



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**1200 Alder Street, Union Gap, WA 98903**

Pacifica SL Ellensburg LLC  
Pacifica Senior Living Ellensburg  
818 E Mountain View Ave  
Ellensburg, WA 98926

RE: Pacifica Senior Living Ellensburg License # 2376

Dear Administrator:

This letter addresses Compliance Determination(s) 47891 (Completion Date 09/27/2024) and 44236 (Completion Date 08/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/27/2024 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-2600-2-i, WAC 388-78A-2703-3

The Department staff who did the on-site verification:  
Lucinda Vautour, Licensor

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

Sincerely,

Stephanie Jenks, Field Manager  
Region 1, Unit Z  
Residential Care Services



## Residential Care Services Investigation Summary Report

**Provider/Facility:** Pacifica Senior Living  
Ellensburg

**License/Cert.#:** 2376

**Compliance Determination #:** 44236

**Investigator:** Lucinda Vautour

**Investigation Date(s):** 07/16/2024 through 08/05/2024

**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 138757

**Region/Unit #:** RCS Region 1 / Unit G

### Allegation(s):

A named resident was found unresponsive with burns outside a Assisted Living Facility (ALF).

### Investigation Methods:

|                        |                                                                                                                                     |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 71<br>Resident sample size: 70<br>Closed records sample size: 1                                                    |
| <b>Observations:</b>   | Environment<br>Cares<br>Residents<br>Facility response time to resident needs                                                       |
| <b>Interviews:</b>     | Residents<br>Facility Staff<br>Others not associated with the facility                                                              |
| <b>Record Reviews:</b> | Named Resident's Record<br>Hospital records<br>Ambulance records<br>Facility incident report and Investigation<br>Facility Policy's |

### Investigation Summary:

Observations, interviews and record reviews showed that a facility staff member was aware the named resident was outside in the facility courtyard and failed to check on them for 90 minutes. The temperature outside was reported at 102 degrees and the resident was found unresponsive in the facility courtyard, in direct sunlight in a metal chair. Facility staff responded immediately and made all notifications and assessed the resident to be very hot with excessive sun exposure and sunburns. Staff called for an emergency ambulance transport of the resident to the hospital for further evaluation and treatment. The resident was diagnosed with [REDACTED] and [REDACTED]. Failed facility practice found when the A left the resident outside in excessive heat



for 90 minutes in a metal chair. WAC 388-78A-2600 (2)(i) Policies and Procedures ; WAC 388-78A-2703 (3) Safety of the built environment

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**Conclusion / Action:**

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



## Residential Care Services Investigation Summary Report

**Provider/Facility:** Pacifica Senior Living  
Ellensburg

**License/Cert.#:** 2376

**Compliance Determination #:** 44236

**Investigator:** Lucinda Vautour

**Investigation Date(s):** 07/16/2024 through 08/05/2024

**Complainant Contact Date(s):** 07/30/2024

**Provider Type:** Assisted Living Facility

**Intake ID:** 138883

**Region/Unit #:** RCS Region 1 / Unit G

### Allegation(s):

A named resident was found unresponsive with burns outside a Assisted Living Facility (ALF).

### Investigation Methods:

|                        |                                                                                                                                     |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 71<br>Resident sample size: 70<br>Closed records sample size: 1                                                    |
| <b>Observations:</b>   | Environment<br>Cares<br>Residents<br>Facility response time to resident needs                                                       |
| <b>Interviews:</b>     | Residents<br>Facility Staff<br>Others not associated with the facility                                                              |
| <b>Record Reviews:</b> | Named Resident's Record<br>Hospital records<br>Ambulance records<br>Facility incident report and Investigation<br>Facility Policy's |

