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

10/12/2026

NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC
Wenatchee Senior Living
1550 CHERRY STREET
WENATCHEE, WA 98801

RE: Wenatchee Senior Living # 2415

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 84812 (Completion Date 10/12/2026) and 77246 (Completion Date 08/11/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/12/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660 Resident rights. The assisted living facility must:

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

(7) Not allow any staff person to abuse or neglect any resident; and

The Department staff who did the On Site verification:
Nicole Mcgraw, Community Complaint Investigator

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

Sincerely,

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

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: 226108
Compliance Determination #: 77246
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 05/12/2026 through 08/11/2026
Complainant Contact Date(s): 05/11/2026, 08/07/2026

Allegation(s):

1) Facility staff had not responded to call light timely and resident had delayed wait times.
2) The named resident had 2 falls within two weeks of their admission to the facility.
2) The named resident had not received a shower for 6 weeks.

Investigation Methods:

Sample:	Total residents: 69 Resident sample size: 8 Closed records sample size: 0
Observations:	Environment, Resident, Staff to resident interactions, Staff availability and response to resident's needs
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic Roster, Resident Records, Faciltiy Policies, Facility incident reports and investigations

Investigation Summary:

1) Observation, interview and records review showed that residents had delayed call light response times that caused resident's needs to not be met in a timely manner and staff had turned call lights off without addressing resident's needs. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2660(2)(7) and WAC 388-78A-2160, reference Statement of Deficiencies dated 08/05/2026.
2) Observation, interview and record review showed residents falls were investigated, all notifications were made and the named resident's care plan was reviewed and updated as needed. No failed practice identified.
3) Observations showed a resident to be dissheveled and with body odor present. Resident interviews showed they had went long periods of time without showers that caused them physical and emotional distress. Record review showed residents were not being showered as scheduled. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2660(2)(7) reference Statement of Deficiencies dated 08/05/2026.

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

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: 222408
Compliance Determination #: 77246
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 05/12/2026 through 08/11/2026
Complainant Contact Date(s):

Allegation(s):

1) The faciity had not responded to call lights timely.
2) The named resident had not been taken to the dining room for meal and had not eaten a meal for an unknown amount of time.
3) The named resident's bed sheets had not been changed.

Investigation Methods:

Sample:	Total residents: 69 Resident sample size: 8 Closed records sample size: 0
Observations:	Environment, Residents, Staff to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents and staff
Record Reviews:	Characterstic rosters, Resident records, Facility Call light reports, Facility polcies, Faciltiy incident log,

Investigation Summary:

1) Observation, interview and records review showed that resident's call light response times were delayed and not resident's needs were not met in a timely manner. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2660(2)(7) and WAC 388-78A-2160, reference Statement of Deficiencies dated 08/05/2026.
2) Observation, interview and record review showed the named resident ate their meals in their room and their meals were delivered to their room. No failed practice identified.
3) Observations showed the named resident's bed sheets were clean and free of odors. Interview with the named resident showed the facility staff changed their bed sheets frequently. Staff interview and record review showed the named resident had skin irritation that required frequent bed sheet changes every one to two day. No failed practice identified.

Conclusion / Action:

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

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

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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 05/12/2026, 08/16/2026 and 06/16/2026 of:

Wenatchee Senior Living
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 222408, 226108

The following sample was selected for review during the unannounced on-site visit: 8 of 69 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Niccle 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.

Laura Williams-Davis
Residential Care Services

08/18/2026
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.

Administrator (or Representative)

8/20/26
Date

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

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

(7) Not allow any staff person to abuse or neglect any resident; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide cares and services to residents in a manner that maintained residents' dignity, respect and physical and mental well-being for 4 of 8 residents (Resident 1, 2, 4 and 5). These failures resulted in Resident 4's needs not being met, Resident 2 feeling disgusted and embarrassed and Resident 5 feeling shame and embarrassment when they were not provided showers, residents having poor hygiene, and placed residents at risk for unmet needs and a decreased quality of life.

Findings included...

Washington Administrative Code (WAC) 388-78A-2020 defines neglect as a pattern of conduct or inaction resulting in the failure to provide goods and services necessary to maintain a resident's physical or mental health or to prevent physical harm, pain or mental suffering.

