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) 34501 (Completion Date 01/16/2024) and 29695 (Completion Date 11/03/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/16/2024 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-f, WAC 388-78A-2600-1-a, WAC 388-78A-2850-1-b-i, WAC 388-78A-2850-1-b-iii, WAC 388-78A-2850-1-b-vii, WAC 388-78A-2850-3

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

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, 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 #: 29695
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 94917
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/18/2023 through 11/03/2023
Complainant Contact Date(s): 11/06/2023

Allegation(s):
The named resident fell and waited 55 minutes for assistance to arrive,

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 58 Closed records sample size: 1
Observations:	Environment Cares Named Resident Residents Facility response time to resident concerns
Interviews:	Named resident Facility staff Others not associated with the facility
Record Reviews:	Named resident's record Facility Policy's Emergency Call Log

Investigation Summary:
Observations, interviews and record reviews showed that the facility failed to respond to the named resident's calls for assistance timely as facility policy and the Department required. Failed facility practice found. WAC 388-78A-2600 1A and 2F Policies. Reference statement of deficiencies dated 11/03/2023.

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: Avamere at Englewood Heights
License/Cert.#: 2460
Compliance Determination #: 29695
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 99921
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/18/2023 through 11/03/2023
Complainant Contact Date(s): 10/27/2023

Allegation(s):

1. A named resident was charged by the facility for rent and care after they were discharged from the facility.
2. Facility staff was not delegated to administer Insulin to the named resident.
3. A named resident called for staff assistance on 8/3/2023 and waited for an extended amount of time and was found on a chair sitting in bowel movement.
4. A named resident's bed sheets not changed by staff.
5. A named staff member argued with a named resident about receiving Insulin.
6. A named resident fell twice and waited an extended amount of time for staff assistance.
7. A named resident is missing towels, bedding and clothing.
8. A named resident was not given their acid reflux medication.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 58 Closed records sample size: 1
Observations:	Environment Cares Residents Resident apartments Facility staff response to resident needs
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Named resident's record Facility policy's Emergency Call Log

Investigation Summary:

Observations, interviews and record reviews showed:

1. The named resident was charged by the facility for rent and care after they were discharged from the facility and the facility reversed the charges. No failed facility

practice found.
2. The facility does not complete delegated tasks and the resident, resident family were aware prior to admission to the facility. No failed facility practice found.
3. and 6. A named resident called for staff assistance when they fell and on 8/3/2023 and waited for an extended amount of time and was found on a chair sitting in bowel movement. The facility failed to respond timely to the named resident's calls for assistance as facility policy and the Department required. WAC 388-78A-2600 1A and 2F, Policies,
4. Resident's apartments were observed to be clean and tidy, garbage removed and bedding clean. No failed facility practice found.
5. The named resident received their Insulin by their family and a named staff member discussed the need for Insulin administration with the named resident to ensure a medication error was not made. No failed facility practice found.
7. The facility was informed of missing belongings of the named resident and began a search and returned items found to the resident. No failed facility practice found.
8. The named resident was administered all medications ordered by their physician. No failed facility practice found.

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: Avamere at Englewood Heights
License/Cert.#: 2460
Compliance Determination #: 29695
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 103298
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/18/2023 through 11/03/2023
Complainant Contact Date(s): 11/06/2023

Allegation(s):

1. A named resident was charged by the facility for rent and care after they were discharged from the facility.
2. Facility staff did not order medications timely and the staff were not delegated to administer Insulin to the named resident.
3. A named resident called for staff assistance on 8/3/2023 and waited for an extended amount of time and was found on a chair sitting in bowel movement.
4. A named resident's bed sheets not changed by staff.
5. A named staff member argued with a named resident about receiving Insulin.
6. A named resident fell twice and waited an extended amount of time for staff assistance.
7. A named resident is missing towels, bedding and clothing.
8. A named resident was not given their acid reflux medication.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 58 Closed records sample size: 1
Observations:	Environment Cares Residents Resident apartments Facility staff response to resident needs
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Named resident's record Facility policy's Emergency Call Log

Investigation Summary:

