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 Memory Care
3706 Kern Way
Yakima, WA 98902

RE: Avamere at Englewood Heights Memory Care License # 2462

Dear Administrator:

This letter addresses Compliance Determination(s) 33867 (Completion Date 12/13/2023) and 29693 (Completion Date 10/19/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/13/2023 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-2160, WAC 388-78A-2850-1-b-i, 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 Memory Care
License/Cert.#: 2462
Compliance Determination #: 29693
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 97131
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/18/2023 through 10/19/2023
Complainant Contact Date(s): 10/13/2023

Allegation(s):

1. The facility common area is crowded because of facility construction.
2. The food served to residents is cold and of poor quality.
3. The facility staffing levels are low.
4. The facility had significant water damage that led to a large section of the facility being separated by plastic and left only a small common area for the residents.

Investigation Methods:

Sample:	Total residents: 19 Resident sample size: 19 Closed records sample size:
Observations:	Environment Cares Residents Meal service Staff response to resident needs
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Facility policy's Food temperature logs Current staffing logs

Investigation Summary:

1. Observations, interviews and record reviews showed that the facility suffered water damage to the facility and the facility initiated reconstruction of the damaged area of the facility. Observations of the residents in the facility showed they utilized the common areas of the facility that were under construction without difficulty and no safety concerns were noted. No failed practice identified.
2. The food served to residents was observed to be nutritious, with adequate portions and residents stated the food served was good. Observations and record reviews showed the temperature of food served the residents was appropriate. No failed facility practice found.

3. Observations and record review showed facility staff responded to resident needs in a timely fashion. No failed facility practice found.
4. Record review, 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. Failed practiced identified, WAC 388-78A-2850 Required review of building plans. Reference Statement of Deficiencies dated 10/19/2023.

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 Memory Care
License/Cert.#: 2462
Compliance Determination #: 29693
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 98059
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/18/2023 through 10/19/2023
Complainant Contact Date(s): 10/09/2023

Allegation(s):

1. A named resident fell and fractured pelvis at facility and facility may not have reported.
2. A named resident's toenails were long and curled under their feet.
3. Staff members sit and complete puzzles and don't work and staffing in always turning over.
4. A named resident with fecal matter on bedspread and staff didn't wash.
5. A named resident with bladder infection as they sat in fecal matter.
6. A named resident very skinny, not fed enough at facility and ate all food at hospital.
7. A named staff member did not listen to a named resident's family member.

Investigation Methods:

Sample:
Total residents: 19
Resident sample size: 19
Closed records sample size:

Observations:
Environment
Cares
Residents
Resident apartments
Resident's toenails
Resident bedding
Meal service
Facility Menus
Staff to resident interactions
Staff response to resident requests
Location of incident

Interviews:
Residents
Facility Staff
Others not associated with the faciity

Record Reviews:
Resident Record
Facility incident reports and investigations
Facility Menus
Actual staffing records

Investigation Summary:

1. Record review and interviews showed :
The named resident fell and fractured their hip and the facility reported the fall to the department. No failed facility practice found
2. A named resident's toenails were long and curled under their feet. Observations, interviews and record reviews showed that one named discharged resident and one named current resident did not have assisted toenail care by facility staff as directed by resident's negotiated service agreements. Facility staff stated other residents in the facility also needed toenail care. Failed facility practice found. WAC 388-78A-2160, reference statement of deficiencies dated 10/19/2023.
3. Observations and interviews showed adequate staff available to meet resident needs and observations of appropriate interactions by facility staff to residents and cares provided to residents by staff. No failed facility practice found
4. and 5. Residents were observed to be clan, well groomed and resident apartments including bedding were clean and the facility , tidy with no safety concerns noted. No failed facility practice found.
6. Meal time was observed and residents ate well and stated the food was good. Portion size was adequate and nutritious. No failed facility practice found.
7. Staff to resident interactions were observed to be respectful and residents and resident family's interviewed stated they felt the staff respected the residents. 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

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 #: 2462	Compliance Determination # 29693
Plan of Correction	Avamere at Englewood Heights Memory Care	Completion Date
Page 1 of 6	Licensee: Yakima Operations, LLC	10/19/2023

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 09/18/2023 of:

Avamere at Englewood Heights Memory Care
3706 Kern Way
Yakima, WA 98902

This document references the following complaint number(s): 97131, 98059, 98045

The following sample was selected for review during the unannounced on-site visit: 19 of 19 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Lucinda Vautour, 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.

Gwin Kaercher — Residential Care Services

10/27/2023 — 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.

Statement of Deficiencies	License #: 2462	Compliance Determination # 29693
Plan of Correction	Avamere at Englewood Heights Memory Care	Completion Date
Page 2 of 6	Licensee: Yakima Operations, LLC	10/19/2023

Jodi Montoya
Administrator (or Representative)

11-1-23
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide the care and services as indicated in the Negotiated Service Agreement (NSA) for 2 of 2 residents (Resident 1,2) when they failed to provide nail care. This failed practice resulted in overgrown, thick toenails which curled under the ends of the resident's toes and placed the residents at risk of injury.

Findings included...

Resident 2

Resident 2's NSA dated 03/23/2023 directed staff to provide the resident with nail care twice monthly

On 09/18/2023 at 1:30 PM, all of Resident 2's toenails were observed to be long, thick, and growing over the end of their toes curling under the ends of their toes. The resident stated they would like their toenails trimmed.

