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

09/08/2026

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) 83389 (Completion Date 09/08/2026) and 78696 (Completion Date 07/14/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/08/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

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

(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

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

The Department staff who did the On Site verification:
Brittney Shull, 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

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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: 227570
Compliance Determination #: 78696
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 06/09/2026 through 07/14/2026
Complainant Contact Date(s):

Allegation(s):
The named resident stalked and inappropriately touched another named resident.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 5 Closed records sample size: 0
Observations:	Environment, Residents, Resident to resident interactions, Resident rooms.
Interviews:	Residents, Staff.
Record Reviews:	Resident records, Resident Assessment, Negotiated Service Agreement, Temporary Progress Notes, Incident Investigation, Department records.

Investigation Summary:
Interview and record review showed that a named resident had been followed and had received unwanted contact by another named resident for months. Interview and record review showed that the named resident was also inappropriately touched by the other named resident. Interview and record review showed that the named resident did not have appropriate interventions in the Negotiated Service Agreement in a timely manner to prevent mental or sexual abuse. Interview and record review showed that allegations of mental and sexual abuse were not reported in a timely manner. Failed practice identified. Reference WAC 388-78A-2630 and WAC 388-78A-2130.

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: 226875
Compliance Determination #: 78696
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 06/09/2026 through 07/14/2026
Complainant Contact Date(s):

Allegation(s):
The named residents reported missing items.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 5 Closed records sample size: 0
Observations:	Environment, Residents, Staff to resident interactions, Resident rooms.
Interviews:	Residents, Staff.
Record Reviews:	Resident records, Incident Investigation, Progress Notes, Personnel records.

Investigation Summary:
Observations showed staff to resident interactions were appropriate and respectful and residents felt safe. Interview showed that 3 residents reported missing items or money. Interview showed that 2 of the 3 residents may have misplaced the items. Interview and record review showed that the facility assisted the residents in attempting to find the items and were unable to locate them, and advised residents do not keep items of value in the facility, or locked their items in a secure space. Interview and record review showed that the facility investigated the incident and made all notifications were made, including law enforcement. Interview and record review showed that staff had appropriate background checks. Observation and interview showed that not all residents had access to a locking cabinet. Failed practice identified. Reference consultation for WAC 388-78A-3010.

Conclusion / Action:

- [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

Statement of Deficiencies	License #: 2415	Compliance Determination # 78696
Plan of Correction	Wenatchee Senior Living	Completion Date
Page 1 of 9	Licensee: NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC	07/14/2026

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 06/09/2026 and 06/10/2026 of:

Wenatchee Senior Living
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 224335, 227570, 226875

The following sample was selected for review during the unannounced on-site visit: 5 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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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

07/23/2026
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.

Administrator (or Representative)

8/1/26
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that each staff person immediately reported allegations of sexual and mental abuse for 1 of 1 resident (Resident 2). This failure delayed the investigation of abuse and placed residents at increased risk of further abuse.

Findings included...

RCW 74.34.020
Definitions.
(2) "Abuse" means the intentional, willful, or reckless action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate

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physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:
(a) "Sexual abuse" means any form of nonconsensual sexual conduct, including but not limited to unwanted or inappropriate touching, rape, molestation, indecent liberties, sexual coercion, sexually explicit photographing or recording, voyeurism, indecent exposure, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.
(c) "Mental abuse" means an intentional, willful, or reckless verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.

RCW 74.34.035
Reports—Mandated and permissive—Contents—Confidentiality.
(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.
(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

Review of facility policy titled, "Abuse, Neglect, and Exploitation," dated 06/01/2025, showed that facility staff were mandatory reporters and were required to report allegations or suspicions of abuse as required by state regulations to the Department.

