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

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

RE: Blossom Creek Senior Alzheimer Community License # 2721

Dear Administrator:

This letter addresses Compliance Determination(s) 84802 (Completion Date 10/07/2026) and 80105 (Completion Date 08/18/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/07/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2380-3, WAC 388-78A-2380-4, WAC 388-78A-2380-7-a, WAC 388-78A-2600-1-c

The Department staff who did the on-site verification:
Nicole Mcgraw, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit Z
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Blossom Creek Senior Alzheimer Community
License/Cert.#: 2721
Compliance Determination #: 80105
Investigator: Nicole Mcgraw
Provider Type: Assisted Living Facility
Intake ID: 227697
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 07/08/2026 through 08/18/2026
Complainant Contact Date(s):

Allegation(s):
A named resident left the facility unaccompanied.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 1 Closed records sample size: 0
Observations:	Environment, Cares, Residents, Egress Doors
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Resident records, Facility policies, Facility incident report and investigation.

Investigation Summary:
Observation, interview and record review showed the facility did not allow freedom of movement through front entrance egress doors and did not keep unit egress doors locked and the named resident left the facility unaccompanied. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2380 and WAC 388-78A-2600 reference Statement of Deficiencies dated 08/18/2026.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2721	Compliance Determination #80105
Plan of Correction	Blossom Creek Senior Alzheimer Community	Completion Date
Page 1 of 6	Licensee: AHR Wenatchee WA MC TRS Sub, LLC	08/18/2026

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 07/08/2026 of:

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

This document references the following complaint number(s): 227697

The following sample was selected for review during the unannounced on-site visit: 1 of 47 current residents and 0 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 Z
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

08/28/2026
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)

08/28/2026
Date

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

(4) The installation of access and egress controls that does not restrict the movement of residents who are cognitively and physically able to safely leave the facility independently;

(7) Buildings from which egress is restricted have:

(a) A system in place to inform and permit visitors, staff persons, and appropriate residents freedom of movement; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure there was a system in place to inform and permit visitors, staff persons and appropriate residents' freedom of movement and how they may exit independently without sounding the alarm for 1 of 1 entrance/exit door (Door 1). This failure resulted in restricted freedom of movement and inability to exit the building independently and without sounding an alarm.

Findings included...

Review of facility policy, titled, "Memory Care Neighborhood Controlled Egress," dated, 12/05/2025, showed that anyone exiting the facility had to notify a staff member who would assist them to exit the facility and any resident that lived at the facility that did not require secured placement in the memory care would only be able to enter and exit

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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.

Residential Care Services _____ Date _____

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Administrator (or Representative) _____ Date _____

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Findings included...

Review of facility policy, titled, "Memory Care Neighborhood Controlled Egress," dated, 12/05/2025, showed that anyone exiting the facility had to notify a staff member who would assist them to exit the facility and any resident that lived at the facility that did not require secured placement in the memory care would only be able to enter and exit

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the facility with assistance from staff.

Observations on 07/08/2026 at 10:45 AM showed a vendor required staff assistance to enter and exit the Front Entrance Doors (Door 1), at which time, the staff entered a code into the coded keypad and an alarm sounded.

Observation on 07/08/2026 at 12:18 PM, showed Door 1 had a restricted egress doors and had a coded keypad. Door 1 did not have any type of direction to staff, visitors or residents on how they could exit independently. The sign posted above the coded keypad, stated, "You may exit by pushing the blue button to notify staff that you are ready to leave without sounding the alarm." There was no sign posted to inform and permit visitors, staff persons, and appropriate residents, to allow them to exit the front door independently, without requiring staff assistance.

Observation on 07/08/2026 at 12:41 PM, a visitor required facility staff to open the front door with a code, and when the door was opened, the alarm sounded and the visitor was allowed to exit the facility.

In an interview on 07/08/2026 at 12:38 PM, Staff B, Health and Wellness Director, stated every time Door 1 was opened, the alarm sounds, and it alarms whether it is opened with the code or the egress is pushed until the 15 second alarm goes off and the door opens. They stated the code was not to be given out to anyone other than staff and all other persons had to wait for staff to input the code into the keypad to open the door for them to exit out the front door. I had been told by families that they had to wait for at least 15 minutes for staff to assist them out the front door because the staff were busy caring for residents.

In an interview on 07/08/2026 at 12:52 PM, Staff C, Medication Technician, stated the front door alarm goes off all of the time, night and day, when it was opened. Staff C stated that visitors require staff assistance with entering the code into the coded keypad to open front door and that every time the front door was opened, the alarm sounded.

In an interview on 07/08/2026 at 12:52 PM, Staff D, Medication Technician, stated family members coming in and out of the facility all of the time and every time, the staff have to let them in and out and the staff were not allowed to give the code out to visitors.

Review of an electronic communication on 07/29/2026 at 1:05 PM, Staff A, Executive Director stated that the front door (Door 1) entrance alarms when opened with the coded keypad. They stated that all visitors and residents required staff assistance to get in and out and they could not exit independently as they did not give out the code or instruction to the coded keypad.