Revised Code of Washington (RCW) 70.129.140 Quality of Life-Rights requires the facility to care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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Review of facility policy, titled, "Personal Rights," dated 12/13/2024, showed,
>Community management would ensure that residents were treated with dignity and respect.
>Residents had the right to a dignified existence and access to persons and services inside the facility.
>Facility staff were to promote and protect the rights and quality of life to provide cares and services, consistent with the residents' assessed needs.

<Resident 5>

Record review of Resident 5's face sheet showed the resident was admitted to the facility on [redacted]/2026 with diagnoses of [redacted] and [redacted].

Record review of Resident 5's assessment and NSA, dated 03/20/2026, showed the resident had a history of falling, was at high risk for falls and required staff assistance and the use of a gait belt (a safety belt that staff can hold on to keep the person from falling while they ambulate or transfer) for transfers, ambulation for safety due to resident's instability and assistance with showers.

Record review of Resident 5's shower log for 03/17/2026, through 03/31/2026, showed the resident failed to receive three of their four scheduled showers on:
>03/18/2026
>03/21/2026
>03/25/2026

Record review of Resident 5's shower log for April 2026, showed the resident went 17 days without a shower. The resident did not receive four of their nine schedule showers on:
>04/08/2026
>04/11/2026
>04/15/2026
>04/18/2026

Record review of Resident 5's shower log for May 2026, showed the resident received two showers in 24 days. The resident did not receive five of their nine scheduled showers on:
>05/02/2026
>05/09/2026
>05/13/2026
>05/18/2026
>05/21/2026

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In an interview on 06/03/2026 at 10:23 AM, Collateral Contact 1 (CC1), Resident Representative, stated they had to go into the facility on 04/29/2026, to speak with Staff D, Regional Vice President of Operations, regarding Resident 5 not receiving showers for many weeks. They stated that on 04/29/2026, Resident 5 had called them crying because they felt filthy and wanted a shower. CC1 stated that on 05/25/2026, they received another call from Resident 5, CC1 stated Resident 5 was in mental anguish because they had not been showered for two weeks. Resident 5 informed CC1 that facility staff promised the resident a shower on 05/23/2026 and on 05/24/2026 but Resident 5 was not showered. Then on 05/25/2026, CC1 contacted the facility to express the need for Resident 5 to have a shower and Resident 5 was showered on 05/25/2026.

In an interview on 06/03/2026 at 1:00 PM, Resident 5 stated they had received seven showers between when they were admitted on [redacted]/2026 and 06/03/2026. During the interview, the shower documentation was reviewed with the resident, and they stated they had not received the showers that were documented on 04/22/2026 and 04/25/2026. They stated this was a pivotal point because they had voiced their concerns to CC1, and CC1 met with the facility staff on 04/29/2026 and it was not until then that the resident received a shower. Resident 5 stated that going for long periods of time without getting a shower made them feel a physical and emotional discomfort and a feeling of embarrassment and being ashamed.

In an electronic communication on 07/29/2026 at 8:55pm, Staff B, Licensed Practical Nurse, stated they had documented that the resident had showered but had not provided a shower to the resident on 4/22/2026 or on 04/25/2026 and could not personally verify that the showers were given. Staff B confirmed that CC1 had been into the facility on 4/29/2026 and spoke with Staff D, regarding some concerns of Resident 5 not having been showered.

<Resident 4>

Review of Resident 4's assessment and NSA, dated 02/02/2026, showed the resident had diagnoses of [redacted] and [redacted]. The document showed the resident was legally blind and required staff assistance with dressing, showers, personal hygiene and ambulation.

