



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

BFG Kennewick Master Tenant LLC
Columbia Crossing of Grandridge Memory Care
575 N Young St
Kennewick, WA 99336

RE: Columbia Crossing of Grandridge Memory Care License # 2448

Dear Administrator:

This letter addresses Compliance Determination(s) 29100 (Completion Date 09/07/2023) and 25976 (Completion Date 07/17/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/07/2023 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-2600-2-a, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b, WAC 388-78A-2630-1

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,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services



Residential Care Services Investigation Summary Report

Provider/Facility: Columbia Crossing of
Grandridge Memory Care
License/Cert.#: 2448

Provider Type: Assisted Living Facility

Intake ID: 85579

Compliance Determination #: 25976

Region/Unit #: RCS Region 1 / Unit G

Investigator: Tracy Ramirez

Investigation Date(s): 06/27/2023 through 07/17/2023

Complainant Contact Date(s):

Allegation(s):

The named resident had inappropriate behaviors towards four named residents.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 5 Closed records sample size: 1
Observations:	The facility's common areas, resident rooms, resident to resident and staff to resident interactions were observed.
Interviews:	Facility staff and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (face sheets, care plans, progress notes, an investigation, temporary service plan), staff roster, and the facility's abuse and incident policy.

Investigation Summary:

The facility failed to follow their policy and failed practice identified WAC 388-78A-2600 and WAC 388-78A-2630. Reference Statement of Deficiencies (SOD) 07/17/2023.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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

Statement of Deficiencies	License #: 2448	Compliance Determination # 25976
Plan of Correction	Columbia Crossing of Grandridge Memory Care	Completion Date
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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 06/27/2023 and 06/27/2023 of:

Columbia Crossing of Grandridge Memory Care
575 N Young St
Kennewick, WA 99336

This document references the following complaint number(s): 85579

The following sample was selected for review during the unannounced on-site visit: 5 of 51 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Tracy Ramirez, Assisted Living Facility Licenser

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.

Grvin Kaercher
Residential Care Services

07/27/2023

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.

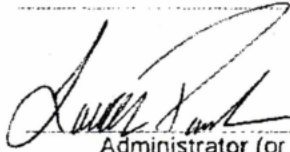
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Administrator (or Representative)

8/4/23

Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff followed the facility's policies and procedures for 4 of 4 Residents (1, 2, 3, 4) who were identified by the ALF as potential victims of abuse. This failed practice placed the residents at risk of abuse and unmet safety needs.

Findings included...

Record review of the facility's, "Abuse and Incident Investigations," dated on 08/01/2021, showed that it is designed for staff to follow the process when there are allegations of abuse and incidents. The policy shows that employees will know when to make required notifications, do an incident report, and begin an investigation.

Resident 1's record review of the Negotiated Service Agreement (NSA) dated on 04/07/2023, showed that the resident had a diagnosis of [REDACTED]. The NSA also included that Resident 1 had chronic poor judgment issues, was unable to make appropriate decisions on their own, and needs supervision.

Resident 1's record review of the progress notes dated 06/09/2023 showed staff had witnessed an incident of another resident touching Resident 1 inappropriately. The progress note did not show the time of the incident. Further record review showed the facility reported to the Compliant Resolution Unit on 06/09/2023 that Resident 5 had their face in Resident 1's breast.

Resident 2's record review of the NSA dated on 04/20/2023, showed that the resident had a diagnosis of [REDACTED]. The NSA also included that Resident 2 had frequent poor judgment issues, needed protection and supervision.

Resident 2's record review of the progress notes dated 06/14/2023 showed as a late entry of an incident where Resident 5 had attempted to get into bed with Resident 2 and indicated

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to staff, they were going to sleep together. The progress notes had no date and time of the incidents.

Interview on 06/27/2023 at 11:25 AM with Staff C, Campus Director of Nursing, stated that Resident 5 had attempted multiple times to reenter Resident 2's room.

Resident 3's record review of the NSA dated on 05/05/2023, showed that the resident had a diagnosis of [REDACTED]. The NSA also included that Resident 3 had chronic poor judgment issues, cannot make appropriate decisions, and needs supervision.

Resident 3's record review of the progress notes dated 06/09/2023 showed staff witnessed an incident that had occurred on 06/01/2023, where Resident 5 had taken Resident 3 into their apartment. The progress notes had no time of the incident.

Interview on 06/27/2023 at 11:23 AM with Staff C, stated that Resident 5 had Resident 3 in their apartment with their shirt lifted up and a towel around their chest.

Resident 4's record review of the NSA dated on 03/22/2023, showed that the resident had a diagnosis of [REDACTED]. The NSA also included that Resident 4 had chronic poor judgment issues, was unable to make appropriate decisions for their self, and needed supervision.

Resident 4's record review of the progress notes dated 06/01/2023 showed staff had witnessed Resident 5 fondling 4's breast. The progress note stated that staff redirected Resident 5 away from Resident 2.

Interview on 06/27/2023 at 11:15 AM with Staff C, stated that the incidents were discovered late due to nursing not reviewing the charting from staff until 06/09/2023. Staff C stated that the incidents were noted to have begun on 06/01/2023. Staff C stated that on 06/09/2023 they began their investigation.

Interview on 06/27/2023 at 11:30 AM with Staff A, Campus Executive Director, stated that the most recent training provided to staff on abuse, neglect, and mandated reporting occurred on 03/08/2023.

