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

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

RE: Avista Senior Living Yakima License # 2682

Dear Administrator:

This letter addresses Compliance Determination(s) 63676 (Completion Date 08/05/2025) and 60203 (Completion Date 07/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/05/2025 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-2371-2, WAC 388-78A-2371-3

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
Compliance Determination #: 60203
Investigator: Felicia Cantu
Investigation Date(s): 05/28/2025 through 07/08/2025
Complainant Contact Date(s):

Intake ID: 180847
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1) A named resident was found outside unconscious with second degree burns.
2) A named resident was neglected.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Outdoor courtyard
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies State reporting log Hospital records Incident report Resident records (face sheets, care plans, assessments, chart notes)

Investigation Summary:

1) Observations showed that the named resident was no longer in the facility. Staff to resident interactions appeared safe and helpful. Interview and record review showed that the named resident was found outside in the court yard unresponsive and had blisters and burns on their skin. The facility failed to check on the resident while being outside in hot weather condition. 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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2682
Compliance Determination #: 60203
Investigator: Felicia Cantu
Intake ID: 180829
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 05/28/2025 through 07/08/2025
Complainant Contact Date(s):

Allegation(s):
1) A named resident was left outside in the sun, and was found unresponsive.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Court yard
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Incident report State reporting log Facility policies Hospital records Resident records (face sheet, care plan, assessments, chart notes)

Investigation Summary:
Observations showed that the named resident was no longer in the facility. Interview and record review showed that the named resident was found outside in the court yard unresponsive and had blisters and burns on their skin. The facility failed to check on resident for a prolonged time while they were outside in the courtyard during warm weather conditions. 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

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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 05/28/2025 of:

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

This document references the following complaint number(s): 180847, 179537, 178730, 180829, 181382, 181687

The following sample was selected for review during the unannounced on-site visit: 3 of 44 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

07/18/2025
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 Hiveen
Administrator (or Representative)

7/25/25
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;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to thoroughly investigate, document investigative actions, and determine circumstances of severe skin injuries that required hospitalization for 1 of 3 sampled residents (Resident 2). This failure resulted in a lack of interventions to prevent similar incidents and placed residents at risk for injury.

Findings included...

Review of the facility's undated policy titled, "Resident Incident Reporting," showed that resident incidents would be reported and analyzed. The policy showed an "incident" was defined as an unusual occurrence that could result or had resulted in injury. The policy showed examples of incidents included hospitalization, injuries that required emergency intervention, skin integrity issues, and discolorations. The policy further showed that the medication technician and/or caregiver should conduct an immediate investigation of the incident and use the information obtained during the investigation to complete an incident report.

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

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;

(2) Determine the circumstances of the event;

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to thoroughly investigate, document investigative actions, and determine circumstances of severe skin injuries that required hospitalization for 1 of 3 sampled residents (Resident 2). This failure resulted in a lack of interventions to prevent similar incidents and placed residents at risk for injury.

Findings included…

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Review of Resident 2's undated demographic sheet showed that Resident 2 moved into the facility on [redacted]/2022 and was diagnosed with [redacted] and [redacted].

Review of Resident 2's negotiated service agreement, dated 05/01/2025, showed that team members would perform routine safety checks.

Review of Resident 2's most recent facility assessment, dated 05/01/2025, showed that Resident 2's skin integrity was within normal limits (no open sores, discolorations, or rashes).

Review of Resident 2's facility incident report, dated 05/27/2025, showed that Resident 2 was found slouched in their chair outdoors, non-responsive with saliva coming out of their mouth, and was sent to the hospital by ambulance.

Review of Resident 2's hospital record, dated 05/27/2025, showed that Resident 2 arrived at the hospital by ambulance. The record showed that Resident 2 had blisters (bubble on the skin filled with fluid caused by friction, burning or other damage) on their abdomen (stomach), thighs, and breast, had a fever (increase in average body temperature), and had severe sepsis (a life-threatening complication of infection). The document showed that it was unclear on how long Resident 2 was left unattended outdoors. The report showed that Resident 2 could not recall what had happened. The document also showed that Resident 2 did not have a history of "blisters" to their skin but had a history of "sunburning" easily and did not normally go outside.

Review of Resident 2's facility chart notes, dated 05/28/2025, showed that the hospital staff notified Staff B, Medication Technician, that Resident 2 arrived at the hospital with burns on multiple areas of their body.

In an interview on 05/28/2025 at 10:34 AM Staff F, Medication Technician, stated that they were working day shift on 05/27/2025. Staff F stated that Resident 2 was "in and out" of the courtyard throughout the day and that Staff B, Medication Technician found the resident outside unresponsive.

In an interview on 06/02/2025 at 12:00 PM, Collateral Contact (CC1), Resident Representative, stated that on 05/27/2025 they were made aware by the hospital staff that Resident 2 was found in the facility's courtyard unresponsive. CC1 stated that when they went to visit the resident in the hospital, they observed that Resident 2 had "big blisters" above their knees, lower legs, and on their stomach, and that the resident looked like they had been sunburned. CC1 expressed that they were emotionally disturbed because they did not know exactly how the injuries occurred and did not know how long Resident 2 was outside in the courtyard during warm weather

conditions. CC1 further stated they had concerns of possible "neglect". CC1 stated, "There should have been more follow-up to determine what had happened."

In an interview on 06/11/2025 at 4:42 PM, Staff B stated that they started their shift at 2:00 PM on 05/27/2025. Staff B stated a visitor in the facility told them to check on Resident 2 at 4:00 PM because they thought Resident 2's feet appeared "sunburned" and that is when they found Resident 2 unresponsive outside in the courtyard. Staff B explained that Resident 2 appeared "hot".

In an interview on 06/11/2025 at 4:45 PM Staff D, Activity Director, stated that they were working day shift on 05/27/2025 and that it was "hot" that day. Staff D stated that at 1:30 PM they noticed that Resident 1 was sitting outside in the courtyard and noticed that their face was red. Staff D explained that they notified care staff at around 1:35 PM that Resident 1's face was red. Staff D further stated that when they were leaving the facility at 4:00 PM, they noticed that Resident 2 was still outside and was found unresponsive.

Review of the investigative documents provided to the department during the facility visit, showed no documentation of a determination of the circumstances surrounding the incident or any actions taken to prevent future similar incidents.

In an interview on 06/16/2025 at 12:54 PM, Staff C, Health and Wellness Director, stated that the Resident 2's incident report appeared "vague."

In an interview on 07/08/2025 at 10:30 AM, Staff G, Administrator, acknowledged that they could improve their investigative process and retrieve witness statements timelier

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) 7/25/25.

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

Amber Lucas
Administrator (or Representative)

7/25/25
Date

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

_____ _____

Administrator (or Representative) Date