### Investigation Summary:

Observations, interviews and record reviews showed that a facility staff member was aware the named resident was outside in the facility courtyard and failed to check on them for 90 minutes. The temperature outside was reported at 102 degrees and the resident was found unresponsive in the facility courtyard, in direct sunlight in a metal chair. Facility staff responded immediately and made all notifications and assessed the resident to be very hot with excessive sun exposure and sunburns. Staff called for an emergency ambulance transport of the resident to the hospital for further evaluation and treatment. The resident was diagnosed with [REDACTED] and [REDACTED]. Failed facility practice found when the A left the resident outside in excessive heat

for 90 minutes in a metal chair. WAC 388-78A-2600 (2)(i) Policies and Procedures ; WAC 388-78A-2703 (3) Safety of the built environment

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**Conclusion / Action:**

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**1200 Alder Street, Union Gap, WA 98903**

|                           |                                      |                                  |
|---------------------------|--------------------------------------|----------------------------------|
| Statement of Deficiencies | License #: 2376                      | Compliance Determination # 44236 |
| Plan of Correction        | Pacifica Senior Living Ellensburg    | Completion Date                  |
| Page 1 of 7               | Licensee: Pacifica SL Ellensburg LLC | 08/05/2024                       |

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 07/16/2024 and 08/05/2024 of:

Pacifica Senior Living Ellensburg  
818 E Mountain View Ave  
Ellensburg, WA 98926

This document references the following complaint number(s): 138757, 138883

The following sample was selected for review during the unannounced on-site visit: 70 of 71 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Lucinda Vautour, Licenser

From:  
DSHS, Aging and Long-Term Support Administration  
Residential Care Services, Region 1, Unit Z  
1200 Alder Street  
Union Gap, WA 98903

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.

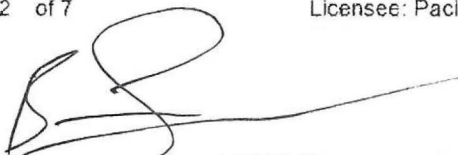
*Michelle Closner*  
Residential Care Services

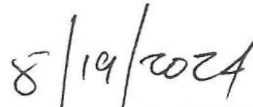
08/13/2024  
Date

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.

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

|                           |                                      |                                  |
|---------------------------|--------------------------------------|----------------------------------|
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| Page 2 of 7               | Licensee: Pacifica SL Ellensburg LLC | 08/05/2024                       |

  
 \_\_\_\_\_  
 Administrator (or Representative)

  
 \_\_\_\_\_  
 Date

**WAC 388-78A-2600 Policies and procedures.**

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Extreme Weather Policies were followed for one of two sampled residents (Resident 1). This failure resulted in the resident being left outside in 102-degree weather for ninety minutes which resulted in second degree burns and hospitalization.

**Findings included...**

Record review of the ALF policy on Extreme Weather dated 12/01/2023, showed that assisted living residents would receive extra monitoring and assistance to ensure their safety during extreme weather situations, such as very hot outdoor temperatures. The policy stated that residents with Dementia would receive increased status checks to ensure they had not ventured outside without supervision. Staff interventions for residents included frequent resident checks, to limit residents' outdoor exposure to brief periods, avoid direct sun exposure, wear lightweight clothing and a hat, encourage residents to seek shade and to drink extra water.

On 07/13/2024 at 3:30 PM, the temperature was a record high of 102 degrees outside per the Weather Channel.

Review of Resident 1's record showed they were admitted to the facility on [REDACTED]/2023. A chart note written on [REDACTED]/2023 stated the resident was admitted from home following a discharge from another ALF where Resident 1 had several episodes of elopement (leaving the facility without staff knowledge) from that facility.

Review of Resident 1's assessment updated 03/04/2024 showed that they had a history of wandering out of their home and previous community living facility.

Review of Resident 1's Negotiated Service Agreement (NSA) updated 03/04/2024



showed that the resident had a diagnosis of [REDACTED], and [REDACTED] which required Resident 1 to be in a secured memory care facility with extra monitoring. Resident 1's NSA showed they were independent with ambulation, was not allowed to leave the facility unassisted.

