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

03/06/2025

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

RE: Avamere at South Hill # 2461

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 55906 (Completion Date 03/06/2025) and 51393 (Completion Date 01/06/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/06/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(ii) Resident living rooms and resident sleeping rooms; and

(iii) Corridors, as well as common and outdoor areas accessible to residents.

The Department staff who did the On Site verification:
Sandra Fast, Community Complaint Investigator

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salzquist

Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at South Hill
Provider Type: Assisted Living Facility
License/Cert.#: 2461
Compliance Determination #: 51393
Intake ID: 156876
Investigator: Sandra Fast
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 12/09/2024 through 01/06/2025
Complainant Contact Date(s): 01/06/2025, 12/09/2024, 12/10/2024

Allegation(s):

1. Allegation of no staff response to call light.
2. Allegation that no assessment was done on the named resident after a fall and that that no incident reports done after the named resident had fallen.
3. A medication technician allegedly had not given the resident some of the named resident's medications.

Investigation Methods:

Sample:	Total residents: 65 Resident sample size: 4 Closed records sample size: 0
Observations:	Common areas Corridors Named resident Named resident's apartment Sampled residents Sampled residents' apartments Activities
Interviews:	Executive Director Health Services Director Medication Technicians Care givers Named residents Sampled residents
Record Reviews:	Disclosure of services Characteristic Roster Staff List Staff schedule House Policies Personnel documents Named residents' face sheets Named residents' negotiated service agreement Named residents' facility investigations Named residents' progress notes Named resident's call light log

Sampled residents' face sheets
Sampled residents' progress notes

Investigation Summary:

1. The named resident stated they had recently had several delayed or no call light response by staff. The Executive Director stated that the facility had replaced the staff's pagers which did not remedy the issues with the system. The Health Services Director (HSD) stated that the call light system software was updated. The call light testing log showed the call system was not functioning properly. Staff members stated that the paging system continued to be unreliable and was problematic. Failed facility practice was identified and a citation issued related to Washington state Administrative Code (WAC) 388-78A-2930(1)(2)(b)(3)(i)(4)(ii)
2. The named resident's progress notes showed on several identified fall dates that the appropriate assessments and monitoring occurred. Record reviews showed that the facility had done an investigation after each of the named resident's witnessed and reported falls. The named resident's progress notes showed each fall had been assessed and that the resident was properly monitored after each fall. No failed facility practice was identified.
3. The HSD stated that they had investigated the named resident's allegation about the named medication technician and found no substantiation of the resident's claims. The HSD stated that they had initiated several interventions related to the named resident's claims regarding the not receiving some of their medications from the named MT. The HSD stated that the named MT was no longer assigned to administer the named resident's medications and treatments. No failed facility practice was identified.

Conclusion / Action:

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

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Statement of Deficiencies	License # 2461	Compliance Determination # 51393
Plan of Correction	Avamere at South Hill	Completion Date
Page 1 of 4	Licensee: Spokane Operations, LLC	01/06/2025

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 12/08/2024, 12/08/2024 and 12/09/2024 of:

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

This document references the following complaint number(s): 156876, 158393

The following sample was selected for review during the unannounced on-site visit: 4 of 65 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community 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.

J Salquist
Residential Care Services

01/14/2025
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.

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

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

This document references the following complaint number(s): 156876, 158303

The following sample was selected for review during the unannounced on-site visit: 4 of 65 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community 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

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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.

Sherri Underkoffler (Quest) 01/20/2025
Administrator (or Representative) Date

WAC 388-78A-2930 Communication system.

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(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain an effective communication system for 4 of 4 (Residents 1, 2, 3, and 4). This failure placed residents at risk for delayed responses when requesting assistance.

Findings include...

Review of the facility's policy called "Resident Emergency Call System," and dated, 10/2021, showed that, "The system should be tested regularly, at least annually," and that, "If the community emergency call system is dysfunctional, staff should check with all residents residing in their apartments, at regular intervals and alert the Maintenance Director or designee as soon as possible."

Review of the facility's call light testing log showed that the facility's call light system had been functioning improperly since 12/05/2024 citing, "Pager issues." The log showed the communication system continued to be malfunctioning through 12/30/2025 stating pager issues.

