STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Yakima Operations, LLC
Avamere at Englewood Heights Memory Care
3706 Kern Way
Yakima, WA 98902

RE: Avamere at Englewood Heights Memory Care License # 2462

Dear Administrator:

This letter addresses Compliance Determination(s) 76929 (Completion Date 05/07/2026) and 72591 (Completion Date 03/09/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/07/2026 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-2210-1-b

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor

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: Avamere at Englewood Heights Memory Care
License/Cert.#: 2462
Compliance Determination #: 72591
Investigator: Anna Cairns
Investigation Date(s): 02/10/2026 through 03/09/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 208669
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
The named resident had been given a medication from another resident by facility staff.

Investigation Methods:

Sample:	Total residents: 20 Resident sample size: 2 Closed records sample size: 0
Observations:	Medication count Staff to resident interactions
Interviews:	Administrator Director of Health Services Staff Resident representative
Record Reviews:	Characteristic roster Facility policies (medication services, medication error) Staff training Resident records (face sheet, care plan, medication administration record, physician orders, progress notes)

Investigation Summary:
Interview and record review showed that facility staff did not administer medications as prescribed to the named resident and to the other sampled resident. Failed practice identified. WAC 388-78A-2210.

Conclusion / Action:

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

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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 02/10/2026 of:

Avamere at Englewood Heights Memory Care
3706 Kern Way
Yakima, WA 98902

This document references the following complaint number(s): 208669

The following sample was selected for review during the unannounced on-site visit: 2 of 20 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

1/19/20

[redacted]

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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement a safe medication system and ensure medications were administered as prescribed for 2 of 2 residents (Resident 1 and 2). These failures placed residents at risk for health complications.

Findings included…

Review of the facility's policy titled, "Medication Management," dated 03/2022, showed that the facility would ensure a safe and accurate system for dispensing medications. In addition, the policy showed that residents that were unable to safely administer their own medications, would have staff assistance with medication administration as order by their physician.

<Resident 1>

Review of Resident 1's Negotiated Service Agreement (NSA), dated 08/13/2025, showed that the resident was diagnosed with [redacted] and required staff assistance with their medications.

Review of Resident 1's physician order, dated 12/05/2025, showed that the resident was prescribed guaifenesin cough syrup on 12/05/2025.

Review of Resident 1's progress notes, dated 12/06/2025, showed that the resident's guaifenesin cough medication had not been delivered to the facility. Additionally, the progress note showed that the medication had been borrowed from another resident and administered to Resident 1.

Review of Resident 1's December 2025 Medication Administration Record (MAR) showed documentation indicating the resident received a dose of guaifenesin, although the medication was not present at the facility and had not yet arrived.

In an interview on 02/10/2026, Staff C, Previous Administrator, acknowledged that a staff member had administered a different resident's guaifenesin to Resident 1.

Review of Resident 1's facility incident investigation, dated 01/15/2026, showed that the resident had been given a medication from another resident's supply by facility staff and that it was not consistent with the facility medication management policy.

<Resident 2>

Review of Resident 2's NSA, dated 12/05/2025, showed that the resident had diagnoses of [redacted] and [redacted]. Additionally, Resident 2's NSA showed that the resident required assistance with their medications and that their medications would be ordered from the pharmacy in a timely manner.

Review of Resident 2's physician order, dated 12/03/2025, showed that the resident had active orders for daily aspirin (for heart health), lisinopril (for high blood pressure) and oxybutynin chloride (for enlarged prostate).

Review of Resident 2's December 2025 MAR, showed that the following documentation:

- Aspirin mg was not available to be administered daily from 12/05/2025 through 12/22/2025, although it was documented as given on 12/19/2025.
- Lisinopril was documented as administered on 12/05/2025 and was then shown as not available to be administered from 12/06/2025 through 12/17/2025.
- Oxybutynin was not available to be administered from 12/04/2025 through 12/12/2025, although it was documented as given on 12/13/2025.

In an interview on 02/25/2026 at 2:36 PM, Staff B, Director of Health Services, stated

that Resident 2's medications had not been administered on 12/05/2025, 12/13/2025, 12/19/2025 as the medications were not at the facility. Staff B stated the administration dates were documentation errors. Staff B stated that Resident 2 moved into the facility with medications brought in by their family, that did not match their physician orders. Staff B acknowledged that they did not have a uniform process or timeline for medications when residents were admitted to the facility. Additionally, Staff B stated that medication availability could vary due to factors such as obtaining physician orders, family timeliness in bringing in medications, and medications waiting to be delivered by the pharmacy.

Review of a facility investigation, dated 03/06/2026, showed that Resident 2's lisinopril prescription was not available for administration until 12/17/2025 (14 days after prescribed). Further review showed that the resident's aspirin and oxybutynin were not available to be administered until 12/22/2025 (19 days after prescribed). The investigation showed that the facility staff did not follow up on Resident 2's physician orders to ensure that their medications were obtained and available to them.

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 Englewood Heights Memory Care is or will be in compliance with this law and / or regulation on (Date) 04/23/2026

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

Sheri Underkoffler — Administrator (or Representative)

03/19/2026 — 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