Review of Resident 1's ambulance report showed that on 07/13/2024 at 3:43 PM the ambulance staff arrived at the facility and found the resident sitting in direct sunlight in an outside area that was reflecting heat onto the resident. The resident was unconscious, not responsive, not able to communicate and was very hot to the touch. Facility staff told them the resident was last seen at 2:00 PM and found at 3:30 PM and was very "sick." Resident 1's skin was hot, dry, red and blistered. They were breathing rapidly, and lungs sounded wet, and their arms and legs were very hot. The ambulance staff were unable to obtain the resident's blood pressure, their pulse (heart rate) was 88 and respiratory (breathing) rate was 28. The resident's temperature was 109.1 degrees. The report also stated the resident was in severe distress and required immediate interventions.

Review of Resident 1's hospital emergency room report showed that on 07/13/2024 at 3:47 PM the ambulance staff arrived at the hospital with the 74-year-old resident who had a history of Advanced Dementia. The resident was noted to have 1st and 2nd degree burns to their arms and legs with notable blistering under their forearms to both elbows (where the resident's arms contacted the metal chair the ambulance staff reported). The resident's heart rate was listed as 220 and their highest body temperature in the emergency room was 109.9 degrees. The resident was cooled with icepacks fans and Intravenous Solutions. The resident had significant hyperthermia, respiratory distress and an elevated body temperature.

Review of Resident 1's chart note written by Staff C on 07/15/2024 showed that on 07/13/2024 during shift change [2:00 PM] they were notified by Staff D, Caregiver, that Resident 1 was still outside. During an interview, Staff C stated, that they "got a little tied up with helping residents and went to check up on the resident when they found him at 3:20 PM (No resident supervision for one hour and 20 minutes after being informed the resident was still outside in over 100-degree temperatures).

During an interview on 07/16/2024 at 2:15 PM, Staff A, Executive Director (ED), stated the facility had a policy in place about hot weather and the staff failed to follow the policy when they did not frequently check on the resident when they were informed the resident was outside. He said, "Ninety minutes is not considered frequently."

During an interview on 07/16/2024 at 2:15 PM, Staff B, Resident Service Director, stated that they were notified by staff that they had found Resident 1 outside [07/13/2024 at 3:20 PM] and that the resident was unresponsive, and told staff to call 911. Staff B stated that day shift staff reported to the evening shift staff [07/13/2024 at 2:00 PM] Resident 1 was outside and did not want to come in and needed to be checked on. Staff B also stated that the resident was sun burned and staff said the resident's temperature was 105 to 108 degrees.

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| Page 4 of 7               | Licensee: Pacifica SL Ellensburg LLC | 08/05/2024                       |

Review of Resident 1's Hospital Discharge Summary dated, [REDACTED]/2024 at 7:41 PM showed that Resident 1 was hospitalized due to, Hyperthermia and Sunburns, Acute Encephalopathy (a group of conditions which cause brain dysfunction), developed Heatstroke (the body's temperature rises rapidly, sweating mechanism fails, and the body is unable to cool down). The discharge summary also stated that Resident 1 had a core body temperature at a maximum of 109.9 degrees. The resident also was diagnosed with [REDACTED]

[REDACTED]. The resident died on [REDACTED]/2024 at 6:45 PM.

During an interview on 07/23/2024 at 3:07 PM, Staff A stated that Staff C was suspended pending the investigation because they did not check on the resident for 90 minutes following the report that the resident was outside the facility in extreme heat.

During an interview on 7/24/2024 at 3:15 PM, Staff D stated that on 7/13/2024 at 1:50 PM, they found Resident 1 outside sitting in the courtyard. Staff D stated the resident was not wearing a hat (per policy), was not hot to the touch and was wearing sweatpants and a short sleeve tee shirt with slippers (was not wearing light weight clothing like it states in the policy). They also stated they did not offer the resident anything to drink at that time (per policy). Staff D stated another resident needed assistance and at 1:55 PM when they were on her way to speak with the oncoming staff, they saw the resident through the window sitting under the gazebo. During shift change at 07/13/2024 at 2:00 PM, Staff D, stated they informed Staff C, Caregiver (oncoming staff), that Resident 1 was still outside. Staff D stated she felt terrible about what happened and that she should have done more to get the resident back inside the building at 1:50 PM.