Review of Resident 1's Assessment, dated 05/22/2026, showed Resident 1 had occasional disorientation to person, place, time, or situation that did not interfere with functioning in familiar surroundings and required some redirection and reminders from others. The assessment showed Resident 1 had no behaviors.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 05/22/2026, showed that Resident 1 had vascular dementia (decline in memory or cognition caused by decreased blood flow to the brain). The NSA showed that interventions for sexually inappropriate behaviors were added to the NSA on 06/09/2026 which included unwanted sexual comments, gestures, touching, advances or boundary violations. The NSA showed that the behaviors put others at risk of emotional distress and compromised the safety, dignity and comfort of the community. The NSA showed that staff were to remain calm, verbally enforce boundaries and redirect attention to an appropriate activity or topic and Resident 1's physician would be notified of ongoing or worsening behaviors. The updated NSA showed that interventions for behaviors of stalking/following Resident 2 were added on 06/11/2026.

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Review of Resident 1's Temporary Service Plan (TSP), a care plan created to provide guidance to staff on a short-term basis, dated 05/29/2026, showed that Resident 1 demonstrated sexually inappropriate behaviors with staff and facility should observe and report any inappropriate behaviors made toward other residents.

Review of Resident 1's and 2's Progress Notes showed:
-On 02/20/2026, Resident 2 reported they were distressed because a resident was following them around and made them feel uncomfortable. Law enforcement was notified.
-On 05/29/2026, Resident 2 reported another resident drove by on their wheelchair and touched their bottom without permission.
-On 05/29/2026, Resident 1 touched another resident's bottom.
-On 06/05/2026, Resident 2 reported that Resident 1 attempted to get into Resident 2's room and a staff member stopped Resident 1 from entering. Resident 2 also reported that Resident 1 goes into the parking lot and stared at Resident 2 through their window.

Review of Investigative notes dated 06/10/2026 showed:
-Resident 2 had accused Resident 1 of harassing them and making unwanted physical contact of Resident 1's hand on Resident 2's bottom.
-Police were notified on 06/10/2026.

Review of Department records showed that the incidents on 05/29/2026 and 06/05/2026 had not been reported to the Department until 06/08/2026. There were no records of reports of mental abuse from Resident 1 to Resident 2 prior to the report on 06/08/2026.

In an interview on 06/09/2026 at 12:48pm, Resident 2 stated Resident 1 had been stalking Resident 2 for eight months, would repeatedly follow Resident 2 attempting to make close contact, and would stare towards their window while outside in the parking lot. Resident 1 stated that previous administrators who no longer worked for the facility were aware of Resident 2's behavior. Resident 2 stated that one week ago, they had stopped to talk to a staff member and Resident 1 came up behind them and smacked their bottom. Resident 2 stated that one week ago, Resident 1 had followed Resident 2, attempted to enter their room, and staff had to intervene to stop Resident 1 so Resident 2 could lock their door. Resident 2 stated they were afraid of Resident 1.

In an interview on 06/10/2026 at 11:54 am, with Staff A, Senior Vice President of Operations, Staff B, Regional Health and Wellness Director, and Staff C, Regional Executive Director, Staff A stated Resident 1 inappropriately touched Resident 2 on the bottom on 05/29/2026. Staff C stated that a staff member told the Sale's Director, about the incident on Friday, 06/05/2026, at 6pm and did not know who to report the incident to and began making a safety plan in which they had realized that multiple staff were aware of the incident and no formal safety plan had been put in place and no reports had been made to the Department. Staff C stated that the former Executive Director

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had been notified, was terminated, and had not made the report to the Department. Staff A stated they had not made a report to law enforcement for sexual abuse allegations as they were focused on the stalking reports of mental abuse. Staff A stated based on their initial investigation, they substantiated abuse. Staff A stated that Staff E, Medication Technician, was in close proximity when Resident 1 touched Resident 2's bottom and saw Resident 2's reaction to the alleged inappropriate touch.

In an interview on 06/10/2026 at 1:39pm, Staff F, Housekeeper, stated they had observed Resident 1 stalking Resident 2 and did not report it to the Department. Staff F stated they had not received education about mandatory reporting to the Department until 06/09/2026. Staff F stated that during orientation, they were only told to report abuse to administrators who no longer worked at the facility. Staff F stated that prior to 06/09/2026, they were confused about who they should report abuse to due to a change in administrators.

