



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

06/16/2025

Yakima AL, LLC
Avista Senior Living Yakima
5100 W Nob Hill Blvd
Yakima, WA 98908

RE: Avista Senior Living Yakima # 2682

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 61109 (Completion Date 06/16/2025) and 57768 (Completion Date 05/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/16/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2080 Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident:

- (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or
- (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or
- (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or
- (4) Is a physician with a valid state license to practice medicine; or
- (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

WAC 388-78A-2320 Intermittent nursing services systems.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

- (a) Chapter 18.79 RCW, Nursing care;
- (b) Chapter 18.88A RCW, Nursing assistants;
- (c) Chapter 246-840 WAC, Practical and registered nursing;
- (d) Chapter 246-841 WAC, Nursing assistants; and
- (e) Chapter 246-888 WAC, Medication assistance.

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: Avista Senior Living Yakima **Provider Type:** Assisted Living Facility

License/Cert. #: 2682

Intake ID: 174596

Compliance Determination #: 57768

Region/Unit #: RCS Region 1 / Unit G

Investigator: Felicia Cantu

Investigation Date(s): 04/09/2025 through 05/07/2025

Complainant Contact Date(s):

Allegation(s):

- 1) The facility has been out of food for seven days.
- 2) There is facility staff who are not delegated to give insulin to residents.
- 3) The facility does not have an Executive Director.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size:
Observations:	Residents Dining Kitchen 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 Nurse delegation paperwork Staff credentials

Investigation Summary:

1) Observations showed that the residents were eating lunch. Interviews with residents showed that they enjoyed the food and had enough food at meal times. Interviews and record review showed that the facility had also purchased a large food order for their kitchen. No failed practice identified. 2) Observations showed that residents appeared safe and cared for. Interviews and record review showed that a named staff member gave insulin without being delegated to do so. Failed practice identified. WA 388-78A-2320. 3) Observations showed that staff to resident interactions appeared safe, respectful, and helpful. Interviews showed that the

facility had an interim Executive Director covering the position and a new Executive Director was hired. No failed practice identified.

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: Avista Senior Living Yakima **Provider Type:** Assisted Living Facility

License/Cert. #: 2682

Intake ID: 174671

Compliance Determination #: 57768

Region/Unit #: RCS Region 1 / Unit G

Investigator: Felicia Cantu

Investigation Date(s): 04/09/2025 through 05/07/2025

Complainant Contact Date(s):

Allegation(s):

- 1) The facility is out of food.
 - 2) The Dietary Manager does not have credentials to run the kitchen.
 - 3) The Health service Director is not a qualified assessor to do pre-admission assessments for the residents.
 - 4) There is no management in the building.
-

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size:
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Kitchen
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Staff records House policies

Investigation Summary:

1) Observations showed that the residents were eating lunch. Interviews with residents showed that they enjoyed the food and had enough food at meal times. Interviews and record review showed that the facility had also purchased a large food order for their kitchen. No failed practice identified. 2) Observations showed that the residents were eating lunch. Interviews with residents showed that they enjoyed the food. Interviews and record review showed that the Dietary Manager had certifications on file. No failed practice identified. 3) Records and interviews

showed that the Health and Wellness Director was not a qualified to do pre-admission assessments. Failed practice identified. WAC 388-78A-2080. 4) Observations showed that the Health and Wellness Director was in the building. Residents appeared safe and cared for. Interviews and record review showed that the facility's Regional Director was the Executive Director interim until the new Director starts in the Executive Director role. Staff stated that they were able to contact interim Director at any time and that they were responsive to their needs for the residents. No failed practice identified.

