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
Ciel Senior Living of the Tri-Cities
7255 W Grandridge Blvd
Kennewick, WA 99336

RE: Ciel Senior Living of the Tri-Cities License # 2449

Dear Administrator:

This letter addresses Compliance Determination(s) 44396 (Completion Date 07/19/2024) and 39809 (Completion Date 05/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/19/2024 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-2660-1, WAC 388-78A-2660-4, RCW 70.129.140.1

The Department staff who did the on-site verification:
Laurel Knight, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Columbia Crossing of Grandridge
License/Cert.#: 2449
Compliance Determination #: 39809
Investigator: Melissa Milanez
Investigation Date(s): 04/16/2024 through 05/23/2024
Complainant Contact Date(s): 05/13/2024

Provider Type: Assisted Living Facility

Intake ID: 123944
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Facility staff entered identified resident's rooms without permission and removed personal belongings.

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: 6 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Therapy staff
Record Reviews:	Facility policies Staff patterns Characteristic roster, Resident Records (Face sheet, Assessment, Care Plan, Progress Notes, Physician orders) Disclosure of Services Room lists Room audits

Investigation Summary:
Interviews and record review showed that facility staff completed room audits and removed bed canes and medications. Interviews with residents showed that staff entered their rooms while they were not present and took items without their permission. Identified residents stated they felt violated and disrespected. Failed

practice identified, 388-78A-2660 and RCW 70.129.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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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 04/16/2024 and 04/17/2024 of:

Columbia Crossing of Grandridge
7255 W Grandridge Blvd
Kennewick, WA 99336

This document references the following complaint number(s): 123944

The following sample was selected for review during the unannounced on-site visit: 6 of 74 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

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.

Michelle R. Closner — Residential Care Services

06/03/2024 — 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) 06/14/2024 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;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents' rights and dignity were protected and promoted when facility staff entered resident's apartments without permission, and removed personal belongings without consent for 4 of 6 residents (Resident 1, 2, 3, 4). These failures resulted in residents having their right to privacy violated, having their rooms searched without being present, having their personal items taken from them without consent, and caused residents to have emotional and psychosocial distress.

Findings included...

Review of Revised Code of Washington (RCW) 70.129.020 showed that A facility must protect and promote the rights of each resident and assist the resident which include:
(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States and the state of Washington.
(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.
(3) In the case of a resident adjudged incompetent by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed to act on the resident's behalf.

Review of Revised Code of Washington (RCW) 70.129.100 showed that the resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

Review of Revised Code of Washington (RCW) 70.129.105 showed that no long-term facility licensed under Chapter 18.51 shall not require or request residents to sign waivers residents' rights set forth in this Chapter.

Review of Revised Code of Washington (RCW) 70.129.140 showed that:
(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.
(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:
(c) Make choices about aspects of his or her life in the facility that are significant to the resident;
(e) Unless adjudged incompetent or otherwise found to be legally incapacitated, participate in planning care and treatment or changes in care and treatment;
(f) Unless adjudged incompetent or otherwise found to be legally incapacitated, to direct his or her own service plan and changes in the service plan, and to refuse any particular service so long as such refusal is documented in the record of the resident.
(e) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.
(f) The resident has the right to refuse to perform services for the facility except as voluntarily agreed by the resident and the facility in the resident's service plan.
(5) A resident has the right to:
(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

Review of the facility's Resident Agreement, revised on 01/2020, showed that for the Resident's safety and comfort, the staff must be permitted to enter the resident's Suite to perform basic housekeeping services, respond to emergencies, make repairs and improvements, and perform other management functions as they (facility) deemed necessary or advisable. As unauthorized agent, upon stating the purpose of their visit, (staff) can enter and inspect any licensed portion of the community, including the resident's suite, without advance notice. "Whenever feasible, [the facility's] staff attempt to give the Resident reasonable notice before entering the Suite."

Record review of the facility's Residency Agreement Appendix C, last updated on 08/01/2023, showed that each resident shall continue to "enjoy his/her civil and legal rights and not be requested to waive any of those rights or the rights under this law; care that promotes, maintains, or enhances respect for individual's and each person's dignity."

Record review of the facility's Medication policy: Self-Administration Assessment Policy & Procedure, dated 07/2023, showed that the purpose of this policy was to promote independence and autonomy whenever possible. The Policy also showed that any resident that has a diagnosis of [redacted] or [redacted] disqualifies them to administer his or her own medications.