On 06/10/2026 at 2:00pm, Staff E, Medication Technician, stated that another staff member and Resident 2 told Staff E that Resident 1 had smacked their bottom. Staff E stated they witnessed Resident 2 jump when Resident 1 passed by in the hallway. Staff E stated Resident 1 had a history of inappropriate sexual behaviors towards staff prior to that incident. Staff E stated they had reported the incident to Staff C who advised Staff E did not need to make an incident report. Staff E stated that they later learned that Staff C was confused and thought the sexual abuse was towards a staff member, not towards another resident. Staff E stated that they should have reported the incident to the Department and not just to another staff member

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) 8/28/26.

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

Administrator (or Representative) Maggie Date 8/1/26

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

(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

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resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a Negotiated Service Agreement (NSA) was updated after a change in a resident's behavior occurred that affected 2 of 2 residents (Resident 1 and Resident 2). This failure resulted in Resident 1 and Resident 2 not having their NSA updated with Resident 1's behaviors and safety interventions that resulted in Resident 2 experiencing fear and anxiety.

Findings included...

<Resident 1>

Review of Resident 1's Negotiated Service Agreement (NSA) dated 02/02/2026, showed Resident 1 had a diagnosis of [redacted]. The NSA showed Resident 1 was alert and oriented and did not have confusion or behaviors.

Review of Resident 1's Progress Notes showed:
-On 2/24/2026, Resident 2 hid from Resident 1 in the dining room and requested a to go order (to avoid interaction with Resident 2).
-On 03/05/2026, Resident 1 signed an "acknowledgement," about inappropriate behaviors.
-On 05/29/2026, Resident 1 touched another resident's bottom, made sexually inappropriate comments and attempted inappropriate physical contact with others. Resident 1 showed limited insight into the inappropriate nature of behavior.
-On 06/05/2026, Resident 2 reported that Resident 1 attempted to get into Resident 2's room and a staff member stopped Resident 1 from entering. Resident 2 also reported that Resident 1 had gone into the parking lot and stared at Resident 2 through their window. Resident 1 was advised to lock their door and call 911 if Resident 1 attempted to break in.

Review of Resident 1's Assessment dated 05/22/2026 showed Resident 1 had occasional disorientation to person, place, time, or situation that did not interfere with functioning in familiar surroundings and required some redirection and reminders from others. The assessment showed Resident 1 had no behaviors.

<Resident 2>

Review of Resident 2's Assessment dated 03/31/2026, showed Resident 2:
-Had mild orientation impairment that did not interfere with functioning in familiar

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environments.
-Had anxiety and depression.
-Did not have behaviors, or safety concerns with other residents.

Review of Resident 2's NSA dated 03/31/2026 did not show any interventions for safety or behavioral concerns with other residents.

Review of Resident 2's Progress Notes showed:
-On 02/20/2026, Resident 2 was distressed because a resident was following them around and made them feel uncomfortable. Law enforcement was notified.
-On 05/29/2026, Resident 2 reported another resident drove by on their wheelchair and touched their bottom without permission.
-On 06/05/2026, Resident 2 reported that Resident 1 attempted to get into Resident 2's room and a staff member stopped Resident 1 from entering. Resident 2 also reported that Resident 1 goes into the parking lot and stared at Resident 2 through their window. Resident 1 was advised to lock their door and call 911 if Resident 1 attempted to break in.

Review of Resident 1's Temporary Service Plan (TSP), a care plan created to provide guidance to staff on a short-term basis, was not created until 05/29/2026. The TSP showed that Resident 1 had sexually inappropriate behaviors towards staff and directed staff to redirect inappropriate conversation, set clear boundaries, and provide care with two caregivers present. The TSP directed staff to report inappropriate behaviors towards other residents. The TSP did not include interventions to prevent sexual behaviors directed toward other residents. The TSP did not address behaviors of stalking/following other residents or trying to enter other resident rooms without permission.

