STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

12/11/2025

Cherrywood Care LLC
Cherrywood Care
100 E Dalke Ave
Spokane, WA 99208

RE: Cherrywood Care # 2751

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 69986 (Completion Date 12/11/2025) and 67202 (Completion Date 10/17/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/11/2025 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:
Amy Wright, NCI Complain Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cherrywood Care
Provider Type: Assisted Living Facility
License/Cert.#: 2751
Compliance Determination #: 67202
Intake ID: 196919
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/14/2025 through 10/17/2025
Complainant Contact Date(s): 10/08/2025, 10/20/2025

Allegation(s):

1. Medications not available.
2. Blood pressure not being monitored routinely.

Investigation Methods:

Sample:
Total residents: 49
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Activities
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter
Executive Director
Resident Care Coordinator
Alleged Victim
Resident
Medication Technician

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plans
*Medication administration records
*Progress notes
*Staff credentials
*Staff training records
*Staff in-service education
*Medication Administration Policy
*Provider notes

Investigation Summary:

1. Record review and interview confirmed that residents went without their prescribed medications because the medications were not available. Failed facility practice identified and cited under WAC 388-78A-2240 Nonavailability of medications.
2. Record review showed that the Alleged Victim's blood pressure was monitored routinely as ordered. The Alleged Victim was interviewed, and they confirmed that staff checked their blood pressure twice daily. Staff were observed monitoring the Alleged Victim's blood pressure. No failed facility practice.

Conclusion / Action:

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

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8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 10/14/2025 of:

Cherrywood Care
100 E Dalke Ave
Spokane, WA 99208

This document references the following complaint number(s): 196919

The following sample was selected for review during the unannounced on-site visit: 3 of 49 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2761	Compliance Determination #67202
Plan of Correction	Cherrywood Care	Completion Date
Page 2 of 9	Licensee: Cherrywood Care LLC	10/17/2025

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 — 10/22/2025 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) — 10-24-25 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 facility failed to obtain prescribed medications in a correct and timely manner for residents who required assistance with medication reordering for 2 of 3 residents (Residents 1 and 2). This failed facility practice resulted in missed medications and placed the residents at risk for unmanaged symptoms, discomfort, and decreased quality of life.

Findings included...

<Resident 1>

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 01/27/2025, showed that the resident required staff assistance with reordering medications.

Review of an undated face sheet for Resident 1 showed the resident had diagnoses including [redacted] and [redacted].

<Medication 1>

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-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 facility failed to obtain prescribed medications in a correct and timely manner for residents who required assistance with medication reordering for 2 of 3 residents (Residents 1 and 2). This failed facility practice resulted in missed medications and placed the residents at risk for unmanaged symptoms, discomfort, and decreased quality of life.

Findings included…

<Resident 1>

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 01/27/2025, showed that the resident required staff assistance with reordering medications.

Review of an undated face sheet for Resident 1 showed the resident had diagnoses including [redacted], and [redacted].

<Medication 1>

Review of a Medication Administration Record (MAR) for Resident 1, dated July 2025, showed the resident took magnesium oxide daily as a supplement for their low magnesium levels. The MAR showed that the magnesium oxide was not administered on 07/20/2025, 07/21/2025, 07/22/2025, 07/27/2025, 07/28/2025, 07/29/2025, and 07/30/2025.

Review of a progress note for Resident 1, dated 07/20/2025 at 8:27 AM, showed the resident did not take their magnesium oxide that day because they were waiting for it to be delivered.

Review of a progress note for Resident 1, dated 07/30/2025 at 9:42 AM, showed that ten days later, the resident was still waiting for their magnesium oxide to be delivered.

<Medication 2>

Review of a MAR for Resident 1, dated July 2025, showed the resident took aripiprazole (a medication used to treat mental and mood disorders) daily.

Review of a progress note for Resident 1, dated 08/12/2025 at 9:12 AM, showed the resident did not take their aripiprazole that day because they were waiting for it to be delivered.

<Medication 3>

Review of a MAR for Resident 1, dated July 2025, showed the resident took famotidine (a medication used to treat GERD) one time daily at bedtime.

