STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

CENTRAL COLUMBIA SENIOR LIVING
THE CAMBRIDGE
301 H ST SW
QUINCY, WA 98848

RE: THE CAMBRIDGE License # 1716

Dear Administrator:

This letter addresses Compliance Determination(s) 60264 (Completion Date 06/03/2025) and 56906 (Completion Date 04/02/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/03/2025 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-2210-2-a, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2700-1-g, WAC 388-78A-2700-1-g-i, WAC 388-78A-2700-1-g-ii, WAC 388-78A-2700-1-g-iii, WAC 388-78A-2700-1-g-iv, WAC 388-78A-2700-1-g-v, WAC 388-78A-2700-1-g-vi, WAC 388-78A-3010-8-e

The Department staff who did the on-site verification:
Elaine Lopez, Licensor

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 1716	Compliance Determination # 56906
Plan of Correction	THE CAMBRIDGE	Completion Date
Page 1 of 8	Licensee: CENTRAL COLUMBIA SENIOR LIVING	04/02/2025

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 the unannounced on-site full inspection and complaint investigation on 03/31/2025, 04/01/2025 and 04/02/2025 of:

THE CAMBRIDGE
301 H ST SW
QUINCY, WA 98848

This document references the following complaint numbers: 172428.

The following sample was selected for review during the unannounced on-site visit: 5 of 24 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Elaine Lopez, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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
Residential Care Services

04/11/2025
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.

L. Rupio
Administrator (or Representative)

4/16/2025
Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a resident received their medication for decreasing water retention as prescribed for 1 of 5 residents (Resident 1). This failure resulted in Resident 1 not receiving an increased dose of medication when they showed an increase in weight of three pounds or more.

Findings included...

Record review of Resident 1's Negotiated Service Agreement (NSA), dated 05/24/2024, showed that the resident had diagnoses of [redacted], [redacted], [redacted], and [redacted]. The NSA showed that Resident 1 had fluid restrictions to one beverage at every meal. Additionally, the NSA showed that facility staff were to assist Resident 1 with medication management including ordering, storing and assisting with medication. Facility staff were to record vitals and weights.

Record review of Resident 1's doctor's order, dated 03/03/2025, showed an order to give Torsemide (to decrease water retention) 20 Milligrams (MG) in the morning and 10 mg at noon. Additional directions were that if weight increased 3 pounds from last weight give an extra 20 mg of the Torsemide.

Review of the March 2025 Medication Administration Record (MAR) showed that on 03/03/2025, Resident 1's weight was recorded as 218 pounds. On 03/05/2025, Resident 1's weight was recorded as 224 pounds (increase in 6 pounds). The March 2025 MAR did not show that the extra Torsemide 20 mg was given on 03/05/2025 as prescribed.

Additionally, Resident 1's March 2025 MAR showed that on 03/10/2025, Resident 1's weight was recorded as 221 pounds. On 03/12/2025 Resident 1's weight was recorded as 224 pounds (increase in 3 pounds). The March 2025 MAR did not show that the extra Torsemide 20 mg was given on 03/12/2025 as prescribed.

In an interview on 04/02/2025 at 9:45 AM, Staff A, Administrator, stated that the Torsemide medication was not given to Resident 1 on 03/05/2025 and 03/12/2025. Staff A stated that the medication technician had not realized the order due to the order not being transcribed on the March 2025 MAR as it was prescribed on the doctor's order.

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, THE CAMBRIDGE is or will be in compliance with this law and / or regulation on (Date) 5/9/2025 .

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

Administrator (or Representative) — Date: 4/16/2025

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that the Registered Nurse Delegator (RND) assessed each resident and reviewed and documented delegation every 90 days as required, for residents who received delegated task assistance from staff for 1 of 1 resident (Resident 4). This failure resulted in the resident

not being assessed every 90 days for their delegation care needs.

Findings included...

Review of Washington Administrative Code (WAC) 246-840-930, titled, "Criteria for delegation," showed that the RND was to assess the resident for the need and appropriateness for each delegated task every 90 days.

Review of the facility's Disclosure of Services, undated, showed that the facility had a contracted Registered Nurse who would oversee the nurse delegation services. Additionally, the disclosure of services showed that diabetic management, which included blood glucose monitoring and insulin by injection, would be nurse delegated.

Review of Resident 4's Negotiated Service Agreement, dated 04/02/2025, showed that the resident had a diagnosis of [redacted] ([redacted]) and required nurse delegation for their insulin and daily blood sugar checks.