Review of Resident 1's NSA dated 05/22/2026, showed that interventions for sexually inappropriate behaviors were not added until 06/09/2026. The updated NSA did not show any interventions for behaviors of stalking/following Resident 2 until 06/11/2026, over 3 months after the behaviors were documented in the progress notes.

Review of Resident 2's TSP dated 06/05/2026, showed that interventions for Resident 2 "being made to feel uncomfortable" by Resident 1 had not been added until 06/05/2026.

In an interview on 06/09/2026 at 11:05am, Staff A, Senior Vice President of Operations, and Staff B, Regional Health and Wellness Director, Staff A stated that Resident 1's behaviors had caused Resident 2 anxiety, fear, and lack of sleep. Staff A stated that Resident 1's behavior appeared targeted towards Resident 2 and last week Resident 1 had touched Resident 2's bottom.

In an observation and interview on 06/09/2026 at 12:48pm, Resident 2 answered the door to their apartment, was shaking and appeared fearful with wide eyes and a tense

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mouth. Resident 2 stated they were scared when they heard a knock at their door because for eight months, Resident 1 had been stalking them. Resident 2 stated Resident 1 would repeatedly follow them attempting to make close contact and would stare towards their window while outside in the parking lot. Resident 2 stated they had been getting a meal tray from the dining room to eat in their room to avoid contact with Resident 1. Resident 2 stated that one week ago, they had stopped to talk to a staff member and Resident 1 came up behind them and smacked their bottom. Around that same time Resident 1 followed them, attempted to enter their room, and a housekeeper had to intervene to stop Resident 1 so Resident 2 could lock their door. Resident 1 stated that previous administrators were aware of Resident 2's behavior, which had been ongoing for 8 months, had notified law enforcement, and Resident 2's behaviors continued.

In an interview on 06/10/2026 at 11:54 am with Staff A, Staff B, and Staff C, Regional Executive Director, Staff A stated that staff had only recently been trained how to set boundaries with Resident 1's sexually inappropriate behaviors. Staff A stated that facility staff were aware of Resident 1's ongoing behaviors, had been checking on Resident 2, assisting Resident 2 to meals, and redirecting Resident 1 when Resident 1 would attempt to approach Resident 2. Staff B stated that on 06/05/2026 they had just discovered that the incident was known to staff and no formal safety plan had been created.

In an interview on 06/10/2026 at 2:53pm, Staff B stated they had completed Resident 2's NSA in May 2026 after Resident 2 returned from the hospital because the previous Health and Wellness Director who was no longer working there, and Staff B was unaware that Resident 2 had behaviors. Staff B stated there were no incident reports documenting behaviors. Staff B stated they were surprised when they read Resident 2's progress notes that the Department had requested and learned that Resident 1 had been stalking Resident 2 since February 2026. Staff B stated they were unable to find the "acknowledgement," of inappropriate behaviors that was documented in Resident 1's progress notes in March 2026. Staff B stated that they learned from facility staff after 05/29/2026 that Resident 2 had inappropriate sexual behaviors for a while.

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Statement of Deficiencies	License #: 2415	Compliance Determination # 78696
Plan of Correction	Wenatchee Senior Living	Completion Date
Page 9 of 9	Licensee: NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC	07/14/2026

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) 8/28/26.

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

Administrator (or Representative) — Date: 8/1/26

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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

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:

The Department completed a complaint investigation of your Assisted Living Facility on 07/14/2026 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Return the Plan/Attestation Statement and report with signatures to:

Laura Williams-Davis, ALF Field Manager
Residential Care Services

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Region 1, Unit G
Preferred methods:
eFax: (509) 454-4160
Email: rcsregion1email@dshs.wa.gov
Optional method:
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (07/14/2026), no later than 08/28/2026 or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan of correction available for review upon request from the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

Observation and interview showed that residents did not have access to a lockable secure space. The failure was corrected before the exit conference.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o You can make an IDR request and find directions on the IDR web page at:
    https://www.dshs.wa.gov/altsa/idr

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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

Enclosure

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