Review of a progress note for Resident 1, dated 08/14/2025 at 9:23 PM, showed the resident did not take their famotidine that night because they were waiting for it to be delivered.

<Medication 4>

Review of a MAR for Resident 1, dated July 2025, showed the resident took hydroxyzine (a medication used to treat anxiety) one time daily at bedtime and every six hours as needed.

Review of a progress note for Resident 1, dated 08/14/2025 at 9:24 PM, showed the resident did not take their hydroxyzine that night because they were waiting for it to be

delivered.

Review of a progress note for Resident 1, dated 09/05/2025 at 10:07 PM, showed the resident did not take their hydroxyzine that night because they were waiting for it to be delivered.

<Medication 5>

Review of a MAR for Resident 1, dated July 2025, showed the resident took tizanidine (a medication used to treat muscle spasticity) two times daily.

Review of a progress note for Resident 1, dated 09/05/2025 at 10:07 PM, showed the resident did not take their tizanidine that night because they were waiting for the pharmacy to deliver it.

Review of a progress note for Resident 1, dated 10/01/2025 at 9:59 AM, showed the resident did not take their tizanidine that day because they were waiting for it to be delivered.

Review of a progress note for Resident 1, dated 10/03/2025 at 10:11 AM, showed the resident did not take their tizanidine that morning because they were waiting for it to be delivered.

<Medication 6>

Review of a MAR for Resident 1, dated July 2025, showed the resident took mirtazapine (an antidepressant medication) one time daily.

Review of a progress note for Resident 1, dated 09/09/2025 at 10:12 PM, showed the resident did not take their mirtazapine that night because it was not available.

Review of a progress note for Resident 1, dated 09/24/2025 at 7:13 PM, showed the resident did not take their mirtazapine that night because they were waiting for it to be delivered.

<Medication 7>

Review of a MAR for Resident 1, dated July 2025, showed the resident took bupropion (an antidepressant medication) one time daily.

Review of progress notes for Resident 1, dated 09/19/2025 at 9:35 AM through 10/08/2025 at 9:58 AM, showed the resident did not take their bupropion on 14 occasions between those dates because the resident was waiting for their medication to be delivered.

<Medication 8>

Review of a MAR for Resident 1, dated July 2025, showed the resident took trazodone (a medication used to induce sleep) one time daily.

Review of a progress note for Resident 1, dated 09/20/2025 at 9:17 PM, showed the resident did not take their trazodone that night because they were waiting for the pharmacy to deliver it.

Review of a progress note for Resident 1, dated 09/24/2025 at 7:14 PM, showed the resident did not take their trazodone that night because they were waiting for the pharmacy to deliver it.

<Medication 9>

Review of a MAR for Resident 1, dated July 2025, showed the resident took clonidine (a medication used to treat high blood pressure) every 12 hours as needed for high blood pressure.

In an interview on 10/08/2025 at 4:18 PM, Collateral Contact 1 (CC1), Non-facility Nurse, stated that on 09/24/2025, Resident 1 had high blood pressure and did not feel well. CC1 stated that Resident 1 had a history of uncontrolled high blood pressure. CC1 stated they told Staff B, Resident Care Coordinator, about Resident 1's high blood pressure and Staff B said they were out of Resident 1's clonidine.

In an interview on 10/14/2025 at 10:04 AM, Staff A, Executive Director, stated that the facility did have issues obtaining Resident 1's clonidine.

In an interview on 10/14/2025 at 10:30 AM, Staff B stated that Resident 1 ran out of clonidine though Staff B was unsure why.

In an interview on 10/14/2025 at 10:52 AM, Resident 1 stated they ran out of clonidine and their other blood pressure medications. Resident 1 stated that they felt sick and not

normal when their blood pressure was high.

<Resident 2>

Review of an NSA for Resident 2, dated 06/16/2025, showed the resident required staff assistance with re-ordering medications.

Review of an undated face sheet for Resident 2 showed they had diagnoses including [redacted], and [redacted].

