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

04/14/2025

Ellensburg AL, LLC
Avista Senior Living Ellensburg
1008 East Mountain View Ave
Ellensburg, WA 98926

RE: Avista Senior Living Ellensburg # 2683

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 57827 (Completion Date 04/14/2025) and 48220 (Completion Date 10/31/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/14/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

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:

(b) Provide the necessary care and services for residents, including those with special needs;

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 Ellensburg
License/Cert.#: 2683
Compliance Determination #: 48220
Investigator: Felicia Cantu
Provider Type: Assisted Living Facility
Intake ID: 149609
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/03/2024 through 10/31/2024
Complainant Contact Date(s): 10/16/2024

Allegation(s):

1) A named staff member neglected a named resident when they were admitted to the facility.
2) A named resident was stuck between their bed rails.
3) A named resident passed away.
4) A named resident was not given call light pennants.
5) A named staff member comes to work drunk.

Investigation Methods:

Sample:	Total residents: 29 Resident sample size: 3 Closed records sample size:
Observations:	Residents 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 Facility policies Incident investigation State reporting log Resident records (face sheets, care plans, assessments, chart notes)

Investigation Summary:

1) Observations showed that staff to resident interactions were safe and helpful. Interviews and record review showed that the named resident was admitted to the facility and was not monitored for several hours. The named resident was found in their apartment with no pulse. Failed practice identified. WAC 388-78A-2600. 2)

Observations showed that the named resident and other residents did not have bed rails attached to their beds. Interviews and record review showed that the named resident did not have a bed rails attached to their bed. No failed practice identified. 3) Observations showed that staff to resident interactions were safe and helpful. Interviews and record review showed that the facility notified all entities. The named resident's record did not show that the named resident was monitored after they were admitted to the facility, then was found later with no pulse. Failed practice identified. WAC 388-78A-2600. 4) Observations showed that resident's in the facility had call light pennants on. Residents had call lights in their rooms that were accessible. Residents stated that they felt safe in the facility and that staff responded to their call light needs. No failed practice identified. 5) Observations showed that the named staff member and other staff members did not appear intoxicated. Interviews showed that the named staff member did not come to work intoxicated. No failed practice identified.

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 Ellensburg
License/Cert.#: 2683
Compliance Determination #: 48220
Investigator: Felicia Cantu
Provider Type: Assisted Living Facility
Intake ID: 149238
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/03/2024 through 10/31/2024
Complainant Contact Date(s): 10/16/2024

Allegation(s):

1) New residents in the facility are not given call light pennants.
2) New residents do not have a pre-admission assessment completed.
3) New residents are not monitored by facility staff

Investigation Methods:

Sample:	Total residents: 29 Resident sample size: 3 Closed records sample size:
Observations:	Residents 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 Facility policies Resident records (face sheets, care plans, assessments, chart notes)

Investigation Summary:

1)Observations showed that the named resident and other residents had call lights in their rooms that were accessible. The named resident stated that they felt safe in the facility and that staff responded to their call light needs. No failed practice identified. 2) Observations showed that staff to resident interactions appeared safe, respectful, and helpful. Interviews and record review showed that the new residents in the facility had required pre-admission assessments on file. No failed practice identified. 3) Observations showed that staff to resident interactions were safe and helpful. Interviews and record review showed that facility did not place the named resident on alert charting and did not monitor the resident after admission

to the facility. Failed practice identified. WAC 388-78A-2600.

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 Ellensburg
License/Cert.#: 2683
Compliance Determination #: 48220
Investigator: Felicia Cantu
Investigation Date(s): 10/03/2024 through 10/31/2024
Complainant Contact Date(s): 10/16/2024

Provider Type: Assisted Living Facility

Intake ID: 149240
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1) New residents are not receiving their medications.
2) A named staff member has a dog in the facility.

Investigation Methods:

Sample:	Total residents: 29 Resident sample size: 3 Closed records sample size:
Observations:	Residents Medication administration Staff to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Resident records (face sheet, care plans, assessment, chart notes, medication administration records)

Investigation Summary:

1) Observations showed that staff were safely administering medications to residents. Interviews and record review showed that the facility failed to initiate, order, and administer a named resident's medications timely. Failed practice identified WAC 388-78A-2240. 2) Observations showed that their were no pets in the named staff members office or in the facility common areas. No failed practice identified.

