Residential Care Services
Investigation Summary Report

Provider/Facility: Wenatchee Senior Living
Provider Type: Assisted Living Facility

License/Cert.#: 2415
Intake ID: 207143
Compliance Determination #: 71554
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 01/14/2026 through 04/10/2026
Complainant Contact Date(s):

Allegation(s):
The facility failed to process and implement physician orders in a timely manner.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 7 Closed records sample size: 2
Observations:	Enviornment, Cares, Residents
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident records, Facility policy

Investigation Summary:
Interview and record review showed the facility had failed to process and implement physician orders and administer medications as ordered. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2350 and WAC 388-78A-2210, reference Statement of Deficiencies dated 04/10/2026.

Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Wenatchee Senior Living
Provider Type: Assisted Living Facility

License/Cert.#: 2415
Intake ID: 205714
Compliance Determination #: 71554
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 01/14/2026 through 04/10/2026
Complainant Contact Date(s):

Allegation(s):
Facility had staff working without appropriate credentials and/or required trainings.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 7 Closed records sample size: 2
Observations:	Staff
Interviews:	Facility staff
Record Reviews:	Personnel Records

Investigation Summary:
Interview and record review showed the facility failed to ensure staff have appropriate credentials, required trainings, background checks and reference checks. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2468, WAC 388-78A-24642 and WAC 388-78A-2350, reference Statement of Deficiencies dated 04/10/2026.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Wenatchee Senior Living
Provider Type: Assisted Living Facility

License/Cert.#: 2415
Intake ID: 209583
Compliance Determination #: 71554
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 01/14/2026 through 04/10/2026
Complainant Contact Date(s):

Allegation(s):
1) Residents did not receive medications as ordered.
2) Facility staff failed to coordinate cares with outside provider.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 7 Closed records sample size: 2
Observations:	Environment, Cares, Residents,
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Facility policy, Resident records,

Investigation Summary:
1) Interview and record review showed that facility staff failed to administer resident's medications per physician orders. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2210, reference Statement of Deficiencies dated 04/10/2026.
2) Interview and record review showed the facility staff failed to coordinate care with outside providers for named residents. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2210 and WAC 388-78A-2320, reference Statement of Deficiencies dated 04/10/2026.

Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 01/14/2026 and 03/09/2026 of:

Wenatchee Senior Living
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 207143, 205714, 209583

The following sample was selected for review during the unannounced on-site visit: 7 of 77 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

This document was prepared by Residential Care Services for the Locator website.

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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure the negotiated service agreements (NSA) were developed with a documented plan to address the assessed needs of residents who required assistance with medications, health support services and behavioral needs for 3 of 7 residents (Resident 1, 2 and 7). This failure placed residents at risk of staff not having timely care plans that reflected the actual care and services needed for residents.

This document was prepared by Residential Care Services for the Locator website.

Findings included…

<Resident 7>

Record review of Resident 7's undated face sheet showed the resident was admitted to the facility on [redacted]/2023.

Record review of Resident 7's progress notes, dated 11/03/2025, showed the resident had a fall and sustained an injury to their right knee.

Record review of Resident 7's progress note dated, 11/05/2025, showed the resident was noted to have a bruise with a blister to the right knee.

Record review of Resident 7's progress note dated, 11/10/2025, showed the resident was noted to have a traumatic wound to the right knee. The right knee was visibly swollen with discoloration from mid-thigh to mid-lower leg. There was a wound that measured 3 inches by 3 inches with an area of hardened black dead tissue over the majority of the wound bed and red open wound along the wound edges.

Record review of Resident 7's progress note dated, 11/15/2025, showed the residents' right knee wound dressing was changed. The note showed the resident had a new skin injury to the buttocks that required a specialty cream for treatment.

Record review of Resident 7's progress note dated 11/25/2025, showed the resident had open wound on their buttocks and a cream for treatment of the wound was applied.

Record review of Resident 7's progress note dated 11/27/2025, 12/05/2026, 12/07/2026, related to the wound on their right lower leg and right buttocks, showed the resident was noted to be taking a medication to treat their wound infection, noted the need for bandage changes with wound, received wound care from home health and there was a foul odor coming from the wound on their right knee.