Interview on 07/17/2023 at 10:38 AM with Staff D, former Assistant Director of Nursing, stated that the staff had not reported the incidents to them and learned of them on 06/09/2023. Staff D stated that is when they had begun making required notifications and began to investigate.

Interview on 07/17/2023 at 12:18 PM with Staff B and Staff C, stated that their communication system for staff to use for alerts is located on their Electronic Healthcare Records (EHR) system's dashboard and their protocol for nursing is to review daily. Staff C stated that on 06/09/2023 when auditing their EHR dashboard they learned of the

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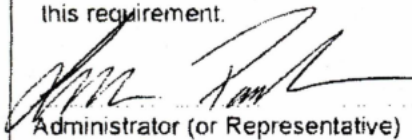
incidents and unclear why staff had not also verbally reported them.

Interview on 06/27/2023 at 3.56 PM with Staff B, Memory Care Director, stated that they had not formally completed investigations for Residents 1, 2, 3 and 4. Staff C stated that they completed an investigation for Resident 5.

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, Columbia Crossing of Grandridge Memory Care is or will be in compliance with this law and / or regulation on (Date) 08/31/2023.

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


Administrator (or Representative)

8/4/2023
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

- (a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and
- (b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to immediately report to the Department's Complaint Resolution Unit (CRU) hotline and local law enforcement when staff had reasonable cause to believe suspected sexual or physical abuse had occurred for 3 of 4 Residents (2, 3, 4). This failed practice resulted in a delayed investigation by the department and placed residents at potential risk of further abuse.

Findings included...

Resident 2's record review of the Negotiated Service Agreement (NSA) dated on 04/20/2023, showed that the resident had a primary diagnosis of [REDACTED]

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Resident 2's record review of the progress notes dated 06/14/2023 showed as a late entry that staff notified the responsible party on 06/09/2023 of the incident of alleged abuse from Resident 5.

Interview on 06/27/2023 at 11:15 AM with Staff C stated that the incidents had occurred on 06/01/2023. The staff notified the responsible party eight days after the incident.

Interview on 06/28/2023 at 4:12 PM with Collateral Contact 1 (CC1). Resident 1's Responsible Party, stated that when the facility notified them of the incident, they were not clear.

Resident 3's record review of NSA dated on 05/05/2023, showed that the resident had a diagnosis of [REDACTED]

Resident 3's record review of the progress notes dated 06/09/2023 showed staff notified the responsible party of alleged abuse from Resident 5 that had occurred on 06/01/2023. The staff notified the responsible party eight days after the incident.

Interview on 06/29/2023 at 8:12 AM with Collateral Contact 2 (CC2). Resident 1's Responsible Party, stated that they were frustrated that the facility had notified them over a week after the incident. CC2 stated that they feel the facility needs to improve on their communication.

Resident 4's record review of the NSA dated on 03/22/2023, showed that the resident had a diagnosis of [REDACTED].

Resident 4's record review of the progress notes dated 06/09/2023 showed staff notified the responsible party of alleged abuse from Resident 5 that occurred on 06/01/2023. The staff notified the responsible party eight days after the incident.

Interview on 06/27/2023 at 11:15 AM with Staff C, Campus Director of Nursing, stated that the incidents were discovered late due to nursing not reviewing the charting from care staff until 06/09/2023. Staff C stated that the incidents had occurred on 06/01/2023. Staff C stated that on 06/09/2023 they performed required notifications.

Plan/Attestation Statement

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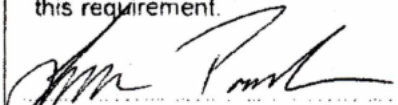
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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Columbia Crossing of Grandridge Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/31/2023.

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


Administrator (or Representative)

8/4/23
Date

Columbia Crossing of Grandridge Memory Care

License Number: 2448

Survey Date: June 27, 2023

Responses to the cited deficiencies do not constitute an admission or agreement by the community to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.

WAC 388-78A-2600 Policies and Procedures

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. Residents 1, 2, 3 4 and 5 will have their service plans reviewed in detail with appropriate interventions by Health and Wellness Director on or before 8/31/2023.

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

1. All staff will be re-trained on mandated reporting, abuse and neglect and incident report documentation on or before 8/31/2023st, 2023. This will be documented on an inservice sign-in sheet. Training will be facilitated by Executive Director and Health and Wellness Director.

2. ED and HWD will be trained by Chief Clinical Officer on or before 8/31/2023 on revised policy and the abuse and neglect investigation packet.

WAC 388-78A-2630 Reporting abuse and neglect

A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list:

1. Residents 1, 2, 3, 4 and 5 will have any incidents that meet the abuse and neglect reporting criteria submitted as a late report. Reports will be submitted by the Executive Director on or before 8/31/2023

B. With respect to what the facility will do to PREVENT the same deficiency from recurring:

1. All staff will be re-trained on mandated reporting, abuse and neglect and incident report documentation on or before 8/31/2023st, 2023. This will be documented on an inservice sign-in sheet. Training will be facilitated by Executive Director and Health and Wellness Director.
2. Executive Director or designee will bring to QAPI each month the Abuse and Neglect Reportables and review for accuracy and completion. This will be monthly for 3 months and quarterly for 3 quarters for tracking and trending purposes.