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
Wenatchee Senior Living
1550 CHERRY STREET
WENATCHEE, WA 98801

RE: Wenatchee Senior Living License # 2415

Dear Administrator:

This letter addresses Compliance Determination(s) 68056 (Completion Date 11/05/2025) and 64615 (Completion Date 09/03/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/05/2025 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-2660-1, WAC 388-78A-2660-2, WAC 388-78A-2660-4, RCW 70.129.140.1, RCW 70.129.140.2.c

The Department staff who did the on-site verification:
Melissa Milanez, 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: 191000
Compliance Determination #: 64615
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 08/26/2025 through 09/03/2025
Complainant Contact Date(s): 08/28/2025

Allegation(s):
The facility did not notify and involve the identified resident's legal representative prior to issuing a discharge notice.

Investigation Methods:

Sample:	Total residents: 76 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Hospital staff
Record Reviews:	Durable Power of Attorney Resident records- face sheet, negotiated service agreement, assessment State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
The identified resident stated that they requested for their legal representative to be involved in all decision making. Record review of the identified residents negotiated service agreement and durable power of attorney showed that the

resident required assistance from family for making major or complex decisions and that they preferred family members to be present and assist with expressing their preferences. The facility failed to contact the resident representative prior to issuing a 30-day discharg notice. Failed practice identified WAC 388-78A-2660 (1)(2)(4) Resident Rights, and RCW 70.129.140 (1)(2)(C) dated 09-03-2025.

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 # 64615
Plan of Correction	Avamere at Wenatchee	Completion Date
Page 1 of 5	Licensee: NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC	09/03/2025

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 08/26/2025 of:

Avamere at Wenatchee
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 191000, 191989

The following sample was selected for review during the unannounced on-site visit: 4 of 76 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, 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

09/08/2025
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.

Gillett Fitts
Administrator (or Representative)

9-10-25
Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:

(c) Make choices about aspects of his or her life in the facility that are significant to the resident;

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

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interviews and record review, the facility failed to promote and protect resident's rights when discharge paperwork was provided to a resident without involvement of their legal representative for 1 of 3 residents (Resident 1). This failure resulted in the facility not honoring the legal documents, care planning, and the resident's preferences to involve the representative in complex decision making.

Findings included....

Record review Resident 1's General Durable Power of Attorney (DPOA), signed and

dated 01/31/2025, showed that the resident designated Collateral Contact 1 (CC1), Resident Representative as the agent to exercise authority regarding health and medical care decisions. The DPOA also authorized the agent to access medical records and make necessary arrangements for the resident's care and placement in facilities.

Record review of the facility's policy titled "Personal Rights" dated 12/13/2024, showed that all senior living staff will observe and respect the personal rights of all residents residing in the community and must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Additionally, the policy showed that a facility must protect and promote the rights of each resident and assist the resident which include:

- The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States and the state of Washington,
- The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.
- In the case of a resident who has not been adjudged incompetent by a court of competent jurisdiction, a resident representative may exercise the resident's rights to the extent provided by law.

Review of Resident 1's Negotiated Service Agreement (NSA), last reviewed on 02/12/2025, showed under the cognition section that Resident 1 was able to make daily decisions such as food, clothing, activities, as needed medications but required assistance from family for making major or complex decisions. Additionally, the NSA under the communication section showed that for significant or complex matters, including care conferences, that Resident 1 preferred family members to be present and assist them with expressing their preferences.

In an interview on 08/26/2025 at 11:13 AM, Resident 1 stated that they received a visit from Staff A, Administrator, while in the hospital. They stated that Staff A left paperwork on their table. The resident stated they felt it was not appropriate and told Staff A they needed to contact their sister. Resident 1 further stated that Staff A told them that they could not come back to the facility.

In an interview on 08/26/2025 at 11:30 AM, CC1 stated that they were Resident 1's primary decision maker and power of attorney. They stated that Resident 1 cannot read or write and requires assistance with all decision making per the resident's request. They stated they never received a phone call from the administrator regarding the visit to the hospital and only became aware that a 30-day discharge notice had been issued when informed by the hospital staff. CC1 further stated that upon arrival at the hospital, Resident 1 remained upset about the situation and it had taken some time for them to calm down.

In an interview on 08/26/2025 at 12:24 PM, Staff A stated that they went to go visit

Resident 1 at the hospital, as they wanted to see Resident 1's condition and get an update on them. Staff A reported that upon arrival they asked to speak with the discharge planner and expressed concern that the resident was lying in bed all day, which was not typical for them. They stated they told the case manager it would not be a good idea for the resident to return to the facility at this time. Staff A stated they had brought paperwork, including a 30-day discharge notice, which they had placed upside down on Resident 1's bedside table. While at the hospital, Staff A stated they received a call from the assisted living's Vice President of Operations, directing them to retract the notice. They stated they had not reached out to the resident's sister, the legal representative, prior to visiting the hospital and administering the discharge notice.

In an interview on 09/03/2025 at 10:49 AM, Staff B, Regional Nurse, stated they did not know the administrator planned to visit the resident that day and only learned of the discharge notice after contacting the hospital to request paperwork. The hospital case manager informed them the administrator had served the discharge notice and then retracted it. Staff B further stated they did not understand why the administrator issued the notice and emphasized that the discharge notice should have been provided to the resident's power of attorney, not the resident. When asked about their understanding of Resident 1's wishes and care plan, Staff B stated they knew decisions were to be made with the resident's sister, the legal representative.

In an interview on 09/03/2025 at 2:29 PM, Collateral Contact 2 (CC2), hospital Nurse Case Manager, stated that Staff A came to the hospital with paperwork in hand and informed them that the facility would not be accepting the resident back. They stated that they asked what the reason was, and that Staff A stated that they were unable to meet the residents' needs. CC2 stated they questioned the decision, noting that the resident had lived at the facility for many years and that Staff A stated that the other reason for the discharge was that the family was "difficult and no cooperating." Additionally, CC2 stated that shortly after their initial conversation, Staff A returned to the resident's room, retrieved the paperwork, and told them that they had made a mistake and provided them with the regional nurse's phone number for further contact.

Statement of Deficiencies	License #: 2415	Compliance Determination # 64615
Plan of Correction	Avamere at Wenatchee	Completion Date
Page 5 of 5	Licensee: NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC	09/03/2025

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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 10-18-25 .

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

Administrator (or Representative) 9-10-25 Date