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

MC Wenatchee Opco, LLC
Wenatchee Memory Care
817 Red Apple Road
Wenatchee, WA 98801

RE: Wenatchee Memory Care License # 2772

Dear Administrator:

This letter addresses Compliance Determination(s) 78323 (Completion Date 06/02/2026) and 73624 (Completion Date 04/14/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/02/2026 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-2371-2, WAC 388-78A-2371-1, WAC 388-78A-2371-3, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1, WAC 388-78A-2630-1-b

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Wenatchee Memory Care
Provider Type: Assisted Living Facility

License/Cert.#: 2772
Intake ID: 212492
Compliance Determination #: 73624
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 02/27/2026 through 04/14/2026
Complainant Contact Date(s):

Allegation(s):
1) A resident to resident allegation.
2) A named resident was not assessed or monitored after sustaining an injury.
3) A named resident sexually abused another resident.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, Cares, Resident to residnet 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, Facility policies, Facility incident report and investigation

Investigation Summary:
1) Observations showed resident to resident interactions were appropriate and respectful. Staff were observed to be available and responsive to resident's needs. Staff interview and record review showed the facility failed to complete an incident report after a fall and failed to complete investigations to determine the circumstances of two incidents. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2371 and WAC 388-78A-2630.
2) Observations showed that residents were clean, appropriately groomed, and without any signs of pain or discomfort. Staff were observed to be available and responsive to resident's needs. Staff interviews showed the named resident was assessed after the incident, and interventions were put into place. Further interview showed there was a consult with hospice and the resident's family. Record review showed the resident was monitored, all notifications were made and the resident's care plan was reviewed and updated as needed. No failed practice identified.
3) Allegation was previously investigated on 12/30/2025, see intake ID 206744.

Conclusion / Action:

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☒ 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 02/27/2026 of:

Wenatchee Memory Care
817 Red Apple Road
Wenatchee, WA 98801

This document references the following complaint number(s): 212492, 211990

The following sample was selected for review during the unannounced on-site visit: 4 of 48 current residents and 1 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 #: 2772	Compliance Determination # 73624
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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

04/16/2026
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)

4/20/26
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff investigated and documented investigative actions and findings for an incident that jeopardized resident's welfare and failed to institute appropriate measures for 1 of 2 residents (Resident 1). This failure placed residents at risk of harm and unmet needs.

Finings included...

Record review of facility policy, titled, "Reporting Incidents," dated 04/01/2017, showed all incidents were to be documented, including falls and resident to resident altercations.

Record review of facility policy, title, "Conducting Investigations," dated 10/2017, showed all serious incidents would be investigated including collection, review, evaluation and documentation of evidence to establish chronology of event.

Record review of Resident 1's progress note, dated 02/04/2026 at 6:41 PM, written by

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Staff B, Medication Technician, showed the resident was on the floor in Resident 2's room. The note showed Resident 1 had an abrasion to the left elbow and left knee with complaints of left arm pain.

Record review of Resident 1's progress note, dated 02/05/2026 at 9:33 PM, Staff D, Medication Technician, noted Resident 1 refused to come out of their room, was fearful of staff when they tried to get near the resident and when Staff D had tried to give Resident 1 their meds, the resident stated, "please don't hit me." Staff D noted these behaviors were not normal for Resident 1.

Record review of Resident 1's progress note, dated 02/06/2026 at 1:00 PM, showed Resident 1 had a bruise to the nose and around one eye.

Record review of Resident 1's incident report, dated 02/06/2026, completed by Staff B, showed the resident had an unwitnessed fall with bodily on 02/06/2026 at 2:27 PM. The document showed staff went to Resident 2's room and Resident 1 was on the floor "rolled up in a ball." The record showed the resident sustained bruising to the face as well as a skin tear to the left elbow and abrasion to the knee. Staff B documented that Resident 2 initially stated Resident 1 fell when they were trying to get Resident 1 out of their room. Resident 2 then later reported to facility staff that that they disliked Resident 1 and that they "kicked (Resident 1's) ass and that they wanted them out of (their) room." Resident 2 further reported to facility staff how much they disliked Resident 1.

Record review of facility records, on 02/27/2026, showed the facility did not have a investigation that determined the circumstances of the events for 02/04/2026 and 02/06/2026 events which included an unwitnessed fall and an alleged assault with injury to the face and other body parts.

In an interview on 03/18/2026 at 11:02 AM, Staff A, Executive Director, stated they believed the fall and the statement of physical assault by Resident 2 toward Resident 1 were on the same date. Staff A stated that Staff B had put improper dates into the resident's progress notes that showed Resident 1 had fallen on 02/04/2026. They further stated they determined the circumstances of the 02/04/2026 event to be a fall because the resident's injuries reflect a fall and all of the resident's injuries were all on the left side of the body. Staff A further stated they did not have any additional information when the department requested additional documentation to show the facility investigations and how the facility determined the circumstances of the events that occurred on 02/04/2026 and 02/06/2026.

