STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

04/13/2026

AHR Wenatchee WA MC TRS Sub, LLC
Blossom Creek Senior Alzheimer Community
1740 Madison St
Wenatchee, WA 98801-4700

RE: Blossom Creek Senior Alzheimer Community # 2721

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 75678 (Completion Date 04/13/2026) and 70254 (Completion Date 02/13/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/13/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(3) Review and update each resident's negotiated service agreement consistent with

WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

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;

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: Blossom Creek Senior Alzheimer Community
License/Cert.#: 2721
Compliance Determination #: 70254
Investigator: Nicole Mcgraw
Provider Type: Assisted Living Facility
Intake ID: 204496
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 12/17/2025 through 02/13/2026
Complainant Contact Date(s): 02/19/2026, 12/19/2025

Allegation(s):

1) The named resident had multiple falls and locked behind their door.
2) A resident was trying to leave out the door and set off the door alarm.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: 2 Closed records sample size: 2
Observations:	Environment, Residents, Staff availability and response to resident's needs, door locks,
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident records, Facility policies, Facility incident reports and investigations,

Investigation Summary:

1) Observations showed that residents were safe and staff were available. Staff interview and record review showed that resident representative was not notified of a fall, the named resident's care plan was not updated for falls and when the named resident had a fall, it was not documented or investigated. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2371, WAC 388-78A-2130 and WAC 388-78A-2640, reference Statement of Deficiencies dated 02/13/2026.

2) Observations showed the memory care had locked doors that alarmed when residents attempted to exit. No residents were observed trying to exit out of the memory care. Staff interview showed the staff are aware when a resident is exit seeking because the door alarm goes off. No failed practice identified.

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
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2721	Compliance Determination # 70254
Plan of Correction	Blossom Creek Senior Alzheimer Community	Completion Date
Page 1 of 7	Licensee: AHR Wenatchee WA MC TRS Sub, LLC	02/13/2026

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 12/17/2025 and 12/18/2025 of:

Blossom Creek Senior Alzheimer Community
1740 Madison St
Wenatchee, WA 98801-4700

This document references the following complaint number(s): 202567, 204496

The following sample was selected for review during the unannounced on-site visit: 2 of 43 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Mcgraw, Community Complaint Investigator

From:
DSHS, Home and Community Living 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

02/23/2026
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.

[signature]
Administrator (or Representative)

02/24/2026
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation, or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff investigated and documented investigative actions and findings for a fall that jeopardized the residents' welfare for 1 of 4 residents (Resident 1). This failure placed residents at risk of harm and decline in their mobility and wellbeing.

Findings included...

Review of facility policy, titled, "Incident Reports," dated 06/01/2025, showed any unusual occurrences and incidents required a written Internal Occurrence Investigation Report be completed by facility staff. The document showed the facility was to investigate, document findings, and implement preventative measures.

Review of Resident 1's undated face sheet showed they were admitted to the facility on [redacted]2025, with diagnoses of [redacted] and [redacted].

Review of Resident 1's 11/09/2025 preadmission assessment, showed the resident

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 _____

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

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Based on interview and record review, the facility failed to ensure staff investigated and documented investigative actions and findings for a fall that jeopardized the residents' welfare for 1 of 4 residents (Resident 1). This failure placed residents at risk of harm and decline in their mobility and wellbeing.

Findings included…

Review of facility policy, titled, "Incident Reports," dated 06/01/2025, showed any unusual occurrences and incidents required a written Internal Occurrence Investigation Report be completed by facility staff. The document showed the facility was to investigate, document findings, and implement preventative measures.

Review of Resident 1's undated face sheet showed they were admitted to the facility on [redacted]/2025, with diagnoses of [redacted], and [redacted].

Review of Resident 1's 11/09/2025 preadmission assessment, showed the resident

required moderate assistance for mobility and transfers. The record showed the resident had a history of falling, weakness, would forget their limitations and was a high fall risk.

Review of Resident 1's progress notes showed that on 11/26/2025 at 5:13 AM, Staff B, Medication Technician, documented that the resident had fallen out of bed.

Review of the facility's November 2025 incident log did not show Resident 1 had falls on 11/25/2025 and 11/26/2025.

Review of the facility's November 2025 incident reports showed there was no documented incident report investigations for falls on 11/25/2025 and 11/26/2025 to determine the circumstances of the falls and to document the investigative actions, findings and appropriate measures to prevent similar future situations.

Interview on 12/19/2025 at 12:04 PM, Collateral Contact 1 (CC1), Resident Representative, stated that on the evening of 11/25/2025, CC1 arrived at the facility to visit Resident 1 and found they could not enter the resident's room because the resident had fallen against the door. CC1 stated they had to enter another resident's room and go through the bathroom to get to the resident. CC1 stated they called facility staff to help get the resident up off the floor.

During an interview on 12/17/2025 at 11:50 AM, Staff A, Executive Director stated that they were not aware of the incidents and were not sure as to why the staff had not done an incident report to investigate and document the fall incidents that occurred on 11/25/2025 and 11/26/2025.

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, Blossom Creek Senior Alzheimer Community is or will be in compliance with this law and / or regulation on (Date) 03/30/2026

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

Administrator (or Representative) — Date: 02/24/2026

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident

required moderate assistance for mobility and transfers. The record showed the resident had a history of falling, weakness, would forget their limitations and was a high fall risk.

