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

07/17/2025

Geenlake Management Kennewick, LLC
Three Rivers Place Senior Living
1108 W 5th Ave
Kennewick, WA 99336

RE: Three Rivers Place Senior Living # 2536

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 62704 (Completion Date 07/17/2025) and 58904 (Completion Date 05/29/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/17/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

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.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

The Department staff who did the On Site verification:
Robin Barnes, Assisted Living Facility 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

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 follow-up on 05/22/2025 of:

Three Rivers Place Senior Living
1108 W 5th Ave
Kennewick, WA 99336

This document references the following SOD dated: 05/29/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 37 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Robin Barnes, Assisted Living Facility Licensor
Elizabeth Hall, AFH/ALF 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

06/10/2025
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.

Tonya Williams
Administrator (or Representative)

6/19/25
Date

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

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(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that the registered nurse delegator assessed each resident who received delegated task assistance from staff every 90 days for 1 of 1 resident (Resident 4). Additionally, the facility failed to ensure that nurse delegated medication administration was performed by staff who were trained and/or credentialed to perform delegated tasks for 2 of 2 staff (Staff M and N). These failures placed residents at risk of having their needs not assessed and their medications administered by untrained staff.

Findings included ...

Review of Washington Administrative Code (WAC) 246-840-930, titled, "Criteria for

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.

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.

Administrator (or Representative) _____ Date _____

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(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that the registered nurse delegator assessed each resident who received delegated task assistance from staff every 90 days for 1 of 1 resident (Resident 4). Additionally, the facility failed to ensure that nurse delegated medication administration was performed by staff who were trained and/or credentialed to perform delegated tasks for 2 of 2 staff (Staff M and N). These failures placed residents at risk of having their needs not assessed and their medications administered by untrained staff.

Findings included…

Review of Washington Administrative Code (WAC) 246-840-930, titled, “Criteria for

delegation," showed that the Registered Nurse Delegator (RND) was to reevaluate a resident receiving delegated nursing tasks for safe and effective services, and document their assessment at least every 90 days. The RND must also verify credentials and provide supervision of nurse delegated staff at least every 90 days. Additionally, the RND must ensure that each staff member was individually trained on each task specific to the residents' assessed delegation needs.

Review of the personnel file for Staff M, Medication Technician (MT), showed that they were hired on 05/05/2025. Staff M's file showed that they had an expired nursing assistant registration and did not have a valid credential needed to provide delegated nursing tasks.

Review of the personnel file for Staff N, MT, showed that they were hired as a MT on 04/20/2025. Staff N's file showed that they did not have a valid credential needed to provide delegated nursing tasks.

In an interview on 05/22/2025 at 1:08 PM, Staff I, Business Office Manager, stated that Staff M was hired as a Medication Technician (MT) and had been administering medications.

<Resident 4>

Review of the facility's undated characteristic roster showed that Resident 4 was admitted to the facility on [redacted]/2024. The record showed that Resident 4 received nurse delegation.

Review of Resident 4's full facility assessment, dated 11/07/2024, showed that Resident 4 had a diagnosis of [redacted] ([redacted]). The assessment showed that Resident 4 required nurse delegation for insulin (an injectable medication used to control blood sugar) and capillary blood glucose testing (a blood test to measure the amount of sugar in the blood [CBG]).

Review of Resident 4's nurse delegation paperwork showed the most recent assessment for delegation had been documented on a "Nurse Delegation: Nursing Visit" form, dated 08/14/2024. The form showed that the next nurse delegation assessment and review was to be done by 11/14/2024. There were no additional nurse delegation documents to show that Resident 4's nurse delegation had been reviewed every 90 days as required. Additionally, the form did not list Staff M or N as qualified MTs that were delegated to perform Resident 4's medication administration.

Review of Resident 4's April 2025 medication administration record (MAR) showed that the resident had an order for CBGs three times daily, FIASP insulin (brand of a fast acting injectable medication used to lower blood sugar) to be injected per sliding scale (a way of determining the insulin dose based on the persons CBG) before meals, and

Basaglar (a type of insulin used to control blood sugar).

Review of Resident 4's April 2025 MAR showed that on 04/27/2025, Staff N had administered the morning CBG, the morning FIASP insulin and the morning Basaglar.

Review of Resident 4's May 2025 MAR showed that the resident received their CBG test, three times daily, from 05/01/2025 to 05/21/2025 and their FIASP sliding scale insulin injection, three times daily, from 05/01/2025 to 05/21/2025.

In an interview on 05/22/2025 at 2:18 PM, Staff M stated that they administered medications on evening shift, 2:00 PM to 10:00 PM, Sunday, Monday, Tuesday and Friday, which included Resident 4's insulins and blood sugar checks. Staff M stated that the facility had not yet issued them their computer log-in credentials, so they had been signing off on Resident 4's Medication Administration Record (MAR) with another MT's credentials. (Due to Staff M not using their own sign-on credentials when administering medications to Resident 4, it was unclear which of those days Staff M was the MT who performed Resident 4's delegated tasks.)

Review of the facility as-worked schedule for May 2025 showed that Staff M worked from 2:00 PM to 10:00 PM on 05/08/2025, 05/09/2025, 05/11/2025, 05/12/2025, 05/15/2025, 05/16/2025, 05/18/2025, 05/19/2025, 05/21/2025 and 05/22/2025.