In an interview on 12/09/2024, at 4:03 PM, Staff B, Director of Health Services (DHS), stated that the facility's call system had been, "acting up." Staff B stated that some staff pagers would not get calls and others would. Staff B stated that the system's software had recently been updated to try to remedy the issues.

In an interview on 12/09/2024, at 1:12 PM, Staff B, Medication Technician (MT) stated that the call system had been unreliable and had paged out wrong room numbers. The MT stated that Resident 1 had told them that they had used their call light, and no staff answered it. Staff B stated that the expectation for answering the call lights is before

Administrator (or Representative) Date

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In an interview on 12/09/2024, at 1:12 PM, Staff B, Medication Technician (MT) stated that the call system had been unreliable and had paged out wrong room numbers. The MT stated that Resident 1 had told them that they had used their call light, and no staff answered it. Staff B stated that the expectation for answering the call lights is before

the third announcement and that each announcement is separated by 5 minutes. Staff B stated that if the resident's assigned caregiver (CG) has not responded to a call light by the 3rd announcement then another CG or MT is expected to reach out to the assigned CG or answer the announcement themselves.

In an interview on 12/09/2024 at 3:45, Staff C, MT stated that the call light situation was frustrating. Staff C stated that management had told them that they were working to get the call system reprogrammed but, that the system was still paging out wrong room numbers and that the caregivers must try to figure out which resident is requesting assistance by going from room to room to find the correct resident.

Resident 1

Review of Resident 1's call light log showed on 11/21/2024 at 2:56 PM, the resident's call light was never responded to. The call light log showed that on 11/22/2024 at 1:19 PM, the resident's call light was not responded to for 29 minutes. The call light log showed that on 12/02/2024 at 5:28 PM the resident's call light was not responded to for 26 minutes. The call light log showed that on 12/03/2024 at 6:52 AM the resident's call light log was not responded to for 33 minutes.

Review of Resident 1's progress note dated 12/09/2024 at 9:10 AM, showed that the resident reported pressing their call pendant and receiving no staff response.

In an interview on 12/09/2024, at 12:03 PM, Resident 1 Stated they had fallen from their wheelchair on 2 recent occasions and that they had activated their call pendant, and that staff had not come so they had to get themselves back into their wheelchair. The resident stated that on one of the occasions, the staff told them that the system had displayed another resident's room number instead of their room number. Resident 1 stated they had brought the issue to the Director of Health Services (DHS) and the DHS had nothing to say.

Resident 2

Review of Resident 2's call light log showed that on 12/04/2024 the resident's call light log was not responded to for 27 minutes. The call light log showed that 12/06/2024 at 2:22 PM, the resident's call light was not responded to for 24 minutes. The call light log showed that 12/14/2024 at 12:14 PM, the resident's call light was never responded.

In an interview on 12/09/2024, at 1:49 PM, Resident 2 stated that staff response to their call light had taken up to 30 minutes.

Resident 3

the third announcement and that each announcement is separated by 5 minutes. Staff B stated that if the resident's assigned caregiver (CG) has not responded to a call light by the 3rd announcement then another CG or MT is expected to reach out to the assigned CG or answer the announcement themselves.

In an interview on 12/30/2024 at 3:45, Staff C, MT stated that the call light situation was frustrating. Staff C stated that management had told them that they were working to get the call system reprogrammed but, that the system was still paging out wrong room numbers and that the caregivers must try to figure out which resident is requesting assistance by going from room to room to find the correct resident.

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Resident 2

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Resident 3

Statement of Deficiencies	License #: 2461	Compliance Determination #51393
Plan of Correction	Avamere at South Hill	Completion Date
Page 4 of 4	Licensee: Spokane Operations, LLC	01/06/2025

Review of Resident 3's call light log on 12/07/2024 at 7:28 PM showed the resident's bathroom call light was activated and that, "This alert was never responded to."

Resident 4

Review of Resident 4's call light log on 12/08/2024 showed the resident's call light was activated and took 28 minutes to be responded to by staff.

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) ~~03/01/2025~~ SKU 02/20/2025

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

Sherri Undercoffler (Kyesl) 01/20/2025

Administrator (or Representative) 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