STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Spokane Operations, LLC
Avamere at South Hill
3708 E 57th Ave
Spokane, WA 99223

RE: Avamere at South Hill License # 2461

Dear Administrator:

This letter addresses Compliance Determination(s) 46219 (Completion Date 08/26/2024) and 43649 (Completion Date 07/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/26/2024 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-2466-2

The Department staff who did the on-site verification:
Carla Rose, NCI Community Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2461	Compliance Determination # 43649
Plan of Correction	Avamere at South Hill	Completion Date
Page 1 of 3	Licensee: Spokane Operations, LLC	07/03/2024

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 follow-up on 07/03/2024 and 07/03/2024 of:
Avamere at South Hill
3708 E 57th Ave
Spokane, WA 99223

This document references the following SOD dated: 07/03/2024

The following sample was selected for review during the unannounced on-site visit: 7 of 64 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

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

Randy Rohn RDO
Administrator (or Representative)

7/29/24
Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a fingerprint background check for 1 of 4 sampled staff (Staff K) reviewed for credentials. This failure placed residents at risk of receiving care from a potentially disqualified staff.

Findings included...

Review of Staff K's, Med Tech, personnel file showed they were hired on 12/13/2023. Further review showed the file did not contain a final fingerprint background check.

In an interview on 07/03/2024 at 1:30 PM, Staff D, Business Office Manager, stated that they had not completed a fingerprint background check for Staff K. Staff D further stated that they were unsure if any other staff in the business office had completed the fingerprint background check and they would check. Staff D was unable to provide documentation of a final fingerprint to the department by the conclusion of the investigation.

This is an uncorrected deficiency previously cited on 06/13/2024.

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 South Hill is or will be in compliance with this law and / or regulation on (Date) 7/4/2024 .

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

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Statement of Deficiencies	License #: 2461	Compliance Determination # 43649
Plan of Correction	Avamere at South Hill	Completion Date
Page 3 of 3	Licensee: Spokane Operations, LLC	07/03/2024

Randy Rohn RDO — Administrator (or Representative)

7/29/24 — Date

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at South Hill
Provider Type: Assisted Living Facility
License/Cert.#: 2461
Compliance Determination #: 41495
Intake ID: 129934
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 05/10/2024 through 06/13/2024
Complainant Contact Date(s): 05/10/2024, 05/23/2024

Allegation(s):
Staff left a resident soaked in urine.

Investigation Methods:

Sample:	Total residents: 65 Resident sample size: 10 Closed records sample size: 1
Observations:	Residents' well-being Any unmet residents' needs Hygiene Staff's response to residents' needs/concerns
Interviews:	Twelve residents, including alleged victim (AV) Three resident representatives Three facility caregivers, with two that were also medication aides Two facility nurses Business Office Manager Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, and Progress Notes Seven sampled staff's credentials, included for the alleged perpetrator (AP) Staffing schedules - April and May 2024 Facility's investigation documents

Investigation Summary:
Residents, including the AV, were observed clean and without lingering, objectionable odors. In interviews with the AV, facility nurse, and administrator, they stated a caregiver did not provide proper incontinence care to the AV and another resident. The facility investigated allegations related to the issue, and terminated the AP's employment with the facility however, the facility failed to report the alleged issue to the department abuse/neglect hotline, as required. The facility also failed to complete a national fingerprint background check for the AP. Failed facility practices were found

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and documented in a Statement of Deficiencies under Washington Administrative Code(WAC) 388-78a-2630(1)(a) Reporting abuse and neglect, and WAC 388-78a-2466(2) Background checks-Washington state name and date of birth background check-Valid for two years-National fingerprint background check-Valid indefinitely.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at South Hill
Provider Type: Assisted Living Facility
License/Cert.#: 2461
Compliance Determination #: 41495
Intake ID: 131389
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 05/10/2024 through 06/13/2024
Complainant Contact Date(s): 05/21/2024, 06/13/2024

Allegation(s):

1 - A staff made obscene gesture and derogatory remarks about resident(s), and would not assist a resident with mobility
2 - Nurse is not doing monthly skin assessments
3 - Staff is administering insulin without the proper credentials

