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
3710 Kern Way
Yakima, WA 98902

RE: Avamere at Englewood Heights License # 2460

Dear Administrator:

This letter addresses Compliance Determination(s) 79400 (Completion Date 06/23/2026) and 74772 (Completion Date 05/07/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/23/2026 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, WAC 388-78A-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2160

The Department staff who did the on-site verification:
Felicia Cantu, Community Complaint Investigator

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at Englewood Heights
License/Cert.#: 2460
Compliance Determination #: 74772
Investigator: Felicia Cantu
Investigation Date(s): 03/24/2026 through 05/07/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 216333
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A pressure sore was identified on a named resident's back.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Incident investigation Reporting log Resident records (face sheets, care plans, assessments, chart notes).

Investigation Summary:
Observations showed that the named resident and other residents appeared safe. Staff to resident interactions were safe, respectful, and helpful. Interviews and record review showed that the named resident acquired an unstageable pressure sore on their back. Failed practice identified. WAC 388-78A-2120

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

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☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at Englewood Heights
License/Cert.#: 2460
Compliance Determination #: 74772
Investigator: Felicia Cantu
Investigation Date(s): 03/24/2026 through 05/07/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 216608
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A named resident had a fall while a caregiver was transferring them out of bed.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility polices Incident investigation Resident records (face sheets, care plans, assessments, chart notes)

Investigation Summary:
Observations showed that the named resident no longer lived in the facility. The named resident's Negotiated Service Agreement (NSA) showed that the named resident needed two caregivers to assist the named resident with transfers. Interviews and record review showed that one caregiver assisted the named resident out of bed when the fall occurred. Failed practice identified. WAC 388-78-2160.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

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☐ 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

Statement of Deficiencies	License #: 2460	Compliance Determination # 74772
Plan of Correction	Avamere at Englewood Heights	Completion Date
Page 1 of 6	Licensee: Yakima Operations, LLC	05/07/2026

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 03/24/2026 of:

Avamere at Englewood Heights
3710 Kern Way
Yakima, WA 98902

This document references the following complaint number(s): 216333, 216608, 217526

The following sample was selected for review during the unannounced on-site visit: 3 of 67 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, Community Complaint Investigator

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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Statement of Deficiencies	License #: 2460	Compliance Determination # 74772
Plan of Correction	Avamere at Englewood Heights	Completion Date
Page 2 of 6	Licensee: Yakima Operations, LLC	05/07/2026

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.

Laura Williams-Davis — 05/14/2026
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 Underdoffler (Keene) — 05/15/2026
Administrator (or Representative) — Date

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

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

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

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to monitor residents' skin and identify a unstageable pressure sore for 1 of 3 residents (Resident 2). This failure resulted in a preventable unstageable pressure sore to Resident 2's back.

Findings included...

Review of the facility's' policy titled "Change of Condition Procedure" revised

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01/01/2025 showed that the purpose of the policy is to ensure that the Health Services Team is aware of resident's changes of conditions, are monitored, and documented.

Review of Resident 2's undated demographic sheet showed they moved into the facility on [redacted]/2026, with a diagnosis of [redacted] and [redacted]

Review of Resident 2's pre-admission assessment, dated 02/19/2026, showed that Resident 2 had a high-risk diagnosis of [redacted] and was at risk for skin breakdown due to Resident 1 being chair fast and had fragile skin. Resident 2 required assistance with showering once a week and required full assistance with getting dressed if they were wearing their back brace due to pain.

Review of Resident 2's Negotiated Service Agreement (NSA), dated 02/19/2026, showed that Resident 2 would maintain treatment management with assistance. Staff would perform scheduled treatments as the Treatment Administration Record (TAR) indicates.

Review of Resident 2's TAR orders, dated 02/19/2026, showed that staff may remove back brace for dressing/bathing and to monitor skin daily.

Review of Resident 2's facility chart notes from 02/22/2026 through 03/11/2026 documented by care staff showed the following:

- On 02/22/2026 Resident 2 refused undergarment change.
- On 02/23/2026 Resident 2 was already dressed, had their back brace on, "unable to monitor skin".
- On 02/24/2026 Resident 2 was fully dressed, had their back brace on and was "unable to monitor skin".
- On 02/26/2026 Resident 2 had their brace on, "unable to monitor skin".
- No documentation found by care staff regarding refusals by Resident 2 or skin monitoring from 02/27/2026 through 03/01/2026.
- On 03/02/2026 Resident 2 already had brace on when day shift arrived.
- No documentation found by care staff regarding refusals by Resident 2 or skin monitoring from 03/03/2026 through 03/10/2026.
- On 03/11/2026 a caregiver from an outside agency was assisting Resident 2 with a shower and noted a wound to the lower right back that was open, had drainage, and had a foul odor.