Record review of Resident 7's progress note dated,12/10/2026, showed the resident had wound care by home health of right knee and the front of the R lower leg. Right knee wound had necrotic tissue with areas of increased depth. The necrotic tissue required the tissue to be cut away by the home health nurse.

Record review of Resident 7's facility assessment, dated 12/11/2025, showed the resident had active open wounds to the right knee and buttocks.

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Record review of Resident 7's care plan, dated 12/11/2025, failed to show the resident had open wounds to the left knee, left leg, right and left buttocks, that required monitoring by staff and coordination with an outside agency for wound care. Further review showed the care plan failed to show who was to monitor the wounds and what the roles and responsibilities of the staff were for the resident's wounds.

In an interview on 02/13/2026 at 2:00 PM, Staff B, Health and Wellness Director, stated they were not aware they were supposed to have a care plan for wounds and outside providers who were involved in the resident's care.

<Resident 1>

Record review of Resident 1's undated face sheet showed the resident was admitted to the facility on [redacted]/2019 with diagnoses of [redacted] and [redacted].

Record review of Resident 1's facility assessment, dated 07/19/2025, showed the resident had behavior issues and was prescribed Sertraline (a medication to treat mood disorder).

Record review of Resident 1's care plan, dated 10/02/2025, showed the resident had verbal and physical behavior issues of being disruptive, aggressive and socially inappropriate that required staff training. The care plan failed to show interventions to guide staff on how to intervene when Resident 1 had behaviors.

In an interview on 04/10/2026 at 8: 53 AM, Staff A stated Resident 1's verbal and physical behaviors were situational, and staff would intervene giving the resident time.

<Resident 2>

Record review of Resident 2's undated face sheet showed the resident was admitted to the facility on [redacted]/2019, with diagnoses of [redacted].

Record review of Resident 2's facility assessment, dated 09/19/2025, showed the resident had chronic anxiety and physical aggression.

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Record review of Resident 2's care plan, dated 09/19/2025, showed the resident had a care plan for behaviors without direction for staff on how to intervene when the resident had the behaviors that were identified in their facility assessment.

In an interview on 04/10/2026 at 8:45 AM, Staff A, stated the resident would get anxious and push staff away and would require reapproach by staff. Staff A further stated that care staff did not have access to document in the progress notes and it would require the medication technician to document the behaviors but behaviors were not documented all of the time.

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, Wenatchee Senior Living 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

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to coordinate services with a physician and an outside provider for 2 of 8 residents (Resident 5 and 7). This failure resulted in Resident 7 having new and worsening skin injuries and placed Resident 5 at risk of complications and diminishes cares and services for [redacted] diagnoses and placed residents at risk of harm.

<Resident 7>

This document was prepared by Residential Care Services for the Locator website.

Review of Resident 7's undated face sheet showed the resident was admitted to the facility on [redacted]/2023.

Record review of Resident 7's progress note dated 11/03/2025, showed the resident had a fall and sustained a bruise to their right knee.

Record review of Resident 7's progress note dated 11/04/2025, showed the resident's right knee bruise had a raised area on the knee cap.

Record review of Resident 7's progress notes dated 11/05/2025 and 11/06/2026, showed the resident had a large, bruised area to the right knee with blistering and swelling present.

Record review of Resident 7's progress notes dated 11/10/2025 and 11/11/2026, showed the resident's right knee showed a traumatic wound on the right knee with open wound present measuring 3 inches by 3 inches with black eschar (layer of dead tissue that forms over skin wounds) with bruising present and purulent drainage (discolored drainage that signifies infection) and was sent to the hospital for evaluation.

Record review of Resident 7's progress note dated 11/15/2025, showed the resident was noted to have a pressure injury on their buttocks.

Record review of Resident 7's progress note, dated 11/16/2025, showed the resident was noted to spend most of the day in their recliner.

Record review of Resident 7's progress notes, dated 11/21/2025 and 11/22/2025, showed the resident had a very swollen right leg, red and hot to the touch (signs of infection) and the resident required transport to the hospital for further evaluation.

