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

04/23/2026

Greenlake Management Prosser, LLC
Amber Hills Assisted Living
125 N Wamba Rd
Prosser, WA 99350

RE: Amber Hills Assisted Living # 2616

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 76279 (Completion Date 04/23/2026) and 72790 (Completion Date 02/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/23/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

The Department staff who did the On Site verification:
Robin Barnes, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager

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

Region 1, Unit G
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: Amber Hills Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2616
Intake ID: 208854
Compliance Determination #: 72790
Region/Unit #: RCS Region 1 / Unit G
Investigator: Robin Barnes
Investigation Date(s): 02/11/2026 through 02/26/2026
Complainant Contact Date(s): 02/11/2026

Allegation(s):

1. The named resident and other residents were mentally abused.
2. Residents are being left in wet soiled clothes.
3. The facility nurse was not helpful.
4. The food served at the facility was gross.
5. The facility kitchen was dirty and gross,
6. The maintenance director doesn't do anything all day.
7. The maintenance request logs were full with nowhere to add new entries.
8. The receptionist doesn't directly give the named resident their packages
9. What was on the facility menu does not match what was served.
10. The facility had a flood of toilet water which damaged the named resident's belongings.

Investigation Methods:

Sample:	Total residents: 39 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Housekeeping supply
Interviews:	Identified resident Nursing staff Residents Family members Maintenance staff Human resources Administrator Resident Care Coordinator
Record Reviews:	Medical records (care plans, face sheets, progress notes)

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

Grievance log
Incident investigation
Facility policies
Maintenance logs
Resident characteristic roster
Activity calendar
Menus

Investigation Summary:

1.Observations showed staff to resident interactions were appropriate and professional. Resident interviews showed that they did not feel abused and had not heard of anyone being abused. No failed provider practice identified.
2. Observations showed the sampled residents were clean and dry. Residents observed in the facility were clean, appropriately dressed, in no apparent distress. Resident interviews showed that the residents were not aware of residents being left in wet clothing. Staff interviews showed that residents were changed when soiled. No failed provider practice identified.
3. The facility nurse was out of the facility during the onsite visit. Interviews showed that residents did not have complaints about the nurse being unhelpful. Record reviews showed that the nurse documented monitoring and meeting resident needs. No failed provider practice identified.
4. Observations showed the noon meal to be attractively served and was served at the appropriate temperature, in a timely manner. Residents were observed eating their entire portions. Resident and staff interviews showed the food tasted good. No failed provider practice identified.
5. The facility kitchen was observed to be clean, with food stored appropriately and no sign of pests. Staff were observed to prepare meals with clean practices, and washed hands often. No failed provider practice identified.
6. Resident interviews showed the residents did not have complaints of maintenance work not being done. Review of the maintenance logs showed requested jobs were signed off as being completed in a timely manner. No failed provider practice identified.
7. Review of the maintenance logs showed requested jobs were signed off as being completed in a timely manner. There were several lines of space to write in new requests. No failed provider practice identified.
8. Observations showed no packages lying in the halls or common areas. Interviews showed that residents did not have issues with not receiving packages. The named resident felt that the receptionist did not like them which was why they did not bring packages to the residents room. No failed provider practice identified.
9. Observation showed that the noon meal that was served matched what was listed on the menu. Review of the menu showed no changes had been documented. Interview with the dietary director showed that they rarely had to alter the menu. No failed provider practice identified.
10. Observation showed that the named resident's wall art had signs of water damage. Interview and record review showed that the facility extracted the water and shampooed the carpets when the flooding happened. The facility had the named resident's throw rug professionally cleaned. Interview and record review showed that the resident who lived next to the named resident flooded the facility three times by overflowing their toilet. The facility failed to ensure that the residents' environment and personal items was maintained in a dignified manor when a toilet repeatedly overflowed. Failed practice identified under Washington Administrative Code 388-78A-2660(1) Resident Rights.

Conclusion / Action:

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

- [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: Amber Hills Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2616
Intake ID: 214073
Compliance Determination #: 72790
Region/Unit #: RCS Region 1 / Unit G
Investigator: Robin Barnes
Investigation Date(s): 02/11/2026 through 02/26/2026
Complainant Contact Date(s): 03/05/2026

Allegation(s):

1. A named resident's property was damaged due to flooding from an adjacent apartment.
2. Reporter was requesting to sit in on a resident council meeting to observe.
3. Activities were not occurring as scheduled.