In an interview on 10/14/2025 at 11:30 AM, Resident 2 stated that they went without a routine medication for five days in July 2025 though they could not remember which one. Resident 2 stated that it happened again in August and September 2025. Resident 2 stated that they were sick, in bed all day, and they could not move when they went without their medication.

<Medication 1>

Review of a MAR for Resident 2, dated July 2025, showed the resident took guaifenesin (a medication used to relieve chest congestion) twice a day.

Review of progress notes for Resident 2, dated 07/15/2025 at 7:13 PM through 08/18/2025 at 8:03 PM, showed the resident did not take their guaifenesin on 31 occasions between those dates because the medication was not available.

<Medication 2>

Review of a MAR for Resident 2, dated July 2025, showed the resident took a daily vitamin.

Review of a progress note for Resident 2, dated 07/17/2025 at 5:06 AM, showed the resident did not take their vitamin that day because they were out of the medication.

Review of a progress note for Resident 2, dated 07/20/2025 at 5:39 AM, showed the resident did not take their vitamin that day because they were waiting for the pharmacy to deliver it.

<Medication 3>

Review of a MAR for Resident 2, dated July 2025, showed the resident took gabapentin (a medication used to treat nerve pain) three times daily.

Review of progress notes for Resident 2, dated 07/17/2025 at 7:40 PM through 09/25/2025 at 11:20 AM, showed the resident did not take their gabapentin on 21 occasions between those dates because they were waiting for the medication to be delivered by the pharmacy.

<Medication 4>

Review of a MAR for Resident 2, dated July 2025, showed the resident took buspirone (a medication used to treat anxiety) twice daily.

Review of a progress note for Resident 2, dated 08/14/2025 at 7:51 PM, showed the resident did not take their buspirone that evening because they were waiting for the medication to be delivered.

Review of a progress note for Resident 2, dated 08/18/2025 at 3:20 PM, showed the resident did not take their buspirone that day because they were waiting for the medication to be delivered.

<Medication 5>

Review of a MAR for Resident 2, dated July 2025, showed the resident took famotidine (a medication used to reduce stomach acid production) two times daily.

Review of a progress note for Resident 2, dated 08/14/2025 at 7:52 PM, showed the resident did not take their famotidine that evening because they were waiting for the medication to be delivered.

Review of a progress note for Resident 2, dated 08/18/2025 at 3:21 PM, showed the resident did not take their famotidine that afternoon because they were waiting for the medication to be delivered.

<Medication 6>

Review of a MAR for Resident 2, dated July 2025, showed the resident took clonidine (a medication used to treat high blood pressure) twice daily.

Review of a progress note for Resident 2, dated 08/14/2025 at 7:52 PM, showed the resident did not take their clonidine that evening because they were waiting for the medication to be delivered.

Review of a progress note for Resident 2, dated 08/18/2025 at 3:20 PM, showed the resident did not take their clonidine that afternoon because they were waiting for the medication to be delivered.

<Medication 7>

Review of a MAR for Resident 2, dated July 2025, showed the resident took atorvastatin (a medication used to reduce cholesterol in the blood) once daily.

Review of a progress note for Resident 2, dated 08/14/2025 at 7:53 PM, showed the resident did not take their atorvastatin that evening because they were waiting for the medication to be delivered.

Review of a progress note for Resident 2, dated 08/18/2025 at 8:02 PM, showed the resident did not take their atorvastatin that evening because they were waiting for the medication to be delivered.

<Medication 8>

Review of a MAR for Resident 2, dated July 2025, showed the resident took trazodone (a medication used to induce sleep) once daily.

Review of progress notes for Resident 2, dated 08/14/2025 at 8:24 PM through 09/20/2025 at 8:18 PM, showed the resident missed their dose of trazodone four times during that period because they were waiting for the medication to be delivered.

Statement of Deficiencies	License # 2751	Compliance Determination #87202
Plan of Correction	Cherrywood Care	Completion Date
Page 9 of 9	Licensee: Cherrywood Care LLC	10/17/2025

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, Cherrywood Care is or will be in compliance with this law and / or regulation on (Date) 11/21/25 .

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

Administrator (or Representative) — Date: 10-24-25

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, Cherrywood Care 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