STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 77686 (Completion Date 05/21/2026) and 74235 (Completion Date 03/24/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/21/2026 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-2120-4

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

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

Sincerely,

Stephanie Jenks, Community Field Manager
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 #: 74235
Intake ID: 214492
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 03/12/2026 through 03/24/2026
Complainant Contact Date(s): 03/10/2026, 03/24/2026

Allegation(s):
Resident fell resulting in injuries after leaving facility unsupervised.

Investigation Methods:

Sample:
Total residents: 70
Resident sample size: 2
Closed records sample size: 1

Observations:
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter
Executive Director
Director of Health Services
Residents
Alleged Victim's Representative
Medication Technician
Resident Representative

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plans
*Resident assessments
*Progress notes
*Medication administration records
*Wandering and Elopement Procedure Policy

Investigation Summary:
Interview and record review showed that the Alleged Victim was allowed to leave the facility unsupervised even after signs of cognitive decline and confusion were noted by staff. Failed facility practice identified and cited under WAC 388-78A-2120

Monitoring residents' well-being (4).

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 # 74235
Plan of Correction	Avamere at South Hill	Completion Date
Page 1 of 4	Licensee: Spokane Operations, LLC	03/24/2026

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 03/12/2026 of:

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

This document references the following complaint number(s): 214492, 215595

The following sample was selected for review during the unannounced on-site visit: 2 of 70 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2461	Compliance Determination # 74235
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Page 2 of 4	Licensee: Spokane Operations, LLC	03/24/2026

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 — 03/26/2026 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) — 3/31/2026 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to take appropriate action to protect a resident from elopement after signs of cognitive decline were noted in 1 of 3 residents (Resident 1). This failed practice contributed to Resident 1 suffering an unsupervised fall and medical emergency while alone in the community.

Findings included...

Review of a facility policy titled, "Wandering and Elopement Procedure,", last revised 11/2021, showed that wandering was defined as movement about the area without a fixed goal. Review of the policy showed that elopement was defined as exiting the building when it had been determined the resident was not safe to exit unaccompanied. Further review of the policy showed that a resident identified as a wandering risk should be considered at risk for elopement.

Review of an assessment for Resident 1, dated 02/23/2026, showed that the resident was hospitalized less than three weeks prior following a stroke (a medical emergency occurring when blood flow to the brain is blocked or a vessel bursts, causing rapid brain cell death). The assessment showed that Resident 1 was independent with mobility with the use of a cane. The assessment showed that Resident 1 was oriented and able to recall and retain information including time, place and situation. Further review of the assessment showed that Resident 1 was not at risk for elopement.

Review of a progress note for Resident 1, dated 02/23/2026 at 3:58 PM, showed that the resident was alert and oriented.

Review of a progress note for Resident 1, dated 02/26/2026 at 5:30 AM, showed that the resident was observed out wandering around the halls looking lost and confused. The progress note showed that Resident 1 was confused as to the time. The progress note showed that Resident 1 was anxious about going home to get some belongings from their house.

Review of a progress note for Resident 1, dated 02/27/2026 at 4:22 PM, but documented as a late entry for 02/26/2026, showed that the resident was observed wandering throughout the facility appearing anxious. The progress note showed that the resident repeatedly stated they needed to go to their home to check on their house and to retrieve additional belongings. The progress note showed that even after staff provided reassurance and redirection, Resident 1 continued to express worry about the condition of their home and the location of their belongings. The note showed that in response to the resident's ongoing anxiety and stated needs, the staff coordinated and transported Resident 1 to their house on 02/27/2026.

Review of a progress note for Resident 1, dated 02/28/2026 at 9:44 AM, and documented by Staff A, Health Services Director, showed that the resident was observed leaving the building without their cane that morning. The note showed that Resident 1 was unaware that a car had turned onto the drive behind them and they had to be encouraged by staff to use the sidewalk. The note showed that the resident declined an offer of transportation and they were insistent upon walking to their house (which was 0.7 miles away). The note showed that Resident 1 agreed to call the facility when they arrived home.