Observations, interviews and record reviews showed:
1. The named resident was charged by the facility for rent and care after they were

discharged from the facility and the facility reversed the charges. No failed facility practice found.
2. The facility does not complete delegated tasks and the resident, resident family were aware prior to admission to the facility. No failed facility practice found.
3. and 6. A named resident called for staff assistance when they fell and on 8/3/2023 and waited for an extended amount of time and was found on a chair sitting in bowel movement. The facility failed to respond timely to the named resident's calls for assistance as facility policy and the Department required. WAC 388-78A-2600 1A and 2F, Policies
4. Resident's apartments were observed to be clean and tidy, garbage removed and bedding clean. No failed facility practice found.
5. The named resident received their Insulin by their family and a named staff member discussed the need for Insulin administration with the named resident to ensure a medication error was not made. No failed facility practice found.
7. The facility was informed of missing belongings of the named resident and began a search and returned items found to the resident. No failed facility practice found.
8. The named resident was administered all medications ordered by their physician. No failed facility practice found.

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: Avamere at Englewood Heights
License/Cert.#: 2460
Compliance Determination #: 29695
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 101200
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/18/2023 through 11/03/2023
Complainant Contact Date(s):

Allegation(s):
The facility had not notified Construction Review Services (CRS) of planned and implemented modifications to the ALF's physical structure other than a cooler being replaced.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 58 Closed records sample size: 1
Observations:	The facility's dining room, kitchen, mobile kitchen were observed.
Interviews:	Facility staff and others not associated with the facility.
Record Reviews:	Resident characteristic roster.

Investigation Summary:
Observations and interviews with facility staff and others not associated with the facility, showed that the facility did not notify the required department of planned and implemented modifications to the facility's physical structure. Determined failed practice WAC 388-78A-2850 Required review of building plans. Statement of Deficiency (SOD) 11/03/2023.

Conclusion / Action:

- [x] 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 #: 2460	Compliance Determination # 29695
Plan of Correction	Avamere at Englewood Heights	Completion Date
Page 1 of 10	Licensee: Yakima Operations, LLC	11/03/2023

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 09/18/2023 and 09/28/2023 of:

Avamere at Englewood Heights
3710 Kern Way
Yakima, WA 98902

This document references the following complaint number(s): 94917, 99921, 103298, 101200

The following sample was selected for review during the unannounced on-site visit: 58 of 58 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Tracy Ramirez, Assisted Living Facility Licensor
Lucinda Vautour, 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.

Gwin Kaercher
Residential Care Services

11/14/2023
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.

Jodi Montoya
Administrator (or Representative)

11-20-23
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(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 record review and interview, the Assisted Living Facility (ALF) facility failed to ensure staff implemented their resident emergency call system policy to ensure staff responded to call/light in a timely manner for 2 of 2 sampled residents (Resident 1, 2) who pressed their call buttons for staff assistance and staff response was more than a 30-minute wait time or staff did not respond. This failed practice placed residents living in the facility at risk for a diminished quality of life and unmet care needs.

Findings included...

Record review of the facility's policy titled, "Resident Emergency Call System," dated 10/2019 and revised 10/2021, showed that ALF staff are to provide a prompt response to an activated call from a resident.

During an interview on 09/18/2023 at 2:35 PM with Staff A, previous administrator, she stated she was not aware that residents complained of long wait times for staff to respond when they pushed their call buttons. She stated that the facility has an emergency call system, and a log of resident calls is reviewed by staff in the morning and the facility discussed the results during their morning meeting. Staff A stated that according to the emergency call log the facility's response time to resident calls on an average is 7 to 10 minutes.

During an interview on 10/3/2023 at 3:37 PM Staff A stated that her expectation was that resident call lights will be answered timely and that a staff member looks at the call light report daily and if a trend of long response times is identified they interview residents.

On 10/12/2023 at 12:55 PM Staff A stated that the facility did have open shifts at the facility and that she initiated interviews with residents with long call times. Staff A also stated that because of the open staff shifts at the facility she spoke with corporate staff who approved the use of temporary staff from an agency.

Resident 1

During an interview on 09/18/2023 at 1:46 PM with Collateral Contact 2 (CC2), Resident's Representative, stated they were aware of Resident 1's and multiple other resident complaints about long or no response from staff to resident call lights.

