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

Yakima Operations, LLC
Avamere at Englewood Heights
3710 Kern Way
Yakima, WA 98902

RE: Avamere at Englewood Heights License # 2460

Dear Administrator:

This letter addresses Compliance Determination(s) 61096 (Completion Date 06/13/2025) and 56316 (Completion Date 04/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/13/2025 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-2600-2-f

The Department staff who did the on-site verification:
Tracy Ramirez, Assisted Living Facility Licensor

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: Avamere at Englewood Heights
License/Cert.#: 2460
Compliance Determination #: 56316
Investigator: Tracy Ramirez
Investigation Date(s): 03/17/2025 through 04/10/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 170331
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1. The facility staff performed Cardio-Pulmonary Resuscitation on the named resident when they were a Do Not Attempt Resuscitation.
2. The facility did not honor the named resident's contract and needs to be clearer if cost may raise.

Investigation Methods:

Sample:	Total residents: 66 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Facility common areas.
Interviews:	Nursing staff Residents Family members Administrator
Record Reviews:	Medical records Incident investigation Resident Agreement (contracts) Facility policies Personnel files Electronic mail

Investigation Summary:

1. Interviews and record reviews showed that the facility staff performed Cardio-Pulmonary Resuscitation on the named resident when they were a Do Not Attempt Resuscitation. Interviews and record review showed that the facility did not follow their policies and procedures. Failed practice identified. Refer to Washington

Administrative Code (WAC) 388-78A-2600 (2)(f) Policies and Procedures.
2. Interviews and record reviews showed that the facility is attempting to resolve the financial concerns. Record review of the named resident's contract showed that the facility would give 30-day notice when costs may rise. No failed practice identified.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

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 the unannounced on-site full inspection and complaint investigation on 03/17/2025, 03/18/2025, 03/19/2025 and 03/20/2025 of:

Avamere at Englewood Heights
3710 Kern Way
Yakima, WA 98902

This document references the following complaint numbers: 170331.

The following sample was selected for review during the unannounced on-site visit: 9 of 66 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Elaine Lopez, Licensor
Tracy Ramirez, Assisted Living Facility Licensor

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.

Staci Dilg, IDR PM for Reg 1G
Residential Care Services

May 22, 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)

05-22-2025
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:

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure staff followed their policies and procedures regarding life-sustaining treatments for 1 of 1 resident (Resident 10). This failed practice had resulted in Resident 10 receiving life saving measures when they were a Do Not Attempt Resuscitation.

Findings included...

Review of the facility's policy, "Residency and Move-In Process and Procedure," revised 12/2023, showed that the facility was to copy any forms of healthcare directives including but not limited to living wills, Portable Orders for Life-Sustaining Treatments (POLST), advance directives, and then would place into the residents' records.

Review of the facility's Disclosure of Services, undated, showed that the facility would support any advanced directives residents had regarding end-of-life decisions.

Review of Resident 10's Resident Agreement, signed and dated 04/30/2024, showed that the facility would honor advance directives/POLST forms.

Review of Resident 10's POLST form, dated 10/07/2023, showed that the resident was a

Do Not Attempt Resuscitation (DNAR)/Allow Natural Death code status in an event the individual had no pulse and was not breathing.

Review of Resident 10's Admission Record profile, dated 05/01/2024, showed that the resident was a DNAR under the advance directions section.

Review of Resident 10's Negotiated Service Agreement, dated 11/21/2024, showed that the resident had diagnoses of [redacted] and [redacted].

Review of a facility incident report dated [redacted]/2025, showed that Resident 10 was unresponsive, staff called 911 and was instructed to perform Cardio-Pulmonary Resuscitation (CPR), staff (no identification of staff) looked for the resident's code status paperwork on their refrigerator and was blank, the staff (no identification of staff) proceeded to do CPR until the Emergency Medical Technicians (EMT) arrived. The EMTs asked Resident 10's spouse if they had a DNAR and the spouse said they did, the spouse told the EMTs if they didn't perform CPR on the resident then they would do it themselves and the EMTs continued with CPR and life saving measures until they got a heartbeat and transported the resident to the hospital.

Review of Resident 10's progress notes, dated [redacted]/2025, showed that facility Staff B, Health Services Director, Registered Nurse (RN), had called the hospital and received report that the resident had passed away with family at the bedside.

Review of the hospital note dated [redacted]/2025, for Resident 10, showed that they had sustained a cardiac arrest.

In an interview on 03/18/2025 at 8:22 AM, Collateral Contact 1 (CC1), Durable Power of Attorney, stated that Resident 10 was a DNAR, the facility had it on file, and that staff performed CPR on the resident. CC1 stated that they were made aware of Resident 10's spouse's request for staff to perform CPR on Resident 10 and felt the staff did not know the protocol for an unexpected death.

In an interview on 03/20/2025 at 10:39 AM, Collateral Contact 2 (CC2), resident's spouse, stated that they were satisfied that the staff followed CC2's wishes of performing CPR on Resident 10. CC2 stated, "I like the staff a lot and they really do a great job."

In an interview on 03/25/2025 at 9:42 AM, Staff B, RN, stated that they had informed Resident 10's family that the staff had performed CPR on the resident due to the spouse being adamant with staff to do so, although the resident was DNAR. Staff B stated that

this was an unusual situation, and the spouse had stated to staff they would do the CPR themselves if staff did not on Resident 10, in addition, staff were worried the spouse could get hurt in the process, so staff followed the instructions of 911 and the spouse.

