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

RE: Ellensburg Senior Living License # 2376

Dear Administrator:

This letter addresses Compliance Determination(s) 66171 (Completion Date 09/29/2025) and 61560 (Completion Date 08/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/29/2025 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-2371-1, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b, WAC 388-78A-2100-2-b-i

The Department staff who did the on-site verification:
Felicia Cantu, 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Ellensburg Senior Living
Provider Type: Assisted Living Facility

License/Cert.#: 2376
Intake ID: 182644
Compliance Determination #: 61560
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 06/25/2025 through 08/07/2025
Complainant Contact Date(s): 08/06/2025

Allegation(s):

1) A named resident was found hanging off the bed with their arm stuck in the bed rail.
2) A named resident had an injury to the hand from an unknown source.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 5 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster House policies Incident reports State reporting log Hospital records Other agency records Resident records (face sheet, care plans, assessments, chart notes, doctor orders)

Investigation Summary:

1) Observations showed that the named resident was no longer in the facility. Interviews and record review showed that the named resident's arm was injured. The facility failed to assess the resident for their ongoing needs that included the need of a medical device. Failed Practice identified 388-78A-2100. 2)Observations showed that the named resident was no longer in the facility. Interviews and record

review showed that the named resident's arm was injured. The facility failed to document investigative actions. Failed practice identified 388-78A-2371.

Conclusion / Action:

- [x] 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: Ellensburg Senior Living
Provider Type: Assisted Living Facility

License/Cert.#: 2376
Intake ID: 183626
Compliance Determination #: 61560
Region/Unit #: RCS Region 1 / Unit G
Investigator: Felicia Cantu
Investigation Date(s): 06/25/2025 through 08/07/2025
Complainant Contact Date(s):

Allegation(s):
A named resident had an unexpected death.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 5 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies State reporting log Resident records (face sheet, care plans, assessments, chart notes)

Investigation Summary:
Observations showed that staff to resident interactions were safe, respectful, and helpful. Interviews and record review showed that the facility notified all entities. The facility failed to document investigative actions. Failed practice identified WAC 388-78A-2371.

Conclusion / Action:

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

☐ N/A

STATE OF WASHINGTON
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AGING AND LONG-TERM SUPPORT 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 06/25/2025 of:

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

This document references the following complaint number(s): 181405, 182644, 183626, 183793

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:

Felicia Cantu, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
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.

Laura Williams-Davis
Residential Care Services

08/15/2025
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)

8/22/2025
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;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to investigate and document investigative actions and findings when residents had an incident that impacted the resident's health for 2 of 5 residents (Residents 1 and 2). This failed practice placed residents at risk of injury by the facility of not investigating resident incidents to prevent or implement protective measures.

Findings included...

Review of the facility's policy titled" Incident Reports" dated 12/05/2022, showed that an internal occurrence report is completed by staff for all unusual occurrences, injuries, and incidents. The facility must investigate actions and findings for any accident or incident jeopardizing or affecting a resident's health or life, determine the circumstances of the event, and document appropriate measures to prevent similar situations.

Resident 1

Review of Resident 1's undated demographic sheet, showed that they moved into the facility on [redacted]/2024 with diagnosis of [redacted] and [redacted].

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

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) | Date

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Findings included...

Review of the facility's policy titled" Incident Reports" dated 12/05/2022, showed that an internal occurrence report is completed by staff for all unusual occurrences, injuries, and incidents. The facility must investigate actions and findings for any accident or incident jeopardizing or affecting a resident's health or life, determine the circumstances of the event, and document appropriate measures to prevent similar situations.

Resident 1

Review of Resident 1's undated demographic sheet, showed that they moved into the facility on [redacted]/2024 with diagnosis of [redacted] and [redacted].

Review of Resident 1's facility incident report dated [redacted]/2025, showed that Resident 1 was found mainly on the ground with their arm stuck between the metal bars on their bed, and their arm was blue and cold to touch.

Review of Resident 1's hospital record, dated [redacted]/2025, showed that facility staff found Resident 1 to be stuck with their arm trapped in the railing of their bed. Resident 1 had partially fallen out of bed and their arm was trapped behind them. First responders reported that when they arrived at the facility Resident 1's arm was purple below the area of entrapment and was cold. Resident 1 appeared to have impaired circulation due to the compression of the bed railing pinching down to the right forearm. Resident 1 was unable to provide history on what had occurred.

Review of Resident 1's contracted agency service records, dated 06/11/2025, showed that their agency was notified by care staff that Resident 1 had an incident the previous night and was "hanging" from their bed rails. It was documented by the agency nurse that Resident 1's right arm was dark purple in color, covered in petechiae (tiny round purple spots due to bleeding under the skin that can be caused by physical trauma to the skin).

During an interview on 08/06/2025 at 2:45 PM, Collateral Contact 3 (CC3), Contracted Agency Nurse, stated that on 06/11/2025 they came to visit Resident 1 and observed their right arm was a deep purple color from their elbow surrounding the entire arm from their elbow to their fingertips and had a blister on their hand.

Review of Resident 1's requested incident reports from May 2025 through June 2025, did not include documentation of investigation actions and findings for the incident that occurred on [redacted]2025.

During an interview on 08/07/2025 at 11:00 AM, Staff A, Administrator, agreed that the incident report dated 06/10/2025 did not include documentation of an investigation, actions, and findings.