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: Avista Senior Living Yakima **Provider Type:** Assisted Living Facility

License/Cert. #: 2682

Intake ID: 174947

Compliance Determination #: 57768

Region/Unit #: RCS Region 1 / Unit G

Investigator: Felicia Cantu

Investigation Date(s): 04/09/2025 through 05/07/2025

Complainant Contact Date(s):

Allegation(s):

1) The Health and Wellness Director is assessing residents without being a qualified assessor.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size:
Observations:	Residents Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Staff credentials Resident records (face sheets, care plans, assessments, chart notes)

Investigation Summary:

Records and interviews showed that the Health and Wellness Director was not a qualified to do pre-admission assessments. Failed practice identified. WAC388-78A-2080.

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: Avista Senior Living Yakima **Provider Type:** Assisted Living Facility

License/Cert. #: 2682

Intake ID: 175498

Compliance Determination #: 57768

Region/Unit #: RCS Region 1 / Unit G

Investigator: Felicia Cantu

Investigation Date(s): 04/09/2025 through 05/07/2025

Complainant Contact Date(s):

Allegation(s):

- 1) The residents garbage and laundry are not being done.
- 2) A named staff member is rude to a named staff member.
- 3) The facility has unqualified staff giving insulin.
- 4) The facility had unqualified staff doing assessments.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident care equipment Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Resident records (face sheets, care plans, assessments, chart notes, medication administration records) Staff credentials Nurse delegation paperwork

Investigation Summary:

1) Observations showed that garbage's appeared to be emptied and resident rooms had clean laundry. Interviews with residents showed that their laundry was done by facility staff and the garbage was also emptied. No failed practice identified. 2) Observations showed that staff to resident interactions appeared polite, respectful, and helpful. The named resident stated that staff were polite and did not recall any staff members being rude to them. No failed practice identified. 3) Observations showed that resident and facility staff interactions appeared safe. Interviews and

record review showed that a named staff member was giving insulin without being delegated. Failed practice identified. WAC 388-78A-2320. 4) Observations showed that resident and facility staff interactions appeared safe. Interviews and record review showed that two staff members were performing pre-admission assessments without being a qualified assessor. Failed practice identified. WAC 388-78A-2080.

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 #: 2682	Compliance Determination # 57768
Plan of Correction	Avista Senior Living Yakima	Completion Date
Page 1 of 6	Licensee: Yakima AL, LLC	05/07/2025

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 04/09/2025 of:

Avista Senior Living Yakima
5100 W Nob Hill Blvd
Yakima, WA 98908

This document references the following complaint number(s): 174596, 174671, 174947, 175498

The following sample was selected for review during the unannounced on-site visit: 4 of 42 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

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

Statement of Deficiencies	License #: 2682	Compliance Determination # 57788
Plan of Correction	Avista Senior Living Yakima	Completion Date
Page 2 of 6	Licensee: Yakima AL, LLC	05/07/2025

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

05/21/2025

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.

Amber Green
Administrator (or Representative)

5/23/25
Date

WAC 388-78A-2080 Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident:

- (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or
- (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or
- (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or
- (4) Is a physician with a valid state license to practice medicine; or
- (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to ensure a qualified assessor performed a preadmission assessment for 2 of 4 sampled residents (Resident 1 and 2). This failure placed the residents at risk of not being assessed at the appropriate care level needed.

Findings included....

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

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Review of the ALF's undated policy titled "Preadmission Assessment, Full Assessment" showed that a preadmission assessment will be completed by a qualified assessor prior to move-in, to determine appropriateness of placement. A "Qualified Assessor" means a person who meets the requirements set forth within state regulations.

Resident 1

Review of Resident 1's undated demographic sheet, showed that they moved into the ALF on [REDACTED]/2025, with a primary diagnosis of [REDACTED].

Review of Resident 1's pre-admission assessment showed that Staff A, Health and Wellness Director, signed and completed the pre-admission assessment for Resident 1 on 02/28/2025.

Review of Staff A's credentials showed that they had their Home Care Aide Certification, and did not show that they were qualified to complete Resident 1's pre-admission assessment.