In an interview on 04/09/2025 at 2:28 PM, Staff H, Medication Technician (MT), stated that they had immediately called 911 and were instructed to perform CPR based off Resident 10 having no pulse and was not breathing. Additionally, Staff H stated that there was a blank POLST with no instructions for staff to follow that the other staff found in the resident's apartment.

In an interview on 04/10/2025 at 8:36 AM, Staff I, MT, stated that they were aware that Resident 10 was a DNAR. Staff I stated that the facility keeps copies of POLST forms on residents' refrigerators, inside resident charts in addition to having code status stickers on the outside of the charts, code status on the Medication Administration Records, in their profile page in the electronic medical record, and they also had a binder in the medication room with all residents' code status for staff to follow.

In an interview on 04/10/2025 at 1:13 PM, Staff J, Caregiver, stated that they had immediately called for the MT after finding Resident 10 laying on the floor unresponsive. Staff J stated that the MT immediately arrived, called 911, then Resident 10 had no pulse and was not breathing, 911 instructed them to perform CPR. Staff J stated that they had found a POLST form on the refrigerator and it was blank with no instructions for Resident 10's code status. Staff J stated that they had asked Resident 10's spouse if the resident was a DNAR, they responded yes and was adamant that they perform CPR or that the spouse would do it themselves.

In an interview on 04/10/2025 at 10:08 AM, Staff A, Administrator and Staff B, RN, stated that they were aware of some confusion about if the POLST form was on the refrigerator or not and is unclear if it was at the time of Resident 10's incident. Staff B stated that it is standard that the POLST forms are located on the residents' refrigerators. Staff B stated that the residents' code status is also in their electronic records. Staff A acknowledged what Staff B had stated.

This is a recurring deficiency previously cited on 11/03/2023.

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, Avamere at Englewood Heights is or will be in compliance with this law and / or regulation on (Date) 05-25-2025 .

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

Administrator (or Representative) — Date: 05-22-2025

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

AMENDED
05/22/2025

Yakima Operations, LLC
Avamere at Englewood Heights
3710 Kern Way
Yakima, WA 98902

RE: Avamere at Englewood Heights # 2460

Dear Administrator:

This document references the following complaint numbers 170331.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 04/10/2025 and found that your facility does not meet the Assisted Living Facility requirements.

You requested an Informal Dispute Resolution (IDR) review. The IDR review resulted in the enclosed amended Statement of Deficiencies.

The Department:
• Wrote the enclosed report; and
• May take licensing enforcement action based on many deficiency listed on the enclosed report; and
• May inspect your program to determine if you have corrected all deficiencies; and
• Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately;
• Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

• Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  o Sign and date the enclosed report;
  o For each deficiency, indicate the date you have or will correct each deficiency;
  o Return the Plan/Attestation Statement and report with signatures to:

Laura Williams-Davis, ALF Field Manager
Residential Care Services
Region 1, Unit G
Preferred methods:
eFax: (509) 454-4160
Email: rcsregion1email@dshs.wa.gov
Optional method:
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

The Assisted Living Facility failed to ensure residents' pets at the facility had regular examinations and immunizations. The facility corrected by ensuring one of the pets had been seen by their veterinarian and scheduled an appointment for the other pet.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

The Assisted Living Facility failed to ensure staff who worked unsupervised with residents completed the dementia and mental health specialty training within the required time frame. The facility acknowledged that staff completed the training late, would develop a plan to ensure trainings were completed on time, and scheduled one of

the staff to obtain their training. The deficiency was corrected on-site at the time of the visit.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:

• Please contact me at (509)208-5231.

Sincerely,

Staci Dilley, IDR PM for Laura Williams-Davis

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

Enclosure

Plan of Correction

Agency Name	Citation Date
Avamere	04/10/2025
Submitted by	**Date of POC Submission**
Abiel Paz	05/01/2025-06/06/2025
☐ **Complaint Citation** ☑ **Certification Citation**	

Citation: (list WAC) 388-78A-2600	
What *initial or immediate actions* were taken to address concerns affecting clients?	Following the incident, the facility will conduct an in-service of emergency medical-response procedures. Staff will be educated how to access POLST forms during emergency responses. POLST audit is under review.
How will you apply the correction to all clients you support?	Conducting a facility wide audit of all POLST forms for current residents to ensure availability during emergencies. All direct care and med tech staff will receive in-service training to reinforce procedures and protocols related to emergencies and POLST accessibility.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director Abiel Paz Director of Health, Mirella Gould
Date by which lasting correction will be achieved	Audit will be conducted for current residents in the facility. Starting May 1st , 2025 and ending May 31st . Click here to enter a date.
Additional Information	This Plan of Correction is submitted in good faith while an Informal Dispute Resolution (IDR) is being filed for this citation. The facility believes its staff acted in compliance with policy and state expectations under emergency conditions, and this POC represents proactive reinforcement of existing protocols. This is the original Plan of correction, amended SOD on 5/22/2025, we will utilize the same POC.

Submit to RCS within 10 calendar days of receipt of letter to:

Nicole Vreeland, Field Manager
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600
Fax: (360) 725-3208
VreelNL@dshs.wa.gov

Send copy to DDA Resource Manager or Residential Program Specialist for your region.