Lead Medication Aids

Lori Torres and Brittany Richards