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

AHR WENATCHEE WA LAF TRS SUB, LLC
Blossom Valley Senior Assisted Living Community
1701 Orchard Ave
Wenatchee, WA 98801

RE: Blossom Valley Senior Assisted Living Community License # 2722

Dear Administrator:

This letter addresses Compliance Determination(s) 80621 (Completion Date 07/17/2026) and 76907 (Completion Date 05/22/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/17/2026 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-3090-1-b, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-2-a, WAC 388-78A-2140-5

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 G
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Blossom Valley Senior Assisted Living Community
License/Cert.#: 2722
Compliance Determination #: 76907
Investigator: Nicole Mcgraw
Provider Type: Assisted Living Facility
Intake ID: 219823
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 05/06/2026 through 05/22/2026
Complainant Contact Date(s):

Allegation(s):
A named resident had a fall out of their scooter due to a broken sidewalk.

Investigation Methods:

Sample:	Total residents: 63 Resident sample size: 3 Closed records sample size: 0
Observations:	Environment, Residents
Interviews:	Residents and staff
Record Reviews:	Characteristic roster, Resident records, Facility policy, Facility incident report and investigation.

Investigation Summary:
Observations showed an area of sidewalk that was broken. Interview with the named resident showed the sidewalk had been in disrepair for more than three months and this disrepair was what caused their fall out of their scooter. Staff interviews showed they were aware of the disrepair but the repairs were not done and was the cause of the resident's fall which caused them harm. Staff interview and record review showed the resident's care plan was not updated to reflect the resident's fall risk. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-3090 and WAC 388-78A-2140, reference Statement of Deficiencies dated 05/22/2026.

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 #: 2722	Compliance Determination #76907
Plan of Correction	Blossom Valley Senior Assisted Living Community	Completion Date
Page 1 of 6	Licensee: AHR WENATCHEE WA LAF TRS SUB, LLC	05/22/2026

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 05/06/2026 of:

Blossom Valley Senior Assisted Living Community
1701 Orchard Ave
Wenatchee, WA 98801

This document references the following complaint number(s): 219823

The following sample was selected for review during the unannounced on-site visit: 3 of 63 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 G
1200 Alder Street
Union Gap, WA 98903

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Statement of Deficiencies	License # 2722	Compliance Determination #78907
Plan of Correction	Blossom Valley Senior Assisted Living Community	Completion Date
Page 2 of 6	Licensee: AHR WENATCHEE WA LAF TRS SUB, LLC	05/22/2026

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

06/02/2026
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)

06/08/2026
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure the exterior grounds were in good repair for 1 of 1 sidewalk (Sidewalk 1). This failure resulted in Resident 1 tipping over and falling out of their scooter and placed other residents at risk of harm.

Findings included...

Record review of facility policy, titled, "Routine Community Inspections," dated 01/22/2019, showed routine community inspections were to be conducted to ensure and maintain a livable, efficient and safe environment. The policy showed the exterior of the community was to be inspected weekly including sidewalks, noting any cracks and were they clean. The results of the inspections should be documented on the Community inspection form, noting any maintenance needs and needed to be reviewed with the Executive Director.

Record review of Resident 1's undated face sheet showed they were admitted to the facility on [redacted]/2024 with diagnoses of [redacted]

Record review of Resident 1's facility incident investigation, dated 04/05/2026, showed

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Residential Care Services

06/02/2026
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Record review of Resident 1's facility incident investigation, dated 04/05/2026, showed

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the resident tipped over in their electric scooter when they were riding over an area of damaged concrete on the Sidewalk 1. The resident sustained a head injury with a 2-inch swollen area on the right side of their forehead, an abrasion to their right upper arm and a skin tear to their nose. Resident 1 also complained of pain in their right arm and shoulder. The resident was taken to the hospital for treatment and was admitted. The document showed a picture of the abnormal, broken sidewalk area where concrete was broken away with fractured edges, exposed gravel aggregate, which left uneven sunken areas across the width of the sidewalk.

