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

09/30/2025

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) 66388 (Completion Date 09/30/2025) and 61599 (Completion Date 08/05/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/30/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

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

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

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

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: 184616
Compliance Determination #: 61599
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 06/25/2025 through 08/05/2025
Complainant Contact Date(s):

Allegation(s):
The named resident did not receive a medication as prescribed, for an infection.

Investigation Methods:

Sample:	Total residents: 79 Resident sample size: 4 Closed records sample size: 0
Observations:	Environment, Medication Administration
Interviews:	Resident, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident Records, Facility policy, Facility incident report and investigation

Investigation Summary:
Staff interview and record review showed that the named resident did not received their first dose of a prescribed medication to treat an infection until eight days after it was prescribed. Failed practiced identified, Washington Administrative Code 388-78A-2210(1b)(2)(a), reference Statement of Deficiencies dated 08/05/2025.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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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 06/25/2025 of:

Avamere at Wenatchee
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 184342, 184616, 185034, 185229

The following sample was selected for review during the unannounced on-site visit: 4 of 79 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

08/11/2025
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.

Administrator (or Representative)

8-21-25
Date

WAC 388-78A-2210 Medication services.

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(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure medication was administered in accordance with the negotiated service agreement for 1 of 1 Resident (Resident 1). This failure resulted in a delay in medication treatment for an infection.

Findings included...

Review of Resident 1's Negotiated Service Agreement (NSA), dated 03/12/2025, showed the resident required the facility to assist with their medications.

Review of Resident 1's physician note, dated 06/18/2025, showed that Resident 1 had pain with urination and was more forgetful than usual. The note showed the resident was prescribed an antibiotic (medication to treat infection) for a diagnosis of [redacted]

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

08/11/2025 — 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.

Administrator (or Representative) — Date

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Review of Resident 1's physician note, dated 06/18/2025, showed that Resident 1 had pain with urination and was more forgetful than usual. The note showed the resident was prescribed an antibiotic (medication to treat infection) for a diagnosis of [redacted]

[redacted] and the antibiotic prescription was sent to the pharmacy the same day.

Review of a medication delivery ticket from the pharmacy, signed and dated 06/18/2025, by Staff A, Resident Care Coordinator, showed Staff A had received Resident 1's antibiotic.

Review of Resident 1's June 2025 MAR, showed that the resident started the antibiotic treatment on 06/26/2025, eight days after it was prescribed.

Review of Resident 1's facility incident report, dated 06/26/2025, showed that Staff B, Medication Technician, had received a call from the prescribing physician asking about why Resident 1's antibiotic had not been started. The incident report showed the antibiotic had been received by the facility on 06/18/2025. The incident investigation showed the physician's order for the antibiotic was not entered into the MAR and therefore the administration of the antibiotic was not started when it was received on 06/18/2025.

In an interview on 07/30/2025 at 11:36 AM, Staff C, Licensed Practical Nurse, stated that when Resident's antibiotic was received by Staff A, Staff A took the medication card to the medication technician that was working to put it on the medication cart and then filed the physician order without transcribing it to the Medication Administration Record.

In an interview on 08/05/2025 at 3:30 PM, Resident 1 stated that during the time they had the bladder infection, they were not thinking clearly and had pain and discomfort until the antibiotic was started on 06/26/2025 (8 days after it was prescribed).

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) 9-19-2025

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

Administrator (or Representative) 8-21-25 Date

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Review of a medication delivery ticket from the pharmacy, signed and dated 06/18/2025, by Staff A, Resident Care Coordinator, showed Staff A had received Resident 1's antibiotic.

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Review of Resident 1's facility incident report, dated 06/26/2025, showed that Staff B, Medication Technician, had received a call from the prescribing physician asking about why Resident 1's antibiotic had not been started. The incident report showed the antibiotic had been received by the facility on 06/18/2025. The incident investigation showed the physician's order for the antibiotic was not entered into the MAR and therefore the administration of the antibiotic was not started when it was received on 06/18/2025.

In an interview on 07/30/2025 at 11:36 AM, Staff C, Licensed Practical Nurse, stated that when Resident's antibiotic was received by Staff A, Staff A took the medication card to the medication technician that was working to put it on the medication cart and then filed the physician order without transcribing it to the Medication Administration Record.

In an interview on 08/05/2025 at 3:30 PM, Resident 1 stated that during the time they had the bladder infection, they were not thinking clearly and had pain and discomfort until the antibiotic was started on 06/26/2025 (8 days after it was prescribed).

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