Investigation Methods:

Sample:
Total residents: 65
Resident sample size: 10
Closed records sample size: 1

Observations:
Residents' safety and well-being
Any signs of harm and unmet needs
Medication passes
Staff's care of and interactions with residents
Any unmet needs e.g. interventions for skin issues

Interviews:
Twelve residents, including alleged victims (AVs)
Three resident representatives
Three facility caregivers, with two that were also medication aides
Two facility nurses
Business Office Manager
Administrator

Record Reviews:
Sampled residents' Face Sheets, assessments, care plans, and Progress Notes
Seven sampled staff's credentials, including that of named staff persons
Facility's investigation documents
Facility policy and procedures - abuse and neglect
Staffing schedules - April and May 2024

Investigation Summary:

1 - Staff was observed caring for and interacting with residents with respect. Residents interviewed had no concerns about the manner in which the named staff provided care/assistance. Interviews with the Business Office Manager and Administrator,

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showed they conducted an internal investigation, determined the named staff conducted themselves in a manner that could adversely affect residents, and addressed residents' ongoing safety and well-being. Interviews with a resident, another resident's representative, and staff showed they had concerns related to another caregiver not providing residents with proper incontinence care. Interviews with staff showed the facility did not report an allegation of this caregiver's failure to properly provide a resident with proper incontinence care. Failed facility practice was found and documented in a Statement of Deficiencies (SOD) under Washington Administrative Code (WAC) 388-78a-2630(1) Reporting abuse and neglect. Reviews of sampled staff's credentials showed the facility failed to complete a fingerprint check on one caregiver. Failed facility practice was found and documented in the SOD under WAC 388-78a-2466(2) Background checks-Washington name and date of birth background check-Valid for two years-National fingerprint background check-Valid indefinitely.
2 - Residents interviewed, including sampled residents with skin issues, had no concerns about the care facility provided. Interviews with nurses and review of facility's system for addressing skin issues showed the facility addressed skin problems, as needed. No failed facility practices were found related to allegation.
3 - Medication passes were observed done properly. Residents and representatives interviewed had no concerns about medication services, including diabetic care. Reviews of sampled resident diabetics' medication records and sampled staff's credentials showed qualified staff provided delegated tasks, such as insulin and blood sugar checks. No failed facility practices were found.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at South Hill
Provider Type: Assisted Living Facility
License/Cert.#: 2461
Compliance Determination #: 41495
Intake ID: 131405
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 05/10/2024 through 06/13/2024
Complainant Contact Date(s):

Allegation(s):
Staff stated a resident needed to die because the resident was in a lot of pain.

Investigation Methods:

Sample:	Total residents: 65 Resident sample size: 10 Closed records sample size: 1
Observations:	Residents' safety and well-being Any signs of harm and unmet needs of residents Staff's care of and interactions with residents
Interviews:	Twelve residents, including alleged victim (AV) Three resident representatives Three facility caregivers, with two that were also medication aides Two facility nurses Business Office Manager Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, and Progress Notes Seven sampled staff's credentials Staffing schedules - April and May 2024

Investigation Summary:
Staff was observed caring for and interacting with residents with respect. Residents interviewed had no concerns about the manner in which the named staff provided care/assistance. Interviews with the Business Office Manager and Administrator, showed they conducted an internal investigation, determined the named staff conducted themselves in a manner that could adversely affect residents, and addressed residents' ongoing safety and well-being. Interviews with a resident, another resident's representative, and staff showed they had concerns related to another caregiver not providing residents with incontinence care. Interviews with staff showed the facility did not report an allegation of this caregiver's failure to properly provide a resident with incontinence care. Failed facility practice was found and

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documented in a Statement of Deficiencies (SOD) under Washington Administrative Code (WAC) 388-78a-2630(1) Reporting abuse and neglect. Reviews of sampled staff's credentials showed the facility failed to complete a fingerprint check on one caregiver. Failed facility practice was found and documented in the SOD under WAC 388-78a-2466(2) Background checks-Washington name and date of birth background check-Valid for two years-National fingerprint background check-Valid indefinitely.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2461	Compliance Determination # 41495
Plan of Correction	Avamere at South Hill	Completion Date
Page 1 of 4	Licensee: Spokane Operations, LLC	06/13/2024

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 05/10/2024, 05/10/2024 and 06/13/2024 of:

Avamere at South Hill
3708 E 57th Ave
Spokane, WA 99223

This document references the following complaint number(s): 129934, 129133, 129968, 130103, 131259, 131389, 131405, 131567, 131564

The following sample was selected for review during the unannounced on-site visit: 10 of 65 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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 — 06/20/2024 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.