During an interview on 09/18/2023 at 2:55 PM. Resident 1 stated that not long ago they fell and when they had pressed the call button, they waited over 30 minutes for help to arrive. Resident 1 stated, "Waiting for help is not new and sometimes staff don't ever respond." Resident 1 also stated that staff never discussed with him why staff failed to respond or that he had to wait over 30 minutes for help.

Review of Resident 1's Negotiated Service Agreement (NSA), undated, showed that staff assist the resident with evacuation in the event of an emergency and that he was instructed to utilize his call pendent if he needed staff assistance. Resident 1's NSA also showed that the resident had a diagnosis of [redacted] and [redacted]

Review of the ALF's call light system from 09/01/2023 through 09/21/2023 with calls over 30 minutes or calls not answered:

Resident 1's call light button was pressed on 09/01/2023 at 8:54 AM and no staff responded as of 9:39 AM (45 minutes).

Resident 1's call light button was pressed on 09/03/2023 at 6:20 PM and staff responded at 7:01 PM (41 minutes).

Resident 1's call light button was pressed on 09/04/2023 at 11:23 AM and no staff responded as of 11:59 AM (36 minutes).

Resident 1's call light button was pressed on 09/10/2023 at 12:57 PM and no staff responded as of 1:42 PM (45 minutes).

Resident 1's call light button was pressed on 09/18/2023 at 5:34 AM and no staff responded as of 6:19 AM (45 minutes).

Resident 2

During an interview on 10/09/2023 at 10:10 AM with Collateral Contact 1 (CC1), Resident 2's representative, stated that on 08/03/2023 around 6:00 PM CC1 went to visit Resident 1 and found (Resident 2) naked from the waist down sitting on a dirty pad covered with fecal matter. CC1 stated that the resident told them that they rang for staff many times after breakfast and before lunch as Resident 2 needed to use the bathroom. Staff never came so Resident 2 went themselves and did not do a good job cleaning. CC1 cleaned the resident and called the facility nurse. CC1 was told by the facility's nurse that staff should be coming to assist the resident because Resident 2 was at risk for falls. CC1 stated that the resident had two more falls and was sent to the hospital on [redacted]/2023 and was discharged from the facility.

Review of Resident 2's NSA, undated, showed that the resident was admitted to the facility on [redacted]/2023 with diagnoses included, [redacted] and [redacted] Review also showed staff assisted the resident with evacuation in the event of an emergency, assisted with dressing and bathing, and that he was instructed to utilize his call pendent to request assistance to transfer and to assist with toileting and had a history of falls.

Resident 2's progress notes also showed that the resident had two recent falls on 08/31/2023 at 7:00 PM. The resident was found on the floor in their apartment with a skin tear to his left knee and a bump on their right eye and hit the back of the head on the floor. On [redacted]/2023 at 6:40 AM staff found the resident in their apartment on the floor by their recliner, wet with urine around them. The resident was subsequently sent to the hospital and was transferred to a higher level of care facility and was discharged from the facility.

Review of the ALF's call light system from 08/01/2023 through 09/01/2023 with calls over 30 minutes or calls not answered:

Resident 2's call light button was pressed on 8/02/2023 at 12:50 PM and no staff responded as of 1:21 PM (31 minutes).

Resident 2's call light button was pressed on 08/03/2023 at 5:19 AM and no staff responded as of 5:49 AM (30 minutes).

Resident 2's call light button was pressed on 08/03/2023 at 8:50 AM and staff responded at 9:25 AM (35 minutes).

Resident 2's call light button was pressed on 08/04/2023 at 11:05 AM and staff responded at 11:43 AM (38 minutes).

Resident 2's call light button was pressed on 08/04/2023 at 12:50 PM and staff responded at 1:28 PM (38 minutes).

Resident 2's call light button was pressed on 08/05/2023 at 12:00 AM and staff responded as of 12:38 AM (38 minutes).

Resident 2's call light button was pressed on 08/05/2023 at 7:39 AM and staff responded as of 8:14 AM (35 minutes).

Resident 2's call light button was pressed on 08/06/2023 at 1:44 PM and staff responded as of 2:20 PM (36 minutes).

Resident 2's call light button was pressed on 08/06/2023 at 3:15 PM and no staff responded as of 4:00 PM (45 minutes).