Review of Resident 4's nurse delegation visit document, dated 12/05/2024, showed that the resident was nurse delegated for their insulin injections and blood glucose checks. As of 04/02/2025, there was no nurse delegation re-evaluation since 12/05/2025.

In an interview on 04/02/2025 at 11: 07 AM, Staff A, Administrator, stated that the nurse delegation documents were a month late and that the nurse delegator had not been able to come to the facility.

Plan/Attestation Statement

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

S. Arai 4/16/25

Administrator (or Representative) Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to have access to and maintain a current disaster plan for 1 of 1 (Emergency Disaster Plan 1). This failure placed residents living in the facility at risk of harm due to staff not knowing what to do in an emergency.

Findings included...

Review of the facility's disaster plan binder showed two letters, dated 2012 and 2013, for alternate accommodations to two local churches. Additionally, the disaster plan had a Local Law Enforcement (LLE) letter, dated 07/29/2013, for the after-hours phone for the facility staff. The LLE letter showed previous staff who no longer worked at the facility or as the administrator, as the current emergency contacts for the facility.

The disaster plan did not include information for on-duty staff responsibilities, how to summon/coordinate emergency assistance with first responders regarding resident evacuations, how staff were to get resident supplies and medications in case of an emergency, and a facility emergency communication plan.

In an interview on 04/02/2025 at 12:00 PM, Staff A, Administrator, stated that a staff member had purged the disaster plan for online access. Staff A stated that the staff member was the only person to have access to the online disaster manual, was currently out of the facility, and that no other staff had access to the emergency information at that time.

Statement of Deficiencies	License #: 1716	Compliance Determination # 56906
Plan of Correction	THE CAMBRIDGE	Completion 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, THE CAMBRIDGE is or will be in compliance with this law and / or regulation on (Date) 5/9/2025

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

S. [illegible] 4/16/2025

Administrator (or Representative) Date

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure there was a lockable drawer, cupboard, or space in the resident's apartment for 5 of 5 residents (Resident 1, 2, 3, 4, and 5). This failure resulted residents to not have a secured space to lock their valuables.

Findings included...

In an interview on 03/31/2025 at 10:05 AM, Staff A, Administrator, stated that there was no locked box or cupboard in the resident apartments at the facility. Staff A stated that the facility did have residents that administered their own medication.

The resident group meeting, on 03/31/2025 at 2:00 PM, residents stated that they did not have a lockable drawer or cupboard in their apartment.

<Resident 1>

Observation on 04/01/2025 at 9:20 AM, Resident 1's apartment showed that the kitchen, bathroom, or bedroom did not have a lockable drawer or cupboard. Further observation showed a tube of prescription voltaren (anti-inflammatory cream) gel on their side table in the living room.

In an interview on 04/01/2025 at 9:20 AM, Resident 1 stated that they did not have a lockable drawer or cupboard in their apartment.

<Resident 2>

Observation on 04/01/2025 at 11:40 AM, Resident 2's apartment showed that the kitchen, bathroom, or bedroom did not have a lockable drawer or cupboard.

In an interview on 04/01/2025 at 11:40 AM, Resident 2 stated that they did not have a lockable drawer or cupboard in their apartment.

<Resident 3>

Observation on 04/01/2025 at 10:11 AM, Resident 3's apartment showed that the kitchen, bathroom, or bedroom did not have a lockable drawer or cupboard.

In an interview on 04/01/2025 at 10:11 AM, Resident 3 stated that they did not have a lockable drawer or cupboard in their apartment.

<Resident 4>

Observation on 04/01/2025 at 9:55 AM, Resident 4's apartment showed that the kitchen, bathroom, or bedroom did not have a lockable drawer or cupboard.

In an interview on 04/01/2025 at 9:55 AM, Resident 4 stated that they did not have a lockable drawer or cupboard in their apartment.

In an interview on 04/02/2025 at 11:02 AM, Staff A stated that Resident 4 got their prescriptions through the mail and stored their medications in their apartment.

<Resident 5>

Observation on 04/02/2025 at 9:58 AM, Resident 5's apartment showed that the kitchen, bathroom, or bedroom did not have a lockable drawer or cupboard.

In an interview on 04/02/2025 at 9:58 AM, Resident 5 stated that they did not have a lockable drawer or cupboard in their apartment.

Statement of Deficiencies	License #: 1716	Compliance Determination # 56906
Plan of Correction	THE CAMBRIDGE	Completion 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, THE CAMBRIDGE is or will be in compliance with this law and / or regulation on (Date) 5/9/2025.

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

Administrator (or Representative) Date 4/16/2025