Record review of Resident 7's progress note dated 11/25/2025, showed the resident was observed to have sore on their bottom. The note further showed the resident had been spending most of their time sitting in their recliner.

Record review of Resident 7's Outside Provider Summary Sheet, dated 12/05/2025, showed Staff N signed off the document when reviewed on 12/26/2025 (21 days after the visit from the outside provider). The document showed the resident had wound care to right knee and right ankle. Recommendations showed the resident was to keep knee dressing dry and to call the outside agency for any questions or problems.

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Record review of Resident 7's Outside Provider Summary Sheet, dated 12/08/2025, showed Staff N signed the document when reviewed on 01/15/2026 (38 days after the visit from the outside provider). The notes section of the document showed the resident had received wound care to right knee, right shin and right buttocks. Notes the wound specialist was to complete an evaluation and initiate treatment. The resident to was elevate legs for edema and swelling, noting the resident's right leg was firm from the swelling and edema.

Record review of Resident 7's Outside Provider Summary Sheet, dated 12/10/2025, showed Staff N signed the document when reviewed on 12/22/2025 (12 days after the visit from the outside provider). The notes section of the document showed the resident had received wound care to right knee and right lower leg. The plan was for staff to call the outside provider agency if the resident's wound had increased bleeding, or if the dressing gets wet or fails.

Review of Resident 7's facility assessment, dated 12/11/2025, showed the resident had an open wound to their right knee from a fall. The assessment did not address the wounds to the right lower leg or the two pressure injuries the resident developed on their buttocks.

Review of Resident 7's care plan, dated 12/11/2025, did not address the resident's wounds to their right knee and leg, the two pressure injuries to the resident's buttocks or the outside provider summary care instructions and recommendations.

Record review of Resident 7's Outside Provider Summary Sheet, dated 12/12/2025, showed Staff N signed the document when reviewed on 12/21/2025 (9 days after the visit from the outside provider). The document showed the resident had wound care to their right knee with a specialty dressing. The right lower leg, and right and left buttocks were cleansed and dressings applied. Facility staff were to call the outside agency if the resident had increased pain, drainage, redness, failed dressing or a new wound. Staff were to instruct the resident to reposition frequently and elevate their legs.

Record review of Resident 7's Outside Provider Summary Sheet, dated 12/15/2025, showed Staff N signed the document when reviewed on 01/08/2026 (24 days after the visit from the outside provider). The document showed the resident had wound care to right knee, right lower leg and right buttocks. The staff were to remind the resident to reposition off their butt and to elevate their legs at rest and the facility was supposed to contact the outside agency if the resident had increased pain, increased wound drainage, new wounds or if new dressings failed.
Record review of Resident 7's Outside Provider Summary Sheet, dated 12/17/2025, showed Staff N signed the document off when reviewed on 01/08/2026 (22 days after the visit from the outside provider). The document showed the resident had wound care to right knee and right lower leg. The resident had compression wraps to right and left legs. Recommendation was to apply barrier cream to the resident's right buttocks. The

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resident needed to keep the dressings and wraps clean and dry. Facility staff were to call the outside agency if the resident had increased pain, drainage, loose or wet dressings or wraps.
Record review of Resident 7's Outside Provider Summary Sheet, dated 12/23/2025, showed Staff N signed the document when reviewed on 01/08/2026 (16 days after the visit from the outside provider). The document showed wound care was provided to the resident's right knee, right ankle and lower leg, and right and left buttocks. The record showed the resident had a specialty compression wrap applied to left and right legs to edema that were to be kept dry. Facility staff were to report to the outside agency if the resident had increased pain, drainage, redness, odor or swelling. The document further showed that if the resident's dressing to the buttocks came off then staff were to apply a barrier cream. A moisture cream was to be applied to resident's skin two times daily, except under the leg wraps for itch relief.

Record review of Resident 7's Outside Provider Summary Sheet, dated 12/26/2026, showed Staff N signed the document as reviewed when 01/08/2026 (13 days after the visit from the outside provider). The notes showed the resident received wound care to right knee and had right and left leg compression wraps. The resident was provided with a chair cushion to prevent pressure ulcers. Recommendations showed the resident was to have barrier cream applied to buttocks.