Resident 2's call light button was pressed on 08/06/2023 at 4:08 PM and no staff responded as of 4:53 PM (45 minutes).

Resident 2's call light button was pressed on 08/06/2023 at 5:18 PM and staff responded as of 6:03 PM (45 minutes).

Resident 2's call light button was pressed on 08/07/2023 at 1:23 AM and no staff responded as of 2:08 AM (45 minutes).

Resident 2's call light button was pressed on 08/07/2023 at 6:29 AM and staff responded as of 7:02 AM (33 minutes).

Resident 2's call light button was pressed on 08/07/2023 at 11:41 AM and staff responded as of 12:15 PM (34 minutes).

Resident 2's call light button was pressed on 08/07/2023 at 4:52 PM and no staff responded as of 5:37 PM (45 minutes).

Resident 2's call light button was pressed on 08/08/2023 at 3:35 AM and no staff responded as of 4:20 AM (45 minutes).

Resident 2's call light button was pressed on 08/08/2023 at 11:02 AM and staff responded as of 11:39 AM (37minutes).

Resident 2's call light button was pressed on 08/08/2023 at 12:38 PM and staff responded as of 1:10 PM (32 minutes).

Resident 2's call light button was pressed on 08/09/2023 at 2:36 AM and no staff responded as of 3:21 AM (45 minutes).

Resident 2's call light button was pressed on 08/09/2023 at 7:25 AM and staff responded as of 8:02 AM (37 minutes).

Resident 2's call light button was pressed on 08/10/2023 at 7:09 AM and staff responded as of 7:39 AM (30 minutes).

Resident 2's call light button was pressed on 08/10/2023 at 8:37 AM and staff responded as of 9:15 AM (38 minutes).

Resident 2's call light button was pressed on 08/10/2023 at 11:41 AM and staff responded as of 12:14 AM (33 minutes).

Resident 2's call light button was pressed on 08/10/2023 at 5:23 PM and staff responded as of 5:55 PM (32 minutes).

Resident 2's call light button was pressed on 08/11/2023 at 1:01 PM and staff responded as of 1:42 PM (41 minutes).

Resident 2's call light button was pressed on 08/12/2023 at 4:39 AM and no staff responded as of 5:24 AM (45 minutes).

Resident 2's call light button was pressed on 08/12/2023 at 1:56 PM and staff responded as of 2:35 PM (39 minutes).
Resident 2's call light button was pressed on 08/13/2023 at 5:36 PM and no staff responded as of 6:21 PM (45 minutes).

Resident 2's call light button was pressed on 08/14/2023 at 5:14 PM and no staff responded as of 5:59 PM (45 minutes).

Resident 2's call light button was pressed on 08/17/2023 at 11:16 AM and staff responded as of 11:56 AM (40 minutes).

Resident 2's call light button was pressed on 08/18/2023 at 1:11 PM and staff responded as of 1:56 PM (45 minutes).

Resident 2's call light button was pressed on 08/20/2023 at 1:07 AM and no staff responded as of 11:52 AM (45 minutes).

Resident 2's call light button was pressed on 08/21/2023 at 12:04 AM and staff responded as of 12:40 AM (36 minutes).

Resident 2's call light button was pressed on 08/21/2023 at 11:48 PM and no staff responded as of 12:33 AM (45 minutes).

Resident 2's call light button was pressed on 08/22/2023 at 12:35 AM and no staff responded as of 1:20 AM (45 minutes).

Resident 2's call light button was pressed on 08/22/2023 at 4:52 AM and no staff responded as of 5:37 AM (45 minutes).

Resident 2's call light button was pressed on 08/23/2023 at 8:05 AM and no staff responded as of 8:50 AM (45 minutes).

Resident 2's call light button was pressed on 08/25/2023 at 11:48 AM and no staff responded as of 12:33 PM (45 minutes).

Resident 2's call light button was pressed on 08/26/2023 at 4:06 AM and staff responded as of 4:46 AM (40 minutes).

Resident 2's call light button was pressed on 08/26/2023 at 8:46 AM and staff responded as of 9:18 AM (32 minutes).

Resident 2's call light button was pressed on 08/26/2023 at 5:27 PM and staff responded as of 6:04 PM (37 minutes).

