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

01/16/2025

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) 51949 (Completion Date 01/16/2025) and 49045 (Completion Date 11/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/16/2025 and found no deficiencies.

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

The Department staff who did the On Site verification:
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis, Field Manager
Region 1, Unit G

Residential Care Services
Investigation Summary Report

Provider/Facility: Avista Senior Living Ellensburg
License/Cert.#: 2683
Compliance Determination #: 49045
Investigator: Felicia Cantu
Provider Type: Assisted Living Facility
Intake ID: 151720
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/21/2024 through 11/01/2024
Complainant Contact Date(s): 11/04/2024

Allegation(s):

1) A named resident's apartment is not being cleaned.
2) A named resident is not getting showered and left in feces.
3) A named resident is missing money and food.

Investigation Methods:

Sample:	Total residents: 25 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident rooms Resident care equipment Facility environment Staff to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster House policies Resident records (face sheet, care plan, assessment, chart notes)

Investigation Summary:

1) Observations showed that the named resident's apartment appeared clean. Housekeeping was observed cleaning rooms in the facility. Interviews and record review showed that the residents were satisfied with housekeeping services.
2) Observations showed that the named resident was not in the facility. Other residents appeared groomed and showered. Interview's with residents showed that the facility assisted them with showers and toileting. No failed practice identified.
3) Interviews and review showed that the facility failed to investigate an allegation of stolen money and food for a named resident. Failed practice identified WAC 388-78A-2371 (1)(2).

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 #: 49045
Investigator: Felicia Cantu
Investigation Date(s): 10/21/2024 through 11/01/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 152070
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1) A named staff member did not report or investigate and allegation of missing money and missing food.
2) Laundry is not done for a named resident and garbage are not thrown out.
3) A named resident's sheets are not changed in the facility.

Investigation Methods:

Sample:	Total residents: 25 Resident sample size: 4 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster State reporting log Facility policies Resident records (face sheets, care plans, assessments, chart notes)

Investigation Summary:

1) Interviews and review showed that the facility failed to investigate an allegation of stolen money and food for a named resident. Failed practice identified WAC 388-78A-2371 (1)(2).
2) Observations showed that housekeeping was doing laundry, and cleaning rooms that included throwing the garbage out. Residents apartments appeared clean. No failed practice identified.
3) Observations and record review showed that resident's beds were made, and linens appeared clean. Residents stated they had no concerns regarding their beds

not being made. 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

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 10/21/2024 and 10/21/2024 of:

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

This document references the following complaint number(s): 151720, 151338, 152070

The following sample was selected for review during the unannounced on-site visit: 4 of 25 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.

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;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to investigate and determine the circumstances of an allegation of missing money and missing food for 1 of 3 residents (Resident 1). This failure contributed to the facilities inability to retrieve the resident's missing items. This failure placed residents at risk for misappropriation.

Findings included…

Review of the facility's undated policy titled "Resident Incident Reporting" showed that the facility staff shall conduct an immediate investigation and document any alleged incident within twenty-four hours after the incident.

Review of the facility's undated policy titled "Abuse Prevention and Reporting" showed that residents in the facility would not be subjected to exploitation or misappropriation of personal and private property by any person. If an allegation of exploitation has occurred in the facility the facility manager shall initiate an investigation and document the following per regulatory requirements, that included dates, times, and description of the allegation, names of witnesses, and actions taken by the manger to prevent suspected exploitation from occurring in the future. The Policy showed the Director would notify the Home Office that an investigation has been initiated.

Review of Resident 1's face sheet showed that they moved into the facility on [redacted]/2024.

In an interview on 10/18/2024 at 2:11 PM, Collateral Contact 1(CC1), representative stated that the facility office had $350.00 cash in an envelope locked in the facility's locked safe. The cash was specifically for Residents 1's hair appointments. Resident 1 was scheduled for an upcoming hair appointment in October 2024. CC1 stated they asked Staff A, Administrator for the money out of the envelope. Staff A told them that there was only $50.00 left in the envelope. CC1 stated there should have been $300.00 left in the envelope. CC1 expressed that they also notified Staff A of concerns of missing

food from Resident 1's apartment. CC1 explained that they bought $180.00 of groceries and a few days later it was all gone besides two cans of food. CC1 stated that the facility did not give them an explanation of how the incidents of missing food and money could have occurred.

In an interview on 10/23/2024 at 2:45 PM, Staff A stated that they were made aware of the missing food and the missing money but that they did not conduct an internal investigation or document the incident to determine what had occurred. Staff A also stated that they were new to their position and was not aware they needed to do an internal investigation.

Review of Resident 1's facility records on 10/23/20204 did not show that there was an investigation completed.

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