Record review of Resident 7's Outside Provider Summary Sheet, dated 01/06/2026, showed Staff N signed the document when reviewed on 01/15/2026 (9 days after the visit from the outside provider). The notes section showed the resident received wound care to the right knee and leg wraps bilaterally in place for edema. Notes the provider collaborated with staff about speaking to the resident's son regarding obtaining supplements to promote healing.

Record review of Resident 7's progress note dated 01/08/2026, documented on 01/15/2026 at 1:05 PM by Staff N, showed the resident received wound care to right knee and buttocks by an outside provider.

Record review of Resident 7's Outside Provider Summary Sheet, dated 01/09/2026, showed Staff N signed the document when reviewed on 01/15/2026 (6 days after the visit from the outside provider). The document showed the resident had wound care to right knee and compression wraps applied to the left and right legs.

Record Review of Resident 7's Outside Provider Summary Sheet, dated 01/13/2026, showed Staff N signed the document when reviewed on 01/15/2026 (2 days after the visit from the outside provider). This document showed the provider completed wound care to the resident's right knee, right and left buttocks. The notes section showed the resident was to have buttocks wounds cleansed and staff were to reapply barrier cream

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twice daily. The resident had right and left leg compression wraps in place. Facility staff were to call outside agency if the resident had questions, wet or loose dressings or wrap and if wounds have an odor, drainage, redness or swelling to wounds or if the resident develops new wounds.

Record Review of Resident 7's Outside Provider Summary Sheet, dated 01/16/2026, showed this document was unsigned and had not been reviewed by facility staff. The document showed the resident received wound care to right need with initiation of a specialty wound treatment. The recommendations showed the resident would need some help getting into bed at night and getting up in the morning to assure the wound treatment device and tubing were managed so the dressing was not pulled loose and to prevent the resident from tripping. The provider further noted to plug the device into the wall outlet to charge at night and staff were to call the provider agency for any problems or alarms coming from the device. The record noted the provider was on call 24 hours per day and the contact information was on a bright yellow sheet on the resident's refrigerator.

Record review of Resident 7's progress note, dated 01/18/2026, showed the resident was noted to have to open pressure injuries to their buttocks.

Record review of Resident 7's progress note dated 01/18/2026, showed the outside provider removed the wound vacuum treatment from right leg and performed treatment to buttocks wounds.

Record review of Resident 7's Outside Provider Summary Sheet, dated 01/23/2026, showed this document was unsigned and had not been reviewed by facility staff. The document showed the resident received wound care to right knee and left leg with right and left compression wraps in place. The recommended service plan changes were to remind the resident to elevate their legs two to three times daily to decrease the edema.

Record review of Resident 7's Outside Provider Summary Sheet, dated 01/27/2026, showed this document was unsigned and not reviewed by facility staff. The document showed the outside provider completed medication reconciliation, wound care to right knee, left lateral leg with venous stasis with right and left compression wraps applied, and treatment to right and left buttocks. The recommendation for service plan changes showed the dressings to the buttocks were not to be removed unless soiled or partially displaced or wrinkled.

Record review of Resident 7's Outside Provider Summary Sheet, dated 01/29/2026, showed this document was unsigned and not reviewed by facility staff. The document showed the outside provider completed wound care to right and left legs with compression wraps applied. The resident also had wound care performed to two pressure injuries to right and left buttocks. Recommendation of service plan changes were for staff to remind the resident to get out of the chair every two to three hours to

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relieve pressure and to keep leg wraps dry.

As of 02/27/2026, Resident 7's care plan did not integrate relevant information from the outside providers summary care instructions and recommendations for the resident's wounds to their right knee and leg, the two pressure injuries to the resident's buttocks or the outside provider.

In an interview on 02/13/2026 at 10:12 AM, Staff O, Medication Technician, stated the recommendation from home health could not be followed if the facility staff did not know what they were. They stated the care provided to Resident 7 was based on what their standard of care would be for someone who had wounds, nothing specific to the resident that they were aware of.