Review of Resident 2's facility incident/investigation report, dated 03/13/2026, showed that another care agency staff notified facility staff of an unstageable (a full thickness pressure sore where the depth cannot be determined) pressure sore to back area where back brace was worn. The wound was noted to have slough (slimy yellowish and stringy dead tissue substance), purulent drainage (a thick fluid that is often yellow, green or brown in color and signifies infection), and had a foul odor. The report further showed that staff were instructed on the TAR to check Resident 2's skin around the brace area that showed that the skin area around the brace was overlooked consistently.

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In an interview on 04/27/2026 at 2:56 PM Staff C, Medication Technician, stated that they marked off on the TAR as the task completed because they assured Resident 2 had their back brace on but did not have the opportunity to look under the back brace to visualize the skin directly. Resident 2 was often already dressed in their clothes when they went to check on them.

In an interview on 04/28/2026 at 3:40 PM Staff B, Administrator, stated their facility investigation could not prove that the care staff were attempting to monitor Resident 2's skin under the back brace. Additionally, Staff B expressed that they would be working on a plan of correction.

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 is or will be in compliance with this law and / or regulation on (Date) 06/20/2026

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

Sherri Undercoffler (Kreal) 05/15/2026

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interviews and record review the facility failed to implement the Negotiated Service Agreement (NSA) that directed staff to get a resident in and out of bed with two care staff for 1 of 3 residents (Resident 1). This failure contributed to Resident 1's fall which resulted in injuries that required hospitalization.

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Findings included...

Review of the facility's policy titled "Service Plan/Negotiated Service Agreement/Care Plan" dated 01/01/2025, showed that all residents will have an NSA to ensure staff are aware of the residents' care and services needed to live their best life while living at this community.

Review of Resident 1's undated demographic sheet showed that Resident 1 moved into the facility on [redacted]/2024, with diagnosis of [redacted] and [redacted].

Review of Resident 1's NSA dated 02/09/2026, showed that Resident 1 required assistance from two staff members for all transfers. It also showed that staff will provide Resident 1 with assistance when getting in and out of bed with two-person assistance in the morning and at night.

Review of Resident 1's facility chart notes dated 03/14/2026, showed that around 7:00 AM Staff A, Caregiver, was helping Resident 1 stand up with their walker. Staff A's walkie talkie (a hand held two way radio) went off, as Staff A reached for their walkie talkie, Resident 1 took a step, lost their balance and fell, hitting their right hip and head on the floor. Resident 1 was alert and awake when they were sent to the hospital.

Further review of Resident 1's facility chart notes dated 03/16/2026 showed that Resident 1 sustained a hip fracture in three different areas of the hip and was airlifted to another higher-level care hospital.

In an interview on 03/31/2026 at 3:04 PM Collateral Contact 1(CC1), Resident Representative, stated that Resident 1's care plan needs increased in February 2026. Resident 1 required two people to assist them with transfers and assistance in and out of bed. CC1 explained that they were in the facility every day in February and March 2026 except on Tuesdays and had never witnessed two care staff help Resident 1 in and out of bed. CC1 reported that when they went to talk to Resident 1 on 03/14/2026 in the hospital, Resident 1 told them that there was only one care staff trying to assist them out of bed when the fall occurred. CC1 further expressed emotional grief, that had the care staff followed the new care plan Resident 1 may not have fallen and would not have needed surgery. CC1 stated that Resident 1 had complications with the anesthesia and then passed away on [redacted]/2026.

In an interview on 04/01/2026 at 2:57 PM, Staff A stated that Resident 1 was often transferred with one person assist unless they were weak and required a second person to assist with transfers, but would often transfer Resident 1 by themselves, because they were petite and easy to transfer. Staff A stated that they assisted Resident 1 out of

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bed by themselves on 03/14/2026 when the fall occurred.

In an interview on 04/08/2026 Staff B, Administrator, stated that they were not aware that only one care staff assisted Resident 1 out of bed on 03/14/2026 but would review care staff's documentation.

In an interview on 05/07/2026 at 11:12 AM Staff D, Caregiver stated that they recalled that Resident 1's transfer status was changed to a 2 person assist in March 2026 due to increased weakness. Staff D explained that there would be times that they were understaffed and found themselves assisting Resident 1 to the bathroom by themselves two or three times in March 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, Avamere at Englewood Heights is or will be in compliance with this law and / or regulation on (Date) 06/20/2026

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

Sherri Underwood (Quest) 05/15/2026

Administrator (or Representative) Date

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