During an interview on 08/05/2024 at 4:30 PM, Staff A stated that Staff C and Staff D were newly hired and had not been trained on the facility's Extreme Weather Policy. The ED stated that staff who are long term staff would have been trained. The ED stated that they personally discussed the facility Extreme Weather Policy during "stand up meetings" held with department heads prior to 07/13/2024 (the day of the incident). The ED stated that it was up to the department head to ensure that their staff were trained to implement the policy and there was no documentation of those meetings or documentation to show staff were trained to the policy.

#### 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, Pacifica Senior Living Ellensburg is or will be in compliance with this law and / or regulation on

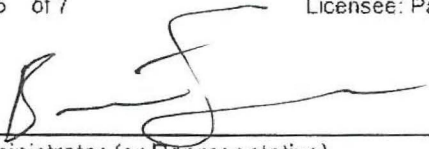
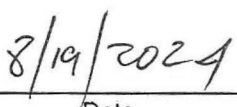
(Date) 9/14/2024

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



|                           |                                      |                                  |
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| Page 5 of 7               | Licensee: Pacifica SL Ellensburg LLC | 08/05/2024                       |

|                                                                                                                        |                                                                                            |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <br>Administrator (or Representative) | <br>Date |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|

**WAC 388-78A-2703 Safety of the built environment.** The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

(3) Keeping exterior grounds, assisted living facility structures, 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 Assisted Living Facility (ALF) failed to ensure a safe environment in the courtyard by allowing residents access to a hot, unsafe, metal chair to be left in direct exposure to the sun within an enclosed area that lacked shade or any external cooling source for one of two sampled residents (Resident 1). This failure contributed to Resident 1 being in direct sunlight in an enclosed area that was radiating heat, sitting in a hot metal chair which caused second degree burns and hospitalization.

Findings included...

Review of Resident 1's record showed they were admitted to the facility on [REDACTED]/2023 and was admitted from home following a discharge from another ALF where Resident 1 had several episodes of elopement (leaving the facility without staff knowledge).

Review of Resident 1's assessment updated 03/04/2024 showed that they had a history of wandering out of their home and previous community living facility. Resident 1 was independent with ambulation, eating and dressing, and needed to be monitored for safety.

Review of Resident 1's Negotiated Service Agreement (NSA) updated 03/04/2024 showed that the resident had a diagnosis of [REDACTED], and [REDACTED] which required Resident 1 to be in a secured memory care facility. Resident 1's NSA showed they were independent with ambulation, was not allowed to leave the facility unassisted, had a history of wandering out of their home and previous community living facility.

Review of a statement written by Staff E, Caregiver, dated 07/13/2024 showed that Staff C requested help at 3:20 PM with Resident 1 and when they arrived the resident was unresponsive, drooling and their breathing was shallow and loud. They stated that

they called 911 and placed wet washcloths on Resident 1 and when the paramedics arrived, they lifted the resident in the chair he was sitting in and took him inside the facility. Staff E stated the resident went to the hospital at 3:40 PM.

Review of Resident 1's ambulance report showed that on 07/13/2024 at 3:43 PM, the ambulance staff arrived at the facility and found the resident sitting in direct sunlight in an outside area that was reflecting heat onto the resident and was sitting in a metal chair that was hot. The resident was unconscious, not responsive, not able to communicate and was very hot to the touch. Facility staff told them the resident was last seen at 2:00 PM and found at 3:20 PM and was very "sick." Their skin was hot, dry, red and blistered. Resident 1 was breathing rapidly, lungs sounded wet, and their arms and legs were very hot. The ambulance staff were unable to obtain the resident's blood pressure, their pulse (heart rate) was 88 and respiratory (breathing) rate was 28. The resident's temperature was 109.1 degrees.