On 04/21/2025 at 10:45 AM, Staff A stated that they do "most" of the pre-admission assessments for residents who are moving into the facility. Additionally, Staff A stated that they were unsure if they were a qualified assessor.

Resident 2

Reviews of Resident 2's undated demographic sheet showed that they moved into the facility on [REDACTED]/2025, with a primary diagnosis of [REDACTED].

Review of Resident 2's pre-admission assessment showed that Staff B, Executive Director, signed and completed the pre-admission assessment on 02/21/2025.

Review of Staff B's credentials did not show that they were qualified to do pre-admission assessments for new residents.

On 05/02/2025 at 09:00 AM, Staff B stated that they had a bachelor's degree in business and completed Resident 2's pre-admission assessment independently. Additionally, Staff B expressed she believed she was qualified to complete pre-admission assessments for all new residents.

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On 05/02/2025 at 2:08 PM, Staff C, Regional Director of Clinical Operations, acknowledged that Staff A and Staff B were not qualified to do pre-admission assessments for Resident 1 and Resident 2.

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, Avista Senior Living Yakima is or will be in compliance with this law and / or regulation on (Date) 5/20/25.

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

Amber Liven mnen
Administrator (or Representative)

5/23/25
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

- (a) Chapter 18.79 RCW, Nursing care;
- (b) Chapter 18.86A RCW, Nursing assistants;
- (c) Chapter 246-840 WAC, Practical and registered nursing;
- (d) Chapter 246-841 WAC, Nursing assistants; and
- (e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure that 1 of 3 staff members (Staff D) were delegated to perform delegation required nurse tasks for 2 of 3 residents (Resident 2,3). This failure put the residents at risk for receiving delegation required tasks incorrectly.

Findings included...

Review of the ALF's undated policy titled "Nurse Delegation" showed that the registered nurse delegator shall decide if a task is appropriate to delegate, verify that the nursing assistant or home care aide is certified to be delegated without restriction before performing delegated nursing tasks in the absence of direct or immediate supervision from a nurse.

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Resident 2

Review of Resident 2's undated demographic sheet showed that they moved into the ALF on [REDACTED]/2025, with a diagnosis of [REDACTED].

Review of Resident 2's nurse delegation record dated [REDACTED]/2025 showed that they required nurse delegation for blood sugar testing and insulin (medication that controls blood sugar) administration. Additionally, the record showed that Staff D, Medication Technician, was not delegated by a registered nurse to give insulin.

Review of Resident 2's Medication Administration Record (MAR) for March 2025 showed that Staff D administered insulin 13 times to Resident 2 in March.

Review of Resident 2's MAR for April 2025 showed that Staff D administered insulin 12 times to Resident 2 in April.

Resident 3

Review of Resident 3's undated demographic sheet showed that they moved into the ALF on [REDACTED]/2024 with a diagnosis of [REDACTED].

Review of Resident 3's nurse delegation record dated 02/07/2025 showed that they required nurse delegation for blood sugar testing and insulin administration. Additionally, the record showed that Staff D was not delegated by a registered nurse to give insulin.

Review of Resident 3's MAR for March 2025 showed that Staff D administered insulin 11 times to Resident 3 in March.

Review of Resident 3's MAR for April 2025 showed that Staff D administered insulin 12 times to Resident 3 in April.

On 05/02/2025 at 9:29 AM, Staff D verified that they administered insulin and checked blood sugars for Resident 2 and 3. Additionally Staff D stated that they had still not been delegated by a registered nurse to administer insulin or check blood sugars for Resident 2 or 3.

On 05/02/2025 at 2:08 PM Staff C, Regional Director of Clinical Operations,

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acknowledged that Staff D had still not been certified or delegated to give insulin to Resident 2 and Resident 3.

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, Avista Senior Living Yakima is or will be in compliance with this law and / or regulation on (Date) 5/20/25.

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

Administrator (or Representative)

Ambur G. [Signature]

Date

5/23/25