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

AMENDED

BFG Kennewick Master Tenant LLC
Columbia Crossing of Grandridge
7255 W Grandridge Blvd
Kennewick, WA 99336

RE: Columbia Crossing of Grandridge # 2449

Dear Administrator:

This document references Compliance Determination 26916 (08/07/2023), which included complaint number(s) 87748, 89564.
The Department completed a complaint investigation of your Assisted Living Facility on 08/07/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Felicia Cantu, Community Complaint Investigator
Gwin Kaercher, Community Field Manager

Consultation:

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

The Assisted Facility's medication system resulted in a medication error.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the facility to determine if you have corrected all deficiencies.

You May:
- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - o What specific deficiency or deficiencies you disagree with;
  - o Why you disagree with each deficiency; and
  - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

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
License/Cert.#: 2449
Compliance Determination #: 26916
Investigator: Gwin Kaercher
Investigation Date(s): 07/20/2023 through 08/07/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 89564
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
1) A named resident received double dosage of medication that thins their blood.

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 3 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Facility environment
Interviews:	Identified resident Residents Others not associated with the facility Facility staff
Record Reviews:	Characteristic roster Incident investigation Facility policies Resident records(face sheet, care plans, assessments, chart notes, doctor orders) Pharmacy records

Investigation Summary:
Interviews and record review showed that facility staff discovered that the medication was discontinued and that a duplicate order was generated by pharmacy. Resident received double the dose for several days. Facility staff made all notifications, sent named resident to doctor's office for evaluation, and investigated the med error. The named resident was not hospitalized and not injured or harmed. Facility staff also conducted an investigation on pharmacy re-order systems, and their medication administration online system. It was found that the pharmacy ignored the manual discontinue date that was entered by the facility. The facility came to conclusion that

they are in process of changing medication administration systems to prevent further medication error. Staff was re-trained on verifying medications orders, and checking medication administration records for other shifts. Consultation was provided on the importance of reviewing all high risk medication orders for all residents to prevent any potential harm. WAC 388-78A-2210

Conclusion / Action:

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