Review of Resident 1's chart note written by Staff C on 07/15/2024 showed that on 07/13/2024 during shift change [2:00 PM] they were notified by Staff D, Caregiver, that Resident 1 was still outside. During an interview, Staff C stated, that they "got a little tied up with helping residents and went to check up on the resident when they found him at 3:20 PM (Unsupervised outside for 90 minutes).

On arrival to the facility on 07/16/2024 at 2:15 PM the outside temperature in the facility parking lot was observed to be 100 degrees.

During an interview on 07/16/2024 at 2:15 PM, Staff B, Resident Service Director, stated that they were notified by staff that they had found Resident 1 outside [07/13/2024 at 3:20 PM] and that the resident was unresponsive, and she told them to call 911.

During a tour of the facility and interview on 07/16/2024 at 3:15 PM, Staff A, Executive Director (ED), stated this was about the exact time of day Resident 1 was found in the courtyard three days prior. The ED also stated on 07/13/2024 at approximately 1:55 PM Resident 1 was observed by staff in the concrete courtyard sitting in a chair in the shade of a gazebo. The ED stated that on 07/13/2024 at 3:20 PM Resident 1 was later found sitting in a metal lawn chair in the direct sunlight next to the facility wall and metal exit door. The area was enclosed on three sides and the heat was intense and it felt like an inferno the ED stated. It was observed that the armrest of the chair and the metal door handle were too hot to touch and the heat was so intense it was difficult to stay in that area for long.

At the end of the facility memory care courtyard tour on 07/16/2024 at 3:25 PM a resident the ED identified as a memory care resident was observed walking independently in the 100-degree courtyard unsupervised. This resident was dressed in long pants and a long sleeve shirt and had access to the enclosed, radiated heat area and a metal chair like the one facility staff found Resident 1 sitting in three days earlier.



|                           |                                      |                                  |
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| Page 7 of 7               | Licensee: Pacifica SL Ellensburg LLC | 08/05/2024                       |

Review of Resident 1's Hospital Discharge Summary dated, [REDACTED]/2024 at 7:41 PM, showed that Resident 1 was hospitalized due to, Hyperthermia and Sunburns, Acute Encephalopathy (a group of conditions which cause brain dysfunction), developed Heatstroke (the body's temperature rises rapidly, sweating mechanism fails, and the body is unable to cool down). The discharge summary also stated that Resident 1 had a core body temperature at a maximum of 109.9 degrees and was unlikely to return to prior level of function. The resident also was diagnosed with [REDACTED]

[REDACTED]. The resident died on [REDACTED]/2024 at 6:45 PM.

During an interview on 07/18/2024 at 11:50 AM, Resident 1's Collateral Contact (CC1), stated that on 07/13/2024 the facility called them following the resident leaving the facility for the hospital and informed them that the resident was found outside in the sun and was sent to the hospital. They stated when they got to the hospital twenty minutes later and the outside temperature was 102 degrees. They stated that the hospital was only a mile from the facility, and it was very hot outside for residents to be outside. They said, "we had not let the grandchildren go outside that afternoon and wondered why the facility let the resident go out and for such a long time." CC1 also stated that Resident 1 developed blisters on their chest and abdomen and that was because "they were heated from the inside out." They stated the resident got blisters on their forearms and across their back and behind their knee wherever Resident 1 had contacted with the metal chair. CC1 also stated the resident should not have had to suffer like that before they died.

During an interview on 07/24/2024 at 3:15 PM, Staff D confirmed staff found the resident at 3:20 PM (90 minutes after being informed that the resident refused to come inside the facility) and stated that they felt terrible about what happened to the resident and that she should have done more to get the resident back inside the building at 1:55 PM.

#### 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, Pacifica Senior Living Ellensburg is or will be in compliance with this law and / or regulation on  
(Date) 9/11/2024

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

[Signature]  
Administrator (or Representative)

8/19/2024  
Date