Record review of Resident 4's shower log for March 2026, showed the resident went 21 days in the month of March without a shower. The resident did not receive seven of eight scheduled showers on:
>03/04/2026
>03/07/2026
>03/11/2026
>03/14/2026
>03/18/2026
>03/21/2026
>03/25/2026

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Record review of Resident 4's shower log for April 2026, showed the resident went 17 days in the month of April without a shower. The resident did not receive four of nine scheduled showers on:
>04/08/2026
>04/11/2026
>04/15/2026
>04/18/2026

Record review of Resident 4's shower log for May 2026, showed the resident went 15 days in the month of May without a shower. The resident did not receive six of ten scheduled showers on:
>05/02/2026
>05/06/2026
>05/09/2026
>05/13/2026
>05/20/2026
>05/27/2026

Record review of Resident 4's shower log for June 2026, showed the resident went 10 days in the month of June without a shower. The resident did not receive three of the nine scheduled showers on:
>06/06/2026
>06/09/2026
>06/20/2026

During an interview on 05/12/2026 at 12:40 PM, Resident 4 stated their basic needs do not get met with the not getting their showers and they felt ignored by staff and that they did not pay attention to them or their needs.

<Resident 1>

Record review of Resident 1's undated face sheet showed they were admitted to the facility on [redacted]/2022 with diagnoses of [redacted] and had a history of falling.

Record review of Resident 1's assessment and NSA, dated 04/01/2026, showed the resident required maximum assistance with mobility, dressing, incontinence care, toileting and bathing.

Record review of Resident 1's shower log for March 2026, showed the resident did not receive three of the nine scheduled showers on:

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>03/03/2026
>03/05/2026
>03/12/2026

Record review of Resident 1's shower log for May 2026, showed the resident did not receive three of their eight scheduled showers on:
>05/05/2026
>05/19/2026
>05/21/2026

In an interview on 05/12/2026 at 12:24 PM, Resident 1 stated there were not enough staff to answer call lights timely, provide the cares that they need and it has affected their quality of life. Observation during the interview showed the resident had oily hair and a noted foul body odor. The resident stated they have missed a lot of showers that were promised to be made up and never were. The resident stated that they felt disgusting and embarrassed to leave their room because they had not received a shower. Resident 1 stated they had voiced their concerns about their showers not being done, to the management multiple times, but nothing improved. The resident stated the lack of care and response by staff was neglect.

In an interview on 05/12/2026 at 11:48 AM, Staff A, Resident Care Coordinator, stated that Resident 1 had made a complaint to them when they were left in bed for two hours and staff did not get them up. Resident 1 had also reported to Staff A, concerns about not getting their showers as scheduled and the make-up showers were not getting done either. Staff A stated they had notified the Executive Director to get assistance with resolving the multiple concerns that had been made by the resident.

<Resident 2>

Record review of Resident 2's undated face sheet, showed the resident was admitted to the facility on [redacted]/2025 with diagnoses of [redacted] and [redacted] and [redacted].

Record review of Resident 2's assessment and NSA, dated 04/06/2026 showed the resident was to receive assistance with bathing two times per week.

Record review of Resident 2's March 2026 shower log, showed the resident did not receive six of their eight scheduled showers on:
>03/02/2026
>03/04/2026
>03/16/2026
>03/18/2026
>03/25/2026

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

Record review of Resident 2's April 2026 shower logs, showed the resident did not receive three of the seven scheduled showers on:
>04/08/2026
>04/13/2026
>04/15/2026

Record review of Resident 2's May 2026 shower log, showed the resident did not receive eight of the nine scheduled showers on:
>05/06/2026
>05/11/2026
>05/13/2026
>05/18/2026
>05/20/2026
>05/23/2026
>05/27/2026
>05/30/2026

Record review of Resident 2's June 2026 shower log, showed the resident did not receive four of eight scheduled showers on:
>06/03/2026
>06/10/2026
>06/13/2026
>06/20/2026

In an interview on 05/12/2026 at 12:00 PM, Resident 2 stated they were not getting bathed and staff had not been going in to offer them a bed bath or any type of bath on their scheduled shower days.

In an interview on 05/12/2026 at 11:48 AM, Staff A, Resident Care Coordinator, stated the shower schedule was not followed and when they would follow up with staff about the showers not being done, the staff would have excuses for why they were not don't but had not asked for help to get the showers done for that day.

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Statement of Deficiencies	License #: 2415	Compliance Determination # 77246
Plan of Correction	Wenatchee Senior Living	Completion Date
Page 8 of 8	Licensee: NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC	08/11/2026

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) 9/25/26.

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

Administrator (or Representative) — Date: 8/20/26

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