Record review of the facility's Safety Assisted Living Protocol dated 12/2023 (that was not distributed or agreed to by the residents) showed a list of prohibited items and that the facility would conduct a quarterly review of each resident's suite.

Resident 1

Review of the face sheet showed Resident 1 was admitted to the facility on [redacted]/2023 with diagnoses that included [redacted] and [redacted].

On 04/16/2024 at 3:05 PM, Resident 1 stated that facility staff entered their room without their consent and "ransacked" their room when they were not present. Resident 1 stated that they had been visiting with friends down the hall in the common area when staff had entered their room. Resident 1 stated that staff removed medications, their bed cane (mobility aide for getting in and out of bed) and had left their room "a mess." Resident 1 stated they believed that staff intentionally waited for them to leave before conducting a room search in their absence. Resident 1 stated they were not given any notice of nursing staff coming into their room to perform a search, and stated that they were "blindsided". Resident 1 stated they did not become aware that someone had been in their room until they went to grab their TUMS (relieves heartburn) and Tylenol (relieves pain) to take before bedtime and noted that their purse was turned upside down and items had been taken. Resident 1 stated "they made me feel really stupid, and I was treated like a child." Resident 1 stated they did not get their Tylenol that night, because it was taken, and they had been in pain all night long. Resident 1 also stated that staff had removed their bed cane, and that they needed it to move in bed. Resident 1 stated they felt trapped without it. They stated they went several days without their bed cane, making it difficult for them to reposition themselves in bed. Resident 1 stated they found the bed cane several days later in their closet and attempted to reattach it back on the bed but was unsuccessful. Although they were unable to secure it to the bed, they stated they needed it, so they placed it at the head of the bed, unsecured. As the resident described what had occurred, the resident was teary eyed, their voice was shaking and at the end of the interview, the residents head was down, and tears were rolling down their cheeks.

On 04/16/2024 at 3:15 PM, Resident 1's bedroom was observed and showed the resident's bed cane was placed near the head of bed. The bed cane was not secured and there was a note reading, "Do not remove bed cane." Resident 1 stated they wrote the note so that staff would not remove it again.

On 04/17/2024 at 12:41 PM, Resident 1 stated in addition, "If I was asked and they said they had to go through my meds I would have said I could help them, I did not appreciate the mess, so that night I went to bed without anything, I hurt 24/7 because of arthritis. I moved in here because I broke both of my feet. I am in pain; I was in rehab for 3 months." "I went without my medication that night and the next morning." Resident 1 also stated that Staff B, Registered Nurse (RN), had told them that they had not passed their mental test and that they could not administer their own medications.

Resident 2

Review of the face sheet showed Resident 2 admitted to the facility on [redacted]/2022 with diagnoses that included [redacted]

[redacted] and [redacted] and [redacted]

On 04/17/2024 at 12:05 PM, Resident 2 stated they lived at the facility for two years and required bed canes for mobility assistance. Resident 2 stated that while they were at lunch, someone came into their room and "ripped off" the two bed canes that had been on their bed and took them without their permission. Resident 2 stated that they were told by facility staff they had to purchase a specific type of bed cane that cost $350.00 or $400.00, that would need to be attached to a metal bed frame. The resident stated they did not have a metal bed frame. Resident 2 stated that they were told that they could not have that type of bed cane, due to the facilities insurance not allowing it. Resident 2 stated that they were unable to move from side to side in bed without the bed canes and they felt confined and helpless, which deeply affected their sense of self-reliance and independence. Resident 2 also stated that after the facility staff took away the bed rails, they asked a friend to bring in any assistive device they had to help them with bed mobility, as they were struggling to move in bed without their bed canes. Resident 2 stated their friend brought to their apartment a small walker (assistive devise) positioning it on the left side of the resident's bed to facilitate bed mobility. Resident 2 stated that because they were not able to secure the walker firmly, its use became challenging.