In an interview on 03/31/2027 at 11:57 AM, Staff B, Health and Wellness Director, stated that the dates the Outside Provider Summary Sheets were reviewed on the date the staff member would date and sign them and if the document was not signed or dated then that specific record had not been reviewed. Staff B stated the recommendations were not followed if not reviewed by staff in a timely manner.

<Resident 5>

Review of Resident 5's undated face sheet showed they were admitted to the facility on [redacted]/2025, with diagnoses of [redacted] and [redacted]

Review of Resident 5's physician order, dated 10/31/2025, showed furosemide 20mg was ordered to be given once daily if the resident had worsening edema or weight gain over 2 lbs in 24 hours.

Review of a primary care provider (PCP) clinic note, dated 12/05/2025, showed Collateral Contact 3 (CC3), Physician, had requested daily weights for 5 days on 11/07/2025 and "this had not been completed,".

Review of Resident 5's PCP clinic records, dated 12/05/2025, showed Collateral Contact 2 (CC2), Clinic Nurse, was unable to obtain the resident's weight that had been requested multiple times

Review of Resident 5's physician order, dated 12/17/2025, showed the resident was to have daily weights done.

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Review of Resident 5's PCP clinic note, dated 01/09/2026, showed CC2 had requested weights, vital signs and the Medication Administration Record (MAR) for a medication used to treat the resident's swelling.

Review of Resident 5's PCP clinic note, dated 01/15/2026, showed CC2 noted multiple ongoing failed attempts to obtain facility records of weight, vital signs and the MARs.

Review of Resident 5's physician orders, dated 01/02/2026 showed the resident was to continue to have daily weights related to a medication that was ordered to be administered based on weight gain parameters. The orders further showed the facility was to continue vital signs daily and notify the physician if the resident's blood pressure was elevated above specific parameters.

In an interview on 01/22/2026 at 9:00 AM, Collateral Contact 1 (CC1), Nurse Practitioner, stated their clinic was not able to obtain documentation of the weights, vital signs and Medication Administration Record as requested because they were not being done as ordered by the physician. CC1 stated that this had been a concern that had been ongoing since November 2025, including daily weights for medication administration to treat edema which was very important because when the weights were not done. The medication was not administered since it was based on the resident's weight. CC1 further stated that the facility failing to follow through with obtaining these weights and vital signs could have resulted in the resident to have detrimental health complications.

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, Wenatchee Senior Living 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

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

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(3) Has received three positive references for the person;

This requirement was not met as evidenced by:

Based on
interview and record review, the facility failed to submit a Washington state background check within one day of hire for 7 of 10 staff (Staff C, E, F, I, J, K and L) and failed to ensure work references were submitted for 10 of 10 staff (Staff C, D, E, F, G, H, I, J, K and L). This failure placed the residents at risk harm from care by disqualified staff.

Findings
included…

Staff records
were reviewed with Staff A, Business Office Manager (BOM), on 01/30/2026 at 11:30 AM.
<Staff C>

Review of
Staff C, Caregiver (CG), personnel file showed they were hired on 01/13/2026. Staff C's file did not show documentation that their work references were checked before they were hired. The record failed to show Staff C had a Washington state background check submitted.

<Staff D>

Review of
Staff D, Medication Technician (MT), personnel file showed they were hired on 07/10/2025. Staff D's file did not show documentation that their work references were checked before they were hired.

<Staff E>

Review of
Staff E, CG, personnel file showed they were hired on 11/14/2025. Staff E's file did not show documentation that their Washington state background was submitted, and work references were not checked before they were hired.

<Staff F>

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Review of
Staff F, MT, personnel file showed they were hired on 11/21/2025. Staff F's file did not show documentation of a Washington state background check was submitted, and work references were not checked before they were hired.

<Staff G>

Review of
Staff G, MT, personnel file showed they were hired on 08/14/2025. Staff G's file did not show documentation that their work references were checked before they were hired.

<Staff H>

Review of
Staff H, MT, personnel file showed they were hired on 06/09/2025. Staff H's file did not show documentation that their work references were checked before they were hired.