In an interview on 03/18/2026 at 11:35 AM, Staff B, stated they did not do an incident report or investigation when Resident 1 had the incident on 02/04/2026. Staff B stated there was no way to determine if Resident 1 had a fall or if there was an alternate reason the resident was on the floor. They further stated they did not complete an incident report on 02/04/2026 because Staff C, Health and Wellness Director, told them

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they did not need to do it. Staff B completed an incident report on 02/06/2026, after Resident 2 made the statement that they had kicked Resident 1's "ass" on 02/04/2026. Staff B further stated that Resident 2 gets upset, was verbally aggressive and would hit the table when they got upset with other residents.

In an interview on 03/20/2026 at 1:09 PM, Staff C stated they had messed up on 02/04/2026, and told Staff B not to do an incident report for the alleged fall. Staff C stated they could not determine if the resident fell or if something else had occurred. They stated they did not review Resident 1's progress notes as a part of their investigation that showed the resident had noted behaviors of being fearful of staff on 02/05/2026. Staff C stated they had consulted with Staff A, and together they determined the incident was a fall and ruled out abuse because Resident 1's injuries were all on the left side of the body. Staff C acknowledged the bruise Resident 1 sustained on the bridge of their nose was not consistent with a fall on the resident's left side as they had determined on the investigation.

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 Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/29/26.

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

Administrator (or Representative) — Date: 4/20/26

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

(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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report injuries of an unknown source and an allegation of abuse to the department's complaint resolution unit (CRU) and Law Enforcement (LE) for 1 of 2 residents (Resident 1). This failure practice placed residents at risk of harm.

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Findings included...

Review of Revised Code of Washington (RCW) 74.34.035, Reports—Mandated and permissive—Contents—Confidentiality. (4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:

(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;

Review of facility policy, titled, "Reporting Incidents," dated 04/01/2017, showed the executive director is responsible for ensuring all appropriate notifications were made. The policy showed all staff were mandatory reporters and were responsible for making a report to CRU in accordance with the regulations when incidents were reportable.

Review of Resident 1's face sheet showed they were admitted to the facility on [redacted]/2025 with diagnoses of [redacted].

Review of Resident 1's progress note, dated 02/04/2026 at 6:41 PM, written by Staff B, Medication Technician (MT), showed the resident was found on the floor in Resident 2's room. The note showed Resident 1 had an abrasion to the left elbow and left knee with complaints of left arm pain.

Review of Resident 1's progress note, dated 02/05/2025 at 9:33 PM, written by Staff D, Caregiver, documented that the resident was frightened when any staff member got near them. Staff D had gone in to give the resident their medications and the resident stated, "please don't hit me," and it took a while for Staff D to administer Resident 1 their medications.

Review of Resident 1's progress note, dated 02/06/2026 at 2:52 PM, Staff B documented that Resident 2 had stated on 02/06/2026 that on 02/04/2026, Resident 2 had kicked Resident 1's "ass" because they wanted Resident 1 out of their room.

Record review of Resident 1's 02/06/2026 incident report, completed by Staff B, showed the resident had an unwitnessed fall with injury on 02/06/2026 at 2:27 PM. The document showed when staff made it to Resident 2's room, the site of the incident, Resident 1 was "rolled up in a ball." The record showed the resident sustained bruising to the face as well as a skin tear to the left elbow and abrasion to the knee. Staff A documented that Resident 2 initially stated Resident 1 fell when they were trying to get Resident 1 out of their room. Resident 2 then later reported to facility staff that that

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they disliked Resident 1 and that they "kicked (Resident 1's) ass and that they wanted them out of (their) room." Resident 2 further reported to facility staff how much they disliked Resident 1.

In an interview on 03/18/2026 at 11:40 AM, Staff B stated they had not reported to any outside agencies when Resident 1 had a fall on 02/04/2026 then on 02/06/2026, Resident 2 made a statement that they had "kicked (Resident 1)'s ass."

In an interview on 03/18/2026 at 11:40 AM, Staff A, Executive Director, stated they did not report the allegation that Resident 2 had assaulted Resident 1 to CRU and had not reported the injuries of unknown source that Resident 1 sustained on 02/04/2026 when they had an alleged unwitnessed fall in Resident 2's room. Staff A further stated that they did not report the incident to CRU because they had ruled out abuse.

In an interview on 03/20/2026 at 1:09 PM, Staff C, Health and Wellness Director, stated they did not report the alleged fall and alleged physical assault to CRU because they did not know the incidents required reporting.

In an interview on 04/14/2026 at 1:14 PM, Staff A confirmed LE was not called for the allegation that Resident 2 had physically assaulted Resident 1 on 02/04/2026.

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 Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/29/26 .

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

Administrator (or Representative) — Date: 4/20/26

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