On 04/17/2024 at 12:15 PM, Resident 2 stated that they were unsure of the exact date, but recalled that Staff B, RN, had entered their room and told them that the facility would have to administer their medications due to them (Resident 2) not knowing the exact medication milligrams and dosage that they were taking. Resident 2 stated that they did not agree with the facility's decision and expressed their concerns to Staff B. Resident 2 stated that they were told by Staff B that the resident would have to get an order from their doctor to be able to self-administer their medication. Resident 2 stated that they reached out to their provider and was able to obtain an order stating they could administer their own medications, and the doctor had no concerns. Resident 2 stated that Staff B had treated them like an "idiot," and like they did not know anything.

On 04/17/2024 at 12:26 PM, Collateral Contact 1 (CC1), stated that they were told by facility staff they had to purchase a $450 Halo bed cane (a ring-shaped assistive device for bed mobility) which required a steel bed frame to secure the device. CC1 stated that without the bed canes, Resident 2 would be unable to assist the caregivers with bed mobility and increased the resident's chances of injury.

On 04/17/2024 at 12:10 PM, Resident 2's room was observed, next to the bed was a small size walker. There were no bed canes attached to the bed, the walker was not secured to the bed or to anything.

In an interview on 05/22/2024 at 4:38 PM, CC2, Resident Representative, stated that the facility failed to inform them or the resident about the room inspections, including entering rooms without notice, and claimed that no prior notification was ever provided for any room entry. CC2 stated since February, many entries had
been made into Resident 1's room for room inspections, medicine and vitamin storage

inspections, and care assessments without any notice. CC2 stated that caregiver had also entered Resident 1's room and conducted medicine storage inspections multiple times without notice and that facility staff have also entered rooms while residents were at meals and conducted inspections. CC2 stated there had been "many unauthorized entries" into the apartment.

Resident 3

Review of the face sheet showed Resident 3 admitted to the facility on [redacted]/2021 with diagnoses that included [redacted] and [redacted].

On 04/16/2024 at 2.51 PM, Resident 3 stated that they had been self-administering their medication for years and that one day the facility nurse entered their apartment and told them that they were no longer allowed to take their own medication. Resident 3 stated that a caregiver and a nurse had entered their room and started "scooping up everything" that looked like medication, they put them in a plastic bag and took them away. Resident 3 had asked them what they were doing but stated that facility staff did not bother telling them, "Not a word, just went about their business and took everything." Resident 3 stated that they had a difficult time understanding why they could no longer take their medication and that they only took one blood pressure medication and two vitamins. Resident 3 stated that they always took their medication and never missed a dose, they stated, "I am a creature of routine, I always took my medications." Resident 3 stated they were unhappy and miserable because of the incident, in which facility staff entered their room without permission and removed their medications, causing them significant emotional distress and impacting their well-being. Resident 3 stated, "This has been too much for me to handle, and I have not felt well ever since they I did this."

On 04/17/2024 at 11.12 AM, Resident 3 was sitting in a chair in their apartment, they were not fully sitting straight up but in a slouched (sitting in a lazy, drooping) position. The resident stated, "I feel I have deteriorated quite a bit since then [when the facility entered the resident's room without permission in and went through their belongings]. Now I don't trust my memory, I am slower than molasses." Resident 3 stated, "They were treating me like I was senile (a person having or showing the weakness of old age), and I did not know what was going on." Resident 3 stated, "At that time, I was mentally capable, now they have done me in, I feel like a prisoner ever since that time, they control my life."

Resident 4

Review of the face sheet showed Resident 4 was admitted to the facility on [redacted]/2023 with diagnoses that included [redacted] and [redacted].

On 04/16/2024 at 3.29 PM, Resident 4 stated that the facility staff entered their room, went through all their cupboards, and looked through all their belongings without permission. Resident 4

stated that facility staff had taken away their Aspirin (over the counter pain medication).

On 04/16/2024 at 3:40 PM, CC3, Resident Representative, stated that the staff came into their parent's room as if it was a drug raid in a prison movie and, "Tossed up their jail cell."

Resident 5

Review of the face sheet showed Resident 5 was admitted to the facility on [redacted]/2021 with diagnoses that included [redacted] and [redacted].

On 05/23/2024 at 12:46 PM, Resident 5 stated that the facility entered their room, and searched their apartment. Resident 5 stated that they were not given notice about their room being searched, and did not recall a list of rules that had been given to them prior. Resident 5 stated that staff came into their apartment and removed their bed cane from their bed. They stated that they used the bed cane to get in and out of bed, and that now it has been difficult for them to do this independently. Resident 5 stated that they were told they had to buy a $400 bed cane instead, but that they did not have the funds to do so. Resident 5 stated they are currently using a step stool that they had stored away to get in and out of bed, but does not feel safe doing so.