<Staff I>

Review of
Staff I, CG, personnel file showed they were hired on 01/19/2026. Staff I's file did not show documentation that their Washington state background check was submitted, and work references were not checked before they were hired.

<Staff J>

Review of
Staff J, Resident Care Coordinator, personnel fire showed they were hired on 11/19/2025. Staff J's file did not show documentation that their Washington state background check was submitted, and work references were not checked before they were hired.

<Staff K>

Review of
Staff K, MT, personnel file showed they were hired on 02/25/2025. Staff K's file did not show documentation that their Washington state background check was submitted, and work references were not checked before they were hired.

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<Staff L>

Review of
Staff L, MT, personnel file showed they were hired on 11/26/2025. Staff L's file did not show documentation that their Washington state background check was submitted, and work references were not checked before they were hired.

In an interview on 01/30/2026 at 11:30 AM, Staff A stated they had only been in the BOM position for two weeks and the previous BOM had not completed the reference checks for Staff C, D, E, F, G, H, I, J, K and L and did not submit Washington state background checks for Staff C, E, F, I, J, K and L.

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, Wenatchee Senior Living 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

WAC 388-78A-2210 Medication services.

(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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received their medications as prescribed in a timely and accurate manner as required for 3 of 10 residents. (Resident 1, 5 and 7). This failure resulted in the residents not receiving their medications as ordered. and delayed the treatment of their illnesses.

Findings included…

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Review of the facility policy titled, “Receiving Orders for New Medications,” dated 06/01/2025, showed the medication technician were to process new orders and put them on the Medication Administration Record (MAR), then sign of with their name, date and signature.

Review of the facility policy, titled, “Medication Refills,” dated 12/13/2024, showed medication refill would be obtained in a timely manner to ensure residents have all ordered medications available.

<RESIDENT 5>

Review of Resident 5’s undated face sheet showed the resident was admitted to the facility on [redacted]/2025, with diagnoses of [redacted] and [redacted].

Review of Resident 5’s Negotiated Service Agreement (NSA), dated 09/18/2025, showed the resident required assistance with medication administration.

>Medication 1<

Review of Resident 1’s physician orders, dated 12/31/2025, showed new orders written for:
-furosemide (treat fluid retention) 20 milligrams (mg), 1 tablet as needed for weight gain over 2 pounds (lbs.) in 24 hours or a 5 lbs. weight gain over a week.

Review of Resident 1’s weights for January 2026, showed no weights documented from 1/2/2026 through 1/31/2026.

Review of Resident 1’s weights for February 2026, showed 3 days of 28 days were not documented. Further review showed the resident had a weight gain documented on three separate occasions.
- 02/04/2026 of 4lb.
- 02/11/2026 of 4.5lb
- 02/20/2026 of 2.5lb

Review of Resident 1’s weights for March 2026, showed the resident did not have weights checked 1 day out of 5 days.

Review of Resident 1’s January 2026, February 2026 and March 2026 MARs, showed no documentation of any furosemide dose administered.

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>Medication 2<

Review of Resident 1's physician orders, dated 12/31/2025, showed new order written for: metoprolol succinate extended release (medication for blood pressure) 25mg daily, hold if systolic blood pressure (top number) was less than 100 or heart rate less than 60 beats per minute.

Review of Resident 1's January 2026, February 2026 and March 2026 vital signs, showed the residents heart rate was not checked 61 days out of 63 days, and the blood pressure was not checked 42 days out of 63 days.

Review of Resident 1's January 2026, February 2026 and March 2026 MARs, showed the resident was administered the metoprolol daily without any doses held.

In an interview on 01/22/2026 at 9:00 AM, Collateral Contact 1 (CC1), Nurse Practitioner, stated the facility had a pattern of not starting medications timely and that delayed treatment for the multiple residents' [redacted] diagnoses and acute illnesses.

<Resident 1>

Review of Resident 1's undated Face Sheet showed that resident was admitted to the facility on [redacted]/2019 with diagnoses of [redacted] and [redacted].