On 09/18/2023 at 2:30 PM, Staff A, Registered Nurse and Staff Member B, Licensed Practical Nurse, stated there was no need to check all 19 residents who resided in the facility as there was a consistent issue in the facility with residents not having their nails trimmed per NSAs and having long toenails.

On 10/09/2023 at 1:29 PM Staff B stated that Resident 2's NSA stated that they were to receive staff assisted nail care twice monthly and acknowledged that nail care was not occurring as indicated in the resident's NSA.

Resident 1

Review of Resident 1's record showed Resident 1's NSA revised on 05/24/2023, directed staff to provide the resident with nail care twice monthly.

During an interview on 09/13/2023 at 2:27 PM, Collateral Contact 1 (CC 1), Resident's Representative, stated that Resident 1 had overgrown toenails which curled over the ends of the resident's toes at the hospital following the discharge of the resident from the ALF on Friday [redacted]/2023 and that they had taken photos of the nails.

On 10/03/2023 at 3:37 PM, Staff C, Administrator, stated that there was not a facility policy on resident nail care. She said staff were not required to document when resident nail care was provided, but it was the facility's expectation that staff follow residents' NSA's. She stated that if residents do not have staff assisted nail care and their nails are trimmed out of facility staff should ensure that their nails were trimmed.

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 Memory Care is or will be in compliance with this law and / or regulation on (Date) ~~12-10-23~~ 12-03-23 jm

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

Jodi Montoya — Administrator (or Representative)

11-1-23 — 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;

(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, interview, and record review, the facility failed to notify Construction Review Services (CRS) of planned and implemented modifications to ensure CRS verified building and construction standards were met for 1 of 1 kitchen/dining area. This failure placed the residents at risk of construction work that did not meet minimum requirements.

Findings included...

In an interview on 09/28/2023 at 10:05 AM, Staff C, Executive Director, stated that the facility had a water leak near the kitchen sink from piping within the walls. Staff C stated that they did not contact CRS as they thought it was not needed due to the projects of like items for like items. Staff C stated that the serve-out wall was affected, and that the sheetrock had been replaced. In addition, Staff C stated that the pipe issue had been fixed and the remaining projects are in progress. Staff C stated that they did not recall dates of when the water leak and the projects began.

Observation on 09/28/2023 at 10:22 AM showed that the kitchen had no cabinets, no kitchen appliances, and the wall with the serve-out window had all new sheetrock. The observation showed that the kitchen and part of the dining room flooring had been ripped out. The hallway floor was covered with thick paper that had been tapped down, the opening of the dining room to the living room area had a false-wall and thick long plastic hanging from ceiling to the floor.

In an interview on 10/05/2023 at 7:54 AM, with Collateral Contact 2 (CC2), CRS Representative stated that the facility had not notified CRS of the projects. CC2 added that these projects require notification to the department.

Observation on 10/16/2023 at 8:07 AM, showed that the cabinetry was placed in the kitchen except for the sink cabinet. There were no countertops, no kitchen appliances, and no new flooring installed. The false-wall and long thick plastic draped from the ceiling had remained in the same place as the previous onsite visit on 09/28/2023.

In an interview on 10/18/2023 at 10:14 AM with CC3, contracted Construction Representative, stated that they had originally went to the facility for a water leak in the kitchen and discovered water damage and mild mold. CC3 stated that they had conducted demolition of the kitchen, removed and replaced sheetrock on the serve-out wall, sheetrock partially to two other walls due to the water leak migrating to the lower kitchen cabinets, underlayment flooring to the kitchen and removed insulation from the crawl space due to the water damage. The water leak had also caused the insulation to become wet within the walls and they had to dry it out. CC3 stated that the mild mold was treated with an anti-microbial (an agent that kills and stops their growth), scrubbed the wood,

ensured the wood was dry, then capsulated it, and used a negative air scrubber machine that isolates and purifies the air throughout the process. In addition, CC3 stated that the mild mold was sporadic and did not have enough of it, to notify an industrial hygienist.

In an interview on 09/28/2023 at 12:20 PM, Staff D, Maintenance Director, stated that the staff notified them of water found on the kitchen floor. Staff D addressed and called outside companies to assess the situation.

Review of Staff D's email of timeframes for the facility projects showed that:

- On 06/09/2023 the facility had approval from their corporation to begin demolition on the facility kitchen area.

- Between 06/09/2023 through 06/22/2023 the safety false wall (black plastic) was put up, the appliances/equipment was removed out of the kitchen, and all the cabinetry was removed.

- 06/22/2023 the dehydration machines were placed in the kitchen and underneath the building to remove all the moisture from the water damage.

- By 06/25/2023 the old sheetrock had been removed and the kitchen flooring. The dehydration machine was still in progress.

- 07/18/2023 a local company came out and measured for the new cabinetry.

- Between 07/18/2023 through 09/14/2023, Insurance Adjusters came and evaluated the project, after insurance was approved the cabinets were ordered and had a 6 to 8 week waiting time for cabinet delivery. The flooring was ordered, all the new plumbing was installed, and the base of the sheetrock was reinstalled.

- Between 09/14/2023 through 10/11/2023 the sheetrock was taped, textured, and painted. The kitchen floor underlayment was installed, and the upper and lower cabinets had been installed.

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

Plan/Attestation Statement

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Page 6 of 6	Licensee: Yakima Operations, LLC	10/19/2023

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 Memory Care is or will be in compliance with this law and / or regulation on (Date) ~~12-10-23~~ 12-03-23 jm

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

Jodi Montoya — Administrator (or Representative)

11-1-23 — Date