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In an interview on 09/19/2026 at 10.00AM, Collateral Contact 1 (CC1), Resident representative, stated they could not exit out Door 1 independently, without staff assistance and that if it were after hours, they would have to wait for a staff member to be available to put the code into the keypad to allow them to exit. They stated it was inconvenient having to wait for staff to let them out.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Blossom Creek Senior Alzheimer Community is or will be in compliance with this law and / or regulation on (Date) 10/01/2026 .

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

TW Wash NP — Administrator (or Representative)

08/28/2026 — Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to.

(c) Safely operate the assisted living facility; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement the facility's policy to confirm restricted egress doors were relocked in a secured memory care unit for 1 of 1 resident (Resident 1) and the facility failed to develop and implement a facility policy on the procedure that staff were to follow when they responded to an alarming, restricted egress door. This failure resulted in Resident 1 leaving the facility unaccompanied from the secured memory care unit without staff knowledge, placing the resident at risk of harm.

Findings included...

Review of facility policy titled, "Memory Care Neighborhood Controlled Egress," dated 12/05/2025, showed the facility's controlled egress doors included alarms and monitoring systems that alert staff to unauthorized attempts to exit. After visitors leave, the staff were to confirm doors were fully closed and secured/relocked to maintain egress control. The policy did not provide a procedure for staff to follow when they responded to the restricted egress door alarm.

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In an interview on 08/18/2026 at 10:00AM, Collateral Contact 1 (CC1), Resident representative, stated they could not exit out Door 1 independently, without staff assistance and that if it were after hours, they would have to wait for a staff member to be available to put the code into the keypad to allow them to exit. They stated it was inconvenient having to wait for staff to let them out.

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Administrator (or Representative) Date

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(c) Safely operate the assisted living facility; and

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Based on observation, interview and record review, the facility failed to implement the facility's policy to confirm restricted egress doors were relocked in a secured memory care unit for 1 of 1 resident (Resident 1) and the facility failed to develop and implement a facility policy on the procedure that staff were to follow when they responded to an alarming, restricted egress door. This failure resulted in Resident 1 leaving the facility unaccompanied from the secured memory care unit without staff knowledge, placing the resident at risk of harm.

Findings included...

Review of facility policy titled, "Memory Care Neighborhood Controlled Egress," dated 12/05/2025, showed the facility's controlled egress doors included alarms and monitoring systems that alert staff to unauthorized attempts to exit. After visitors leave, the staff were to confirm doors were fully closed and secured/relocked to maintain egress control. The policy did not provide a procedure for staff to follow when they responded to the restricted egress door alarm.

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Review of Resident 1's Face Sheet showed the resident was admitted to the facility on [redacted]/2026 with diagnoses of [redacted].

Review of Resident 1's Elopement Risk Assessment and Care plan, dated 06/08/2026, showed the resident had delusions, paranoia and short-term memory loss and was at risk of eloping from the facility.

Review of Resident 1's facility incident report, dated 06/05/2026 at 6:00PM, showed the resident left the facility unaccompanied, through two restricted egress doors. The neighborhood egress door was not locked and did not alarm. The incident report showed Resident 1 had exited through Door 1 (Front entrance/exit door at the front of the building). This door alarm was going off. Staff responded to Door 1 alarm, turned the alarm off and had not checked outside to see who had set the alarm off. Resident 1 was then found by a neighbor, off facility premises, confused and wandering. The neighbor assisted the resident back to the facility.

In an interview on 07/08/2026 at 12:52 PM, Staff C, Medication Technician, stated Resident 1 had eloped because the neighborhood restricted egress door mechanism was not engaged and the light on the door was red. When the resident went out that door, it was not locked and did not alarm. During the interview, Staff C demonstrated how the neighborhood egress doors were to be relocked. Observation showed the light on the door was red when not locked and turned green when the door was relocked and closed. Staff C stated they thought a staff member had triggered the front door alarm when they left for the evening. They stated they had responded to Door 1, that was closed and alarming, and they had not seen Resident 1 outside the facility doors.

In an interview on 07/08/2026 at 1:15 PM, Staff A, Executive Director stated they reviewed the video clips of Door 1 for the evening of 06/05/2026 at 6:05 PM. They stated they could see Resident 1 walk out Door 1 and there were no staff observed going out the door to check and see if there were any residents outside in front of the building.

In an interview on 07/08/2026 at 1:16 PM, Staff A stated that Staff C failed to go out Door 1 and check outside and look around to make sure no residents had gone outside when Door 1's alarm sounded.

Review of an electronic communication dated 08/17/2026 from Staff A, showed if Door 1 is alarming after it is closed, it is because the door alarm was activated by the egress door being pushed open and was not opened using the code on the keypad.

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Statement of Deficiencies	License # 2721	Compliance Determination # 80185
Plan of Correction	Blossom Creek Senior Alzheimer Community	Completion Date
Page 6 of 6	Licensee: AHR Wenatchee WA MC TRS Sub, LLC	08/18/2026

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 08/28/2026

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