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 #: 2683	Compliance Determination # 48220
Plan of Correction	Avista Senior Living Ellensburg	Completion Date
Page 1 of 5	Licensee: Ellensburg AL, LLC	10/31/2024

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 10/03/2024 and 10/03/2024 of:

Avista Senior Living Ellensburg
1008 East Mountain View Ave
Ellensburg, WA 98926

This document references the following complaint number(s): 149609, 149238, 149240

The following sample was selected for review during the unannounced on-site visit: 3 of 29 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.

J Salquist
Residential Care Services

11/13/2024
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: 12-15-24

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interviews and record review, the facility failed to ensure prescribed medications were obtained for 1 of 3 residents (Resident 2). This failure resulted in medication not given as ordered and placed the resident at risk for health complications.

Findings included...

Review of the facility's undated policy titled, "Obtaining and Refilling Medications," showed that the facility would coordinate, obtain, and refill resident medications according to resident service plans. The policy showed that the Health Service Director would process the medication orders.

Review of the facility's undated policy titled, "Medication Variance," showed that the facility staff were to administer medications as ordered and according to their service plans.

Review of the facility's undated policy titled, "Reviewing and Approving Medication Management Program," showed that the medication management program policies and procedures would be reviewed by the Health Service Director.

Review of Resident 2's undated face sheet showed the resident was admitted to the facility on [redacted]//2024 and was diagnosed with [redacted] and [redacted].

Review of Resident 2's Negotiated Service Agreement (NSA), dated 09/14/2024, showed that Resident 1 required community staff to assist with medication administration as prescribed by a health care professional.

Review of Resident 2's medication orders showed that losartan (medication to control blood pressure) was ordered on 10/08/2024.

Review of Resident 2's medication administration record (MAR) showed that Resident 2 received their first dose of losartan on 10/15/2024.

Review of Resident 2's patient plan of care, dated 09/06/2024, showed that Resident 2's ordered medications from their provider were Tylenol (for pain), atorvastatin (for high cholesterol), and a calcium supplement.

Further Review of Resident 2's MAR showed that Resident 2 received their first dose of Tylenol, atorvastatin, and calcium on 10/15/2024.

In an interview on 10/15/2024 at 8:30 AM Staff A, Administrator who was also the Health and Wellness Director, stated that they were not aware that they were responsible for ordering, initiating, and obtaining Resident 2's medications.

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 Ellensburg is or will be in compliance with this law and / or regulation on (Date) 12-15-24 .

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

Administrator (or Representative) — Date: 12-15-24

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:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their policy by implementing safety checks for a newly admitted resident for 1 of 3 residents (Resident

Review of Resident 2's medication administration record (MAR) showed that Resident 2 received their first dose of losartan on 10/15/2024.

Review of Resident 2's patient plan of care, dated 09/06/2024, showed that Resident 2's ordered medications from their provider were Tylenol (for pain), atorvastatin (for high cholesterol), and a calcium supplement.

Further Review of Resident 2's MAR showed that Resident 2 received their first dose of Tylenol, atorvastatin, and calcium on 10/15/2024.

In an interview on 10/15/2024 at 8:30 AM Staff A, Administrator who was also the Health and Wellness Director, stated that they were not aware that they were responsible for ordering, initiating, and obtaining Resident 2's medications.

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 Ellensburg is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) 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:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their policy by implementing safety checks for a newly admitted resident for 1 of 3 residents (Resident

1). This failure placed residents at risk for harm.

Findings included...

Review of the facility's undated policy titled, "Safety Checks," showed that safety checks should be in place to increase supervision to prevent unwanted events. Safety checks would be assigned to maintain the health, safety, and welfare of residents who had just arrived from home or had an illness or condition. For residents who required frequent checks, a chart note would be made after rounds by the Health and Wellness Director or designee.