Resident 2's call light button was pressed on 08/27/2023 at 12:55 PM and staff responded as of 1:31 PM (36 minutes).

Resident 2's call light button was pressed on 08/27/2023 at 6:27 PM and staff responded as of 7:00 PM (33 minutes).

Resident 2's call light button was pressed on 08/28/2023 at 7:57 AM and no staff responded as of 10:54 AM (45 minutes).

Resident 2's call light button was pressed on 08/28/2023 at 10:09 AM and no staff responded as of 5:37 AM (45 minutes).

Resident 2's call light button was pressed on 08/29/2023 at 1:33 AM and no staff responded as of 2:18 AM (45 minutes).

Resident 2's call light button was pressed on 08/30/2023 at 7:00 AM and staff responded as of 7:39 AM (39 minutes).

Resident 2's call light button was pressed on 08/31/2023 at 5:43 PM and staff responded as of 6:14 PM (31 minutes). Review also showed the resident was later found on the floor of their apartment at 7:00 PM.

Resident 2's call light button was pressed on 09/01/2023 at 6:21 AM and staff responded as of 6:42 AM (21 minutes). Review also showed that the resident's progress notes showed Resident 1 was found by staff found on the floor of their apartment because they had fallen.

On 10/24/2023 at 3:30 PM, Staff B, Acting Administrator, stated that the facility does have an emergency call policy and that around seven minutes is the standard in her facility but there are some exceptions. She stated that the number of long call times listed on log for the facility and for Resident 1 and 2 are not acceptable.

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) 12-18-23.

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

Jodi Montoya — Administrator (or Representative)

11-20-23 — Date

WAC 388-78A-2850 Required reviews of building plans.

(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(i) Physical structure;

(iii) Mechanical equipment or systems;

(vii) Kitchen or laundry equipment.

(3) The assisted living facility must submit plans to construction review services as directed by construction review services and consistent with WAC 388-78A-2361 for approval prior to beginning any construction.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to notify Construction Review Services (CRS) of planned and implemented modifications to the ALF's physical structure and the plan to use a mobile kitchen. This failure did not allow the department the ability to review and approve construction work performed at the facility.

Findings included...

On 09/28/2023 at 10:05 AM, Staff A, Executive Director, stated that the facility had construction projects that was not completed within their kitchen. Staff A stated that the construction was needed related to water damage observed after removal of their walk-in refrigerator and freezer. In addition, Staff A added that the dish-pit area was demoed due to needing to replace their dishwasher and decided at that time they would want to redo the entire area. Staff A stated that they had notified CRS months ago and the projects had begun last May. In addition, Staff A stated that today they had a mobile kitchen being setup for staff to use for all meals; therefore, now they can empty the kitchen to complete the remaining projects.

Observation on 09/28/2023 at 10:22 AM showed that the kitchen had a demoed dish-pit, and the walk-in refrigerator and freezer had been removed. The dining room had a temporary refrigerator and freezer setup against a backwall that the kitchen utilized. The ALF had a 32-foot mobile kitchen being set- up in the side parking lot near the kitchen backdoor.

In an interview on 10/05/2023 at 7:54 AM, with Representative at CRS, Collateral Contact 3 (CC3), stated that the facility had notified them of a walk-in project for a cooler referring to the refrigerator and freezer replacement. CC3 stated that the ALF had not notified CRS of the rest of the projects. CC3 added that these projects require notification to the department.

In an interview on 10/18/2023 at 10:14 AM with the outside Construction Company, CC4, stated that they had begun working with the ALF in May 2023. CC4 stated that they had to move the projects to June 2023 due to special orders for needed items of the projects. In addition, CC4 stated that they needed to replace subflooring and supporting structures for the floor due to the water damage from the removed walk-in refrigerator and freezer.

In an interview on 09/28/2023 at 12:20 PM, Staff C, Maintenance Director, stated that the ALF had setup their mobile kitchen and that the construction projects would begin shortly in the ALFs kitchen.

In an interview on 10/19/2023 at 10:53 AM, Staff D, Regional Maintenance Director, acknowledged that the facility had not notified CRS.

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) 12-18-23 .

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

Jodi Montoya
Administrator (or Representative)

11-20-23
Date