Review of Resident 1's Assessment, 07/19/2025, showed the resident required assistance with medications.

Review of Resident 1's hospital after summary, dated 01/16/2026, showed the resident tested positive for influenza. The record showed the resident had a new physician order for oseltamivir (a medication that treats influenza), 30mg one capsule two times per day for nine doses.

Review of Resident 1's clinic note, dated 01/20/2026, showed the Collateral Contact 3 (CC3), Physician, reordered oseltamivir 30mg two times for nine doses.

Review of Resident 1's January 2026 Medication Administration Record (MAR), showed

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the first dose of oseltamivir was not administered until 01/21/2026 at 5:00 PM.

<Resident 7>

Review of Resident 7's undated face sheet showed the resident was admitted to the facility on [redacted]/2023, with diagnoses of [redacted]) and [redacted].

Review of Resident 7's assessment, dated 12/11/2025, showed the resident required assistance with medication management.

Review of Resident 7's physician order, dated 12/09/2025 at 1:37 PM, showed the resident had a new order for an antibiotic to treat a wound infection.

Review of Resident 7's December 2025 MAR showed the resident received their first dose of the newly ordered 7-day (14 doses) antibiotic to treat a wound infection until 5:00 PM on 12/10/2025 (more than 24 hours after the medication was ordered). The MAR further showed the resident did not complete the antibiotic treatment, as they were not given all 14 doses as prescribed.

In an interview on 01/22/2026 at 9:37 AM, CC1 stated there was a delay in starting the resident's antibiotic that was ordered on 12/09/2026 to treat a serious ongoing wound infection.

In an interview on 02/13/2026 at 12:00 PM, Staff B, Health and Wellness Director, stated they did not know why the orders for Resident 1 and Resident 7 were not started timely after they were ordered. Staff B stated Resident 5's furosemide was entered into the MAR as needed and was not reviewed on a schedule for the medication technicians to administered if the resident had a weight gain. They further stated they were not sure why the weights, heart rate and blood pressures were not measured and documented as per physician orders for the furosemide and metoprolol.

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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, Wenatchee Senior Living 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

WAC 388-78A-2320 Intermittent nursing services systems.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to verify that staff held a long-term care worker credential required to be delegated as a medication technician for 1 of 10 staff (Staff G). This failure resulted in residents receiving delegated care and services from uncredentialed staff.

Findings included…

Review of Washington Administrative Code (WAC) 246-840-930(8)(a) titled, “Criteria for Delegation,” showed that the registered nurse delegator was required to verify that the nursing assistant or home care aid was credentialed.

Review of the personnel file for Staff G, Medication Technician, showed that they began working at the facility on 11/19/2025. Staff G’s personnel record showed Staff G had a Nursing Assistant Registration credential that expired on 04/13/2025.

In an interview on 01/30/2026 at, Staff B, Health & Wellness Director, acknowledged that Staff G had been passing delegated medications and performing delegated tasks with an expired credential.

Review of the Department of Health Credential Search on 02/03/2026 showed that Staff G did not

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_____ _____
Administrator (or Representative) Date

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a National Fingerprint Background Check for 3 of 10 Staff (Staff E, F and L). This failure placed residents at risk of being cared for by disqualified staff.

Findings included…

Staff records were reviewed with Staff A, Business Office Manager (BOM), on 01/30/2026 at 11:30 AM.

<Staff E>

Record review of Staff E, Caregiver, personnel file showed they were hired on 01/13/2026. The record failed to show Staff E had a National Fingerprint Background Check completed.

<Staff F>

Record review of Staff F, Medication Technician (MT), showed they were hired on 11/14/2025. The record failed to show Staff F had a National Fingerprint Background Check completed.

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<Staff L>

Record review of Staff L, MT, personnel file showed they were hired on 11/26/2025. The file failed to show Staff L had a National Fingerprint Background Check completed.

In an interview on 01/30/2026 at 11:30 AM, Staff A stated they had only been in the BOM position for two weeks and the previous BOM had not followed up to assure Staff E, Staff F and Staff L had National Fingerprint Background Checks completed.

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, Wenatchee Senior Living 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

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