In an interview on 04/16/2024 at 11:46 AM, Collateral Contact 4 (CC4), Anonymous, stated Residents felt disrespected and violated when staff entered their apartments without permission and expressed concerns about their personal belongings being removed. CC4 stated that staff did not obtain consent and removed personal belongings without resident permission. CC4 also stated that resident's rooms were ransacked, the facility did not ask for permission and staff were abrupt with the residents. CC4 stated that the residents felt like they were in prison, and residents were stressed and crying. CC4 stated Residents 1 and 2 were scared to leave their rooms in fear that a staff member would enter without permission and take their bed canes away. CC4 also stated that Resident 1 was observed crying, they stated to them they were sick to their stomach, were stressed out, and was afraid. CC4 stated, Resident 1 felt they needed to stand guard just in case someone would come into their room unannounced and take their belongings. CC4 stated that bed canes were being taken out of resident rooms before replacements were bought and residents were not able to move in bed to help the residents with transfers or moving in bed.

In an interview on 04/16/2024 at 11:50 AM, Collateral Contact (CC5), Anonymous, stated that Residents 1, 2, 3, and 4 stated to them that they lost their dignity, they were disturbed and fearful of what was happening. CC5 stated that the residents were upset and were hesitant to leave their rooms, in fear that staff would enter and take their things.

In an interview on 04/16/2024 at 12:54 PM, Staff A, Executive Director, stated that the facility started doing room audits per direction from their corporate team. Staff A stated that they had a new policy on self-medication administration that needed to be followed. Staff A stated that the policy was

written July of 2023, but that the facility had just recently started utilizing it. Staff A stated these are their policies and procedures and per there resident agreement they have a "right of entry."

In an interview on 04/16/2024 at 1:15 PM, Staff B, RN, stated that they received direction from corporate to do room audits, and removed items like, candles, heated blankets, heating pads, heaters, bed rails, and all medications from residents who receive medication assistance. Staff B stated, "We do not have to ask for permission to enter resident rooms because it's in our agreement." Staff B stated that the agreement allows facility staff to enter at any point and go through personal belongings.

On 04/17/2024 at 11:13 AM, Staff C, Residential Care Coordinator (RCC), stated that they were told by Staff B to do room audits and remove any items that were prohibited. Staff C stated that some residents were not in their rooms when they entered, and staff did not ask for permission. Staff C stated that they were told by Staff B, if they found any medications, they were to confiscate them. Staff C stated they did enter Resident 1's room while they were not in their room and had taken their Tums (over the counter medications used to treat heartburn) and other items.

On 04/17/2024 at 1:12 PM, Staff A stated that residents could call for assistance if needed with bed mobility and stated that residents can choose to follow the rules and stay at the facility or not.

In an interview on 04/23/2024 at 3:01 PM, CC2 stated that the facility had sent a Licensed Practical Nurse (LPN) to assess Resident 2's cognition without notification and conducted several surprise inspections and random unannounced visits. Staff had entered Resident 2's room several times without notification and performed inspections and moved Resident 2's possessions. They (facility) had threatened monthly cognition and other assessments and have engaged in harassing them with these "surprise assessments," inspections, and increase in care costs with no complete notification of or assessment. C2 stated that Resident 2 was treated horribly.

In an interview on 05/21/2024 at 3:07 PM, Staff B stated that the room audit policy was written in July 2023, but they were not told to follow it until January 2024, once receiving direction from corporate. Staff B stated that room audits are conducted on a quarterly basis, they started room audits on the first floor and residents were notified on that day upon entering the rooms, but stated no policy was ever given or sent out to the residents prior to this happening. Staff B also stated that a policy was only provided to the resident or family member if the bed cane had been removed. Staff B stated they were going to start taking notice and being more aware of the need to review the contract and the resident handbook. They stated that now going forward, they would like to learn more about their community and get the full picture of it. Staff B stated, "I appreciate you kind of opening my eyes to things because it's a forever changing world, and I just want to do what's right by everybody."

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 is or will be in compliance with this law and / or regulation on (Date) 06/30/2024

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

Administrator (or Representative)

06/14/2024
Date