Review of Resident 1's pre-admission assessment, dated 09/06/2024, showed that facility staff would perform routine safety checks that included assurance that the resident's call light pendant (wireless call light attached to the resident) was within reach. Additionally, the assessment showed that Resident 1's safety needs would be met.

Review of Resident 1's undated face sheet showed that Resident 1 moved into the facility on [redacted]/2024 and was diagnosed with [redacted] and [redacted].

Review of Resident 1's facility chart notes, dated 10/01/2024, showed that care staff called Staff A, Administrator, to notify them that Resident 1 had expired. The notes showed that Resident 1 was found in their room at 12:30 AM with no pulse and no respirations. The note showed that Resident 1 was in bed, leaning up against the "bed rail" with feet on the floor.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 10/03/2024, showed that staff would perform routine safety checks and assure that the resident would have a call light pendant.

In an interview on 10/03/2024 at 12:51 PM, Staff A stated that they were also the Health and Wellness Director for the facility and was not aware of what medications Resident 1 arrived at the facility with. Staff A stated they had not been in Resident 1's apartment yet.

In an interview on 10/15/2024 at 8:30 AM, Staff A stated that they worked on [redacted]/2024 and was not aware that Resident 1 arrived at the facility that day. Staff A further stated that Resident 1 should have been on alert charting after they arrived at the facility.

In an interview on 10/15/2024 at 1:45 PM, Staff D, Caregiver stated that Resident 1 arrived at the facility on [redacted]/2024 around 12:00 PM.

In an interview on 10/15/2024 at 12:54 PM, Staff E, Activity Director, stated that Resident 1 arrived at the facility on [redacted]/2024 around 12:00 PM.

In an interview on 10/15/2024 at 1:56 PM, Staff B, Medication Technician, stated that they arrived at the facility for their shift on [redacted]/2024 at 10:00 PM and later found Resident 1 with no pulse at 12:30 AM. Staff B stated that the facility's normal process was that the facility staff should monitor and chart on all new residents every two hours for 72 hours. Staff B further stated that there were no alert charting/safety checks initiated in their charting system for Resident 1.

In an interview on 10/15/2024 at 3:43 PM, Staff C, Caregiver, stated that they arrived at the facility for their shift on [redacted]/2024 at 10:00 PM, and had no information or instructions to chart on and provide frequent checks for Resident 1. Staff C expressed that the computer system was "completely blank" for Resident 1.

In an interview on 10/31/2024, Staff A stated the facility's policy was to ensure new residents were put on "alert charting" at admission. Staff A stated that alert charting would occur every two hours for 72 hours.

Review of Resident 1's record showed no documentation of safety checks/alert charting between the time of Resident 1's arrival to the facility and the time of their death.

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 Ellensburg is or will be in compliance with this law and / or regulation on (Date) 12-15-24.

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

Arlene Walker — Administrator (or Representative)

12-15-24 — Date

In an interview on 10/15/2024 at 12:54 PM, Staff E, Activity Director, stated that Resident 1 arrived at the facility on [redacted]/2024 around 12:00 PM.

In an interview on 10/15/2024 at 1:56 PM, Staff B, Medication Technician, stated that they arrived at the facility for their shift on [redacted]/2024 at 10:00 PM and later found Resident 1 with no pulse at 12:30 AM. Staff B stated that the facility's normal process was that the facility staff should monitor and chart on all new residents every two hours for 72 hours. Staff B further stated that there were no alert charting/safety checks initiated in their charting system for Resident 1.

In an interview on 10/15/2024 at 3:43 PM, Staff C, Caregiver, stated that they arrived at the facility for their shift on [redacted]/2024 at 10:00 PM, and had no information or instructions to chart on and provide frequent checks for Resident 1. Staff C expressed that the computer system was "completely blank" for Resident 1.

In an interview on 10/31/2024, Staff A stated the facility's policy was to ensure new residents were put on "alert charting" at admission. Staff A stated that alert charting would occur every two hours for 72 hours.

Review of Resident 1's record showed no documentation of safety checks/alert charting between the time of Resident 1's arrival to the facility and the time of their death.

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 Ellensburg is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date