Review of Resident 1's progress notes showed that on 11/26/2025 at 5:13 AM, Staff B, Medication Technician, documented that the resident had fallen out of bed.

Review of the facility's November 2025 Incident log did not show Resident 1 had falls on 11/25/2025 and 11/26/2025.

Review of the facility's November 2025 incident reports showed there was no documented incident report investigations for falls on 11/25/2025 and 11/26/2025 to determine the circumstances of the falls and to document the investigative actions, findings and appropriate measures to prevent similar future situations.

Interview on 12/19/2025 at 12:04 PM, Collateral Contact 1 (CC1), Resident Representative, stated that on the evening of 11/25/2025, CC1 arrived at the facility to visit Resident 1 and found they could not enter the resident's room because the resident had fallen against the door. CC1 stated they had to enter another resident's room and go through the bathroom to get to the resident. CC1 stated they called facility staff to help get the resident up off the floor.

During an interview on 12/17/2025 at 11:50 AM, Staff A, Executive Director stated that they were not aware of the incidents and were not sure as to why the staff had not done an incident report to investigate and document the fall incidents that occurred on 11/25/2025 and 11/26/2025.

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident

and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review showed the facility failed to develop an initial negotiated service agreement (NSA) and/or updated the NSA as required for 2 of 4 residents (Resident 1 & 2). This failure resulted in lack of fall intervention for staff to follow and placed resident at risk of harm.

Findings included…

Review of facility policy, titled, “Negotiated Service Agreements,” dated 06/01/2025, showed the residents’ NSA should ensure they were individualized to reflect the resident’s care needs.

Resident 2

Review of Resident 2’s undated face sheet showed the resident was admitted to the facility on [redacted]/2024 with diagnoses of [redacted].

Review of Resident 2’s Fall Assessment, dated 5/23/2025, showed the resident had a fall and were assessed to be a high fall risk.

Review of Resident 2’s facility assessment, dated 10/27/2025, showed the resident was a high fall risk and the action notes the action was to implement high risk fall interventions.

Review of Resident 2’s undated 2025 incident log showed the resident had 10 falls between May 2025 and November 2025, on: 05/15/2025, 09/16/2026, 09/29/2025, 10/09/2025, 10/22/2025, 11/13/2025, two on 11/14/2025, 11/22/2025, and 11/23/2025.

Review of Resident 2's NSA failed to show guidance and direction to staff and caregivers on the resident's immediate safety needs and interventions for fall prevention.

Resident 1

Review of Resident 1's undated face sheet showed the resident was admitted to the facility on [redacted]/2025 with diagnoses of [redacted] and [redacted].

Review of Resident 1's preadmission assessment, dated 11/19/2025, showed the resident was a high fall risk with weakness, used an ambulatory device, would forget their limitations, and had a history of falls.

Review of Resident 1's initial care plan, 11/19/2025, failed to identify the resident's fall risk and provide directions to staff for the residents' immediate safety needs.

Interview on 12/19/2025 at 12:04 PM, Collateral Contact 1 (CC1), Resident Representative, stated that on the evening of 11/25/2025, CC1 arrived at the facility to visit Resident 1 and found they could not enter the resident's room because the resident had fallen against the door. CC1 stated they had to enter another resident's room and go through the bathroom to get to the resident.

Review of Resident 1's progress note dated, 11/26/2025 at 5:50 PM, the resident had a fall out of their bed onto the floor mat.

Review of Resident 1's progress note, dated 11/28/2025 at 3:09 PM, written by Staff B, showed the resident had a fall from their bed on 11/27/2025 at 8:10 PM.

Review of Resident 1's initial NSA failed to identify the residents' immediate safety needs and provide direction to staff on keeping the resident safe, their high fall risk and interventions for fall prevention.

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, Blossom Creek Senior Alzheimer Community is or will be in compliance with this law and / or regulation on (Date) 03/30/2026.

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

Tricia Jupp — Administrator (or Representative)

02/24/2026 — 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;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify a resident representative when there was a change of condition for 1 of 4 resident (Resident 1). This failure resulted in the named resident's representative not being aware Resident 1 had a fall.

Findings included...

Review of facility policy titled, "Falls," dated 06/01/2025, showed the Health & Wellness Director of designee would notify family and/or responsible party immediately when a resident had a fall.

Review of Resident 1's progress note, dated 11/26/2025 at 5:13 AM, showed Staff B, Medication Technician, documented the resident had a fall out of their bed onto the fall mat and there was no documentation showing they had notified the resident's family of the fall.

Review of the facility's November 2025 incident log showed there were no incident report completed for the fall documented on 11/26/2025 at 5:13 AM, where the facility staff would document the notification of families when a resident had a fall.

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Administrator (or Representative) Date

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Review of Resident 1’s progress note, dated 11/26/2025 at 5:13 AM, showed Staff B, Medication Technician, documented the resident had a fall out of their bed onto the fall mat and there was no documentation showing they had notified the resident’s family of the fall.

Review of the facility’s November 2025 incident log showed there were no incident report completed for the fall documented on 11/26/2025 at 5:13 AM, where the facility staff would document the notification of families when a resident had a fall.

During an interview on 12/18/2025 12:04 pm, Collateral Contact 1 (CC1), Resident Representative, stated that they were not notified of Resident 1 having a fall on 11/26/2025.

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Administrator (or Representative) — Date: 02/24/2026

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