Investigation Methods:

Sample:	Total residents: 39 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Housekeeping supply
Interviews:	Identified resident Nursing staff Residents Family members Maintenance staff Human resources Administrator Resident Care Coordinator
Record Reviews:	Medical records (care plans, face sheets, progress notes) Grievance log Incident investigation Facility policies Maintenance logs Resident characteristic roster Activity calendar

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

Investigation Summary:

1. Observation showed the named resident had a wall poster that had signs of water damage. Interview and record review showed that the named resident's room had been flooded three times due to the resident next door overflowing their toilet. The facility had the named resident's throw rug professionally cleaned. The facility shampooed the named resident's carpet in their room. The facility failed to ensure residents' rights were respected when residents' environment and personal items were not maintained in a dignified manor. Failed practice identified under Washington Administrative Code 388-78A-2660(1) Resident Rights.
2. Interviews showed that the facility residents declined to have a non-resident attend their council meeting. No failed provider practice identified.
3. Observation showed that several activities were posted in the facility and staff helped residents facilitate attendance to the activities. Interviews showed residents were satisfied with the activity program. No failed provider practice 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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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 02/11/2026 of:

Amber Hills Assisted Living
125 N Wamba Rd
Prosser, WA 99350

This document references the following complaint number(s): 208854, 214073

The following sample was selected for review during the unannounced on-site visit: 4 of 39 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Robin Barnes, Assisted Living Facility Licensor

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

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and

Administrator (Representative)

3 2026

Date

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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 _____

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that the residents' environment and personal items were maintained in a dignified manor when a toilet repeatedly overflowed, for 2 of 3 residents (Resident 1 and 2). This failure contributed to resident's property being damaged and a decreased quality of life.

Findings included…

Review of Resident 1's Negotiated Service Agreement (NSA), dated 10/10/2025, showed that Resident 1 was diagnosed with a [redacted]. The NSA showed that Resident 1 was alert and oriented and able to make needs known. The NSA also showed that Resident 1 required routine housekeeping and minimal assistance with Activities of Daily Living (ADLs).

Review of Resident 2's NSA, dated 11/14/2025, showed that the resident used a wheelchair, had lower leg swelling, and required wound care for wounds to their lower legs. The NSA showed that Resident 2 was alert and oriented and able to make needs known. The NSA also showed that Resident 2 required routine housekeeping and minimal assistance with ADLs.

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In an interview on 02/11/2026 at 11:23 AM, Staff A, Administrator, stated that another resident's toilet had overflowed and flooded into Resident 1 and Resident 2's apartments, as well as the hallway outside the rooms. Staff A stated that they had to have Resident 1's large throw rug dry cleaned. Staff A stated that the same resident had overflowed their toilet twice; the most recent flood had occurred on 02/07/2026.

In an interview on 02/11/2026 at 11:29 AM, Staff B, Business Office Manager, stated that the first time the resident overflowed their toilet was on 01/20/2026.

Observation on 02/11/2026 at 11:45 AM, showed that there was a cardboard box of cat litter on the floor in Resident 2's bathroom, which was falling apart due to water damage. In an interview at that same time, Resident 2 stated that when another resident's toilet flooded it affected Resident 2's bathroom and ruined the cat litter box. Resident 2 stated that the facility did not replace their cat litter.

Observation on 02/11/2026 at 11:52 AM, showed that an unframed poster on Resident 1's wall was crinkled along the bottom edge slightly . In an interview at that same time, Resident 1 stated that their apartment floor had been flooded two times, and that they felt that was not right. Resident 1 stated that the flooding came from the toilet of the apartment next door. Resident 1 stated that their poster had gotten wet as well as their large throw rug they had kept rolled up in their room. Additionally, Resident 1 stated that the facility had extracted the water from their carpet each time it flooded, but Resident 1 did not believe the facility shampooed the carpets after the floods. Finally, Resident 1 stated that they had a communicable disease and were concerned with infection control in regard to the flooding and cleaning of the carpets.

In an interview on 02/25/2026 at 3:40 PM, Collateral Contact 1 (CC1), Resident 1's family member, stated that they had insisted that the facility have Resident 1's large throw rug professionally cleaned after the 01/20/2026 flooding incident. CC1 stated that when the flooding happened on 02/07/2026, CC1 was present, and Resident 1's carpet did not smell as if it had been shampooed. CC1 stated that Resident 1's apartment had been flooded again on 02/24/2026 due to another resident's toilet overflowing. Additionally, CC1 stated that they did not feel that Resident 1 should have to live in potentially unsanitary conditions which included flooding of toilet water.

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Statement of Deficiencies	License # 2635	Compliance Determination #72790
Plan of Correction	Amber Hills Assisted Living	Completion Date
Page 4 of 4	Licensee: Greenlake Management Prosser, LLC	02/26/2026

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, Amber Hills Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4-6-2026

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

Thomas McDaniel 3-13-2026

Administrator (or Representative) Date

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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, Amber Hills Assisted Living 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

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