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

Administrator (or Representative) 6.21.24 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report allegations of a caregiver's neglect to the Complaint Resolution Unit for 2 of 11 sampled residents (Residents 1 and 2). Failure to report the allegations placed residents at risk of further neglect.

Findings included...

Review of the facility's policy titled, "Abuse Prevention," dated 03/15/2017, showed that the staff should report all alleged cases of resident abuse and neglect to the state hotline.

In an interview on 05/15/2024 at 3:25 PM, Resident 1 stated a night shift caregiver recently "didn't do right by me". The resident couldn't recall the caregiver's name. Resident 1 further stated when they wet their bed, the night shift caregiver put them back into a urine soiled bed. The resident couldn't recall the date the incident happened.

In an interview on 05/15/2024 at 12:30 PM, Staff B, Director of Nursing, stated during day shift recently, Staff I, Caregiver, and another caregiver whose name Staff B couldn't remember, reported to Staff B that Staff E, Caregiver, left Resident 1 and Resident 2 soaked in urine. Staff B stated they didn't report Staff I's and the other caregiver's allegations to the department abuse/neglect hotline because they were not aware of the requirement to make a report. Staff B further stated that they later received a message from Collateral Contact 2 (CC2), Resident Representative, about the allegation, and Collateral Contact 1 (CC1), Resident Representative, called Staff B to discuss the allegation.

In an interview on 05/15/2024 at 3:55 PM, Staff A, Administrator, stated the facility terminated Staff E on 04/28/2024, related to work-performance issues including leaving Resident 1, and another resident they couldn't recall, wet with urine. Staff A stated Staff B and Staff D, Business Office Manager, had details regarding Staff E leaving the two residents wet and that neither Staff B nor Staff D made a report to the department's abuse/neglect hotline. Staff A stated they did not make a report to the department abuse/neglect hotline. Regarding the reasons none of the staff that heard the allegation(s)

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made reports to the department hotline, Staff A stated the reason was that the facility did not have proof that Staff E left the two residents wet.

In an interview on 05/16/2024 at 4:05 PM, CC2 stated Staff B called them and was "apologetic" regarding a caregiver who had "left [Resident 2] alone" and did not assist with incontinence care when the resident was incontinent of urine.

In an interview on 05/16/2024 at 4:20 PM, CC1 stated Resident 1 reported wetting the bed, using their pendant to call for assistance, and a caregiver putting Resident 1 back into the wet bed. CC1 further stated they did not know the identity of the caregiver, they talked to Staff B about Resident 1's remarks, and the facility fired the caregiver.

Review of the April and May 2024 department hotline intakes showed the facility did not report any allegations of staff not providing residents with proper incontinence care.

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 South Hill is or will be in compliance with this law and / or regulation on (Date) 5.16.24.

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

Administrator (or Representative) 6.21.24 Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a national fingerprint background check was completed for 1 of 7 sampled staff (Staff E) reviewed for credentials. This failure placed residents at risk of receiving care from a potentially disqualified staff.

Findings included...

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Review of the Employee Anniversary Listing showed Staff E was hired on 06/23/2023.

In an interview on 05/15/2024 at 3:00 PM, the department investigator asked Staff A, Administrator to provide information regarding Staff E's credentials, including the national fingerprint background check result for Staff E.

Review of an email message, dated 05/17/2024 at 9:29 AM, Staff A informed the investigator that the facility did not have the result of the national fingerprint background check result for Staff E.

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 South Hill is or will be in compliance with this law and / or regulation on (Date) 5.16.24 .

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

Administrator (or Representative) 6.21.24 Date

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