Record review of Hospital Discharge Summary, dated 04/09/2026 showed the resident was admitted to the hospital, after they fell, due to uncontrolled pain and a decline in physical function. The record further showed the resident had an abrasion to their right shoulder, an abrasion to their right forehead, an abrasion to one of their left toes and abrasions to two toes on the right foot.

Observation on 05/06/2026 at 12:44 PM, showed Sidewalk 1, to the left of the front entrance of the buildings showed the damaged sidewalk in an irregular shape that had measured 34 inches by 5 ½ inches.

In an interview on 05/06/2026 at 11:30 AM, Staff A, Executive Director, stated Resident 1 was in their motorized scooter, when the resident went over the uneven, broken sidewalk caused the resident to tip over and fall out of their scooter. Resident 1 was sent to the hospital and was admitted for pain management. Staff A further stated the disrepair in the sidewalk was a building maintenance issue and it was not considered an issue until Resident 1 had the fall on 04/05/2026. Staff A further stated the residents' fall resulted in a negative outcome, causing the resident to be hospitalized.

In an interview on 05/06/2026 at 11:56 PM, Resident 1 stated they had issues going over the rocky part of Sidewalk 1 for more than three months and it should have been repaired awhile ago. They stated after they fell, they were hospitalized because of the fall.

In an interview on 05/20/2026 at 10:12 AM, Staff B, Maintenance Director, stated Sidewalk 1 had been damaged for over six months and there had been bids done last year to fix the sidewalk, but the repair process never moved forward.

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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, Blossom Valley Senior Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 07/06/2026 .

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

Administrator (or Representative) 06/08/2026 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:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(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 Agreement (NSA) included a documented plan to address needs and preferences of a resident who required assistance with activities of daily living for 1 of 1 resident (Resident 1). This failure placed residents at risk of unmet needs, cares and services.

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Plan/Attestation Statement

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Administrator (or Representative) Date

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(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 Agreement (NSA) included a documented plan to address needs and preferences of a resident who required assistance with activities of daily living for 1 of 1 resident (Resident 1). This failure placed residents at risk of unmet needs, cares and services.

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Findings included...

Record review of Resident 1's facility assessment, dated 04/14/2026, showed the resident was a high fall risk.

Record review of Resident 1's progress note, dated 04/16/2026, written by Staff B, Director of Nursing, showed therapy recommendations for the resident's room was redesigned for a better setup specific to the residents' needs and the resident was to walk to the bathroom four times per day.

Record review of Resident 1's progress note, dated 04/17/2026, showed the resident preferred to sleep in there recliner and staff were to encourage the resident to sleep in their bed.

As of 05/06/2026 at 5:00 PM, record review of Resident 1's Care Plan, dated 4/16/2026, showed the resident had a noted sexual behavior toward staff. The care plan failed to show,
>Interventions for staff to implement when the resident showed sexual behaviors towards staff.
>Interventions for staff to implement related to the resident's high risk for falls.
>Therapy recommendations for resident to be encouraged to walk to the bathroom four times per day.
>The residents' preference to sleep in their recliner and staff were to encourage them to sleep in their bed.

In an interview on 05/22/2026 at 9:02 AM, Staff C, Health & Wellness Director, acknowledged they were missing interventions specific to Resident 1's needs and preferences including their preference to use a urinal, the resident being unsafe to stand alone with their transfer pole, the staff were to encourage resident to use the call light to use the bathroom, and therapy recommendations for safety and mobility that the staff were to encourage the resident to do.

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Statement of Deficiencies	License #: 2722	Compliance Determination #76907
Plan of Correction	Blossom Valley Senior Assisted Living Community	Completion Date
Page 6 of 6	Licensee: AHR WENATCHEE WA LAF TRS SUB, LLC	05/22/2026

Plan/Attestation Statement

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Administrator (or Representative) — Date: 06/08/2026

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