Resident 2

Review of Resident 2's, undated demographic sheet showed that they moved into the facility on [redacted]/2024 with a diagnosis of [redacted].
Review of the Departments reporting data base, dated [redacted]/2025, showed that the facility reported to the Department that Resident 2 was found in their bed in their apartment deceased.

Review of Resident 2's facility chart notes from 11/04/2024 through 05/07/2025, did not

show investigative documentation of actions and findings for Resident 1's unexpected death that occurred on [redacted]/2025.

During an interview on 08/07/2025 at 11:00 AM, Staff A stated they also could not find documentation of investigation actions and findings for Resident 2's unexpected death that occurred on [redacted]/2025.

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, Ellensburg Senior Living is or will be in compliance with this law and / or regulation on (Date) 9/15/2025

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

Administrator (or Representative) [signature] Date 8/22/2025

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on interviews and reviews, the facility failed to assess and evaluate the need for bed rails for 1 of 5 Residents (Resident 1). This failure contributed to Resident 1's arm

show investigative documentation of actions and findings for Resident 1's unexpected death that occurred on [redacted]/2025.

During an interview on 08/07/2025 at 11:00 AM, Staff A stated they also could not find documentation of investigation actions and findings for Resident 2's unexpected death that occurred on [redacted]/2025.

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

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(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on interviews and reviews, the facility failed to assess and evaluate the need for bed rails for 1 of 5 Residents (Resident 1). This failure contributed to Resident 1's arm

being entrapped in a bed rail that resulted in injury to Resident 1's arm.

Findings included...

Review of the facility's policy titled "Bed Rails and Enablers" dated 06/01/2025 showed that the use of bed rails is strongly discouraged. Half-bed rails are only utilized to assist in mobility and not as a restraint and are only with specific physician orders. A physician's order will be obtained for all bed rail use. Half bed rails are permitted only after receiving a physician's order confirming the rails are for mobility. Use of rails will be documented in the residents Negotiated Service Agreement (NSA) along with instructions for monitoring.

Review of Resident 1's undated demographic sheet showed that they moved into the facility on [redacted]/2024 with diagnosis of [redacted] and [redacted].

Review of Resident 1's facility incident report dated [redacted]/2025 showed that Resident 1 was found "mainly" on the floor with their right arm stuck "in between the metal bars on [Resident 1's] bed".

Review of Resident 1's hospital record dated [redacted]/2025 showed that facility staff found Resident 1 to be stuck with their arm trapped in the railing of their bed. Resident 1 had partially fallen out of bed and their arm was trapped behind them. First responders reported that when they arrived at the facility Resident 1's arm was purple below the area of entrapment and was cold. Resident 1 appeared to have impaired circulation to their arm due to the compression of the bed railing pinching down to the right forearm.

During an interview on 07/28/2025 at 3:30 PM, Collateral Contact 1 (CC1), Resident 1's Representative, stated that Resident 1's medical condition had been declining. The facility knew they were going against their own facility policy to keep the "bed rails" off the bed frame of Resident 1's bed and that they were used to prevent Resident 1 from falling out of bed.

Review of Resident 1's initial assessment dated 02/20/2024 and updated assessment dated 06/01/2025 did not include the need for the bed rails or a safety device assessment.

Review of Resident 1's NSA most recent, dated 06/06/2024 did not show the need for bed rails.

Review of Resident 1's facility chart notes dated 09/24/2024 through 06/01/2025,

showed that Resident 1 was placed on end-of-life care on 05/30/2025. The record did not show documentation of the use or need for bed rails on their bed.

During an interview on 07/29/2025 at 1:00 PM Collateral Contact 2 (CC2), Health Care Professional, stated that they assist in ordering hospital beds for residents who need them. The bed rails are always removable and require a doctor's order if needed for mobility.

During an interview on 08/06/2025 at 2:45 PM, Collateral Contact 3 (CC3), Agency Nurse, stated that on 08/11/2025 they came to visit Resident 1 and observed their right arm was a deep purple color from their elbow surrounding the entire arm from their elbow to their fingertips and had a blister on their hand.

During an interview on 08/07/2025 at 11:0 AM, Staff A, Administrator, stated that they had an order for a hospital bed for Resident 1 but acknowledged that they did not have a safety assessment completed for Resident 1. Additionally, it was acknowledged by Staff A that there was no proper documentation in Resident 1's NSA regarding their changing needs that included the need for bed rails.

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 8/22/2025

showed that Resident 1 was placed on end-of-life care on 05/30/2025. The record did not show documentation of the use or need for bed rails on their bed.

During an interview on 07/29/2025 at 1:00 PM Collateral Contact 2 (CC2), Health Care Professional, stated that they assist in ordering hospital beds for residents who need them. The bed rails are always removable and require a doctor's order if needed for mobility.

During an interview on 08/06/2025 at 2:45 PM, Collateral Contact 3 (CC3), Agency Nurse, stated that on 06/11/2025 they came to visit Resident 1 and observed their right arm was a deep purple color from their elbow surrounding the entire arm from their elbow to their fingertips and had a blister on their hand.

During an interview on 08/07/2025 at 11:0 AM, Staff A, Administrator, stated that they had an order for a hospital bed for Resident 1 but acknowledged that they did not have a safety assessment completed for Resident 1. Additionally, it was acknowledged by Staff A that there was no proper documentation in Resident 1's NSA regarding their changing needs that included the need for bed rails.

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