In an interview on 03/10/2026 at 12:51 PM, Collateral Contact 1 (CC1), Hospital Nurse, stated that while Resident 1 was out of the facility on 02/28/2026, they fell and were taken to the emergency room. CC1 stated that Resident 1 had a brain bleed and was admitted to the hospital. CC1 stated that Resident 1 knew their own name though they had no idea why they were at the hospital or how they got there. CC1 stated that Resident 1 was not making any sense and they were confused. CC1 stated they felt Resident 1 would be affected by their fall and injuries for the rest of their life. CC1 stated their main concern was that Resident 1 had been allowed to leave the facility alone.

In an interview on 03/12/2026 at 10:25 AM, Staff A stated that they intercepted Resident 1 while they were walking down the drive to go home on 02/28/2026. Staff A stated they had not felt confident with Resident 1 leaving the facility alone and they did have concerns about Resident 1's ability to walk very far following their strokes. Staff A stated that Resident 1 could not be talked out of going though Staff A was able to convince the resident to bring their cane. Staff A stated that Resident 1 had intermittent sundowning (a syndrome that is characterized by increased confusion and restlessness

beginning in the late afternoon and early evening). Staff A stated that it was Resident 1's right to leave the facility. Staff A stated they believed Resident 1 left the facility around 10:00 AM. and when they had not seen or heard back from the resident by 2:45 PM to 3:00 PM, they then attempted to reach Resident 1 and their emergency contact by phone (approximately five hours after Resident 1 left the facility unsupervised).

In an emailed statement, received on 03/24/2026 at 9:10 AM, Staff A stated that if a resident was deemed unsafe to leave the community unescorted and they did so anyway, Staff A would expect staff to follow the Wandering and Elopement procedure. Staff A stated they would expect staff to attempt to redirect the resident back into the community. Staff A stated that if the individual continued to be non-redirectable and continued leaving, Staff A would expect staff to go with or follow the individual to keep them safe.

This is a recurring citation previously cited on 02/06/2025.

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) 05-08-2026.

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

Todd Whittaker — Administrator (or Representative)

03-31-2026 — Date

Plan of Correction

Agency Name	Citation Date
Avamere at South Hill	03/26/2026
Submitted by	**Date of POC Submission**
Todd Whitehead, Executive Director	03/31/2026
☒ **Complaint Citation** ☐ **Certification Citation**	

Citation: (list WAC)	
What *initial or immediate actions* were taken to address concerns affecting clients?	Upon becoming aware of the incident, we initiated an internal review of the circumstances, including staff response to a resident's change in condition and supervision needs. Education was provided to staff regarding the importance of timely reporting of a change of cognition and alert charting process (e.g., behavioral changes, falls, elopement risk, safety concerns, confusion or Anxiety). A meeting was held on 03/25/2026 for Med Techs, caregivers, and clinical leadership team to review the importance of adding residents to alert charting when a change of condition is identified, notifying appropriate parties (ED, RCC, RN, family and provider), and implementation of an ISP for monitoring interventions.
How will you apply the correction to all clients you support?	Alert charting process will be monitored in our stand up and clinical meeting. Clinical team and ED will review the 24 hour/72 hour report and electronic health record in the community Monday through Friday and make any changes to the resident's evaluation and service plan as needed. Shift-to-shift communication tools with be utilized by caregivers and Med Techs. Additional staff training with be completed on Change of Condition policy, Wandering and Elopement procedure, and when to notify RCC, RN, and ED.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	April Winters, Health Services Director and Todd Whitehead, Executive Director, will be responsible for implementing the change and to ensure ongoing compliance with this change.
Date by which lasting correction will be achieved	5/8/2026
Additional Information	None.

Submit to RCS within 10 calendar days of receipt of letter to:

Nicole Vreeland, Field Manager
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600