In an interview on 05/22/2025 at 2:47 PM, Collateral Contact 1 (CC1), RND, stated that Staff M should not be performing delegated tasks yet as they had not provided a valid credential. CC1 stated that they thought Staff N did have a valid credential and would have to look into it.

In an interview on 05/29/2025 at 1:25 PM, Staff A, Administrator, stated that there were no additional nurse delegation records available.

This is an uncorrected deficiency previously cited on 04/04/2025 and a recurring deficiency cited on 10/17/2023 and 09/07/2022.

Statement of Deficiencies	License #: 2535	Compliance Determination # 588904
Plan of Correction	Three Rivers Place Senior Living	Completion Date
Page 5 of 6	Licensee: Geeslake Management Kennewick, LLC	05/29/2025

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) ~~8/14/25~~ 07/13/2025

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

Tonya Williams — Administrator (or Representative)

6/19/25 — Date

Per phone conversation on 06/24/2025, with Tonya Williams, the BIC date has been changed to: 07/13/2025. ME

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were screened for tuberculosis within three days of hire for 1 of 4 staff (Staff M). This failure placed residents at risk of being exposed to a communicable disease.

Findings included...

Review of the personnel file for Staff M, Medication Technician, showed that they were hired on 05/05/2025. Staff M's file showed that as of 05/22/2025 (17 days after their hire date), no tuberculosis (TB) screening had been conducted.

In an interview on 05/22/2025 at 1:17 PM, Staff I, Business Office Manager, stated that the Health Services Director (HSD) was responsible for initiating and tracking the TB screenings.

In an interview on 05/22/2025 at 3:14 PM, Staff A, Administrator, stated that they did not know why the TB screenings had not been done.

This is an uncorrected deficiency previously cited on 04/04/2025 and a recurring deficiency cited on 10/31/2022.

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were screened for tuberculosis within three days of hire for 1 of 4 staff (Staff M). This failure placed residents at risk of being exposed to a communicable disease.

Findings included…

Review of the personnel file for Staff M, Medication Technician, showed that they were hired on 05/05/2025. Staff M's file showed that as of 05/22/2025 (17 days after their hire date), no tuberculosis (TB) screening had been conducted.

In an interview on 05/22/2025 at 1:17 PM, Staff I, Business Office Manager, stated that the Health Services Director (HSD) was responsible for initiating and tracking the TB screenings.

In an interview on 05/22/2025 at 3:14 PM, Staff A, Administrator, stated that they did not know why the TB screenings had not been done.

This is an uncorrected deficiency previously cited on 04/04/2025 and a recurring deficiency cited on 10/31/2022.

Statement of Deficiencies	License # 2535	Compliance Determination # 58904
Plan of Correction	Three Rivers Place Senior Living	Completion Date
Page 6 of 6	Licensee: Cedarlake Management Kennewick, LLC	05/29/2025

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on

(Date) 8/4/25 07/13/2025

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

Tonya Williams 6/19/25

Administrator (or Representative) Date

Per phone conversation on 06/24/2025, with Tonya Williams, the BIC date has been changed to: 07/13/2025. ME

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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 #: 2536	Compliance Determination # 56128
Plan of Correction	Three Rivers Place Senior Living	Completion Date
Page 1 of 20	Licensee: Geenlake Management Kennewick, LLC	04/04/2025

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 03/17/2025, 03/18/2025, 03/19/2025 and 03/20/2025 of:

Three Rivers Place Senior Living
1108 W 5th Ave
Kennewick, WA 99336

This document references the following complaint numbers: 169093.

The following sample was selected for review during the unannounced on-site visit: 7 of 35 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Elizabeth Hall, AFH/ALF Licensor
Robin Rainville, Assisted Living Facility Licensor

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

Statement of Deficiencies	License #: 2536	Compliance Determination # 56128
Plan of Correction	Three Rivers Place Senior Living	Completion Date
Page 2 of 20	Licensee: Geenlake Management Kennewick, LLC	04/04/2025

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

04/14/2025
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.

Tonya Williams
Administrator (or Representative)

4/24/25
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop, and document assessed behavioral intervention to ensure the health and safety for 1 of 7 residents (Resident 3). This failure placed residents at risk of unmet care needs.

Findings included...

Review of Resident 3's *full facility assessment*, dated 11/07/2024, showed that Resident 3 had been known to enter other rooms and take things and that the resident's behavior "required behavioral interventions." Further review of the facility assessment showed that Resident 3 had a history of attempted suicide and liked to steal candy from activities.

Review of Resident 3's Negotiated Services Agreement (NSA), dated 11/07/2024, showed that Resident 3 had diagnoses of [redacted] ([redacted]

[redacted]), [redacted] ([redacted]) and [redacted] ([redacted]).

Review of Resident 3's NSA showed that the resident "exhibited appropriate behaviors" and was independent with their behavior management. Resident 3's NSA did not identify behavioral interventions to ensure the health and safety of the resident when the ALF assessed there was a history of suicide and [redacted] diagnoses.

In an interview on 03/18/2025 at 4:14 PM, Staff A, Administrator, stated that behavior interventions for Resident 3 should have been documented in their NSA.

This is a repeat deficiency previously cited on the Statement of Deficiencies dated 10/22/2023 for WAC 388-78A-2140 (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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25.

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

Tonya Williams — Administrator (or Representative)

4/24/25 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were given as prescribed and failed to ensure a safe medication system was in place when residents required administration of their medication for 3 of 5 residents (Resident 1, 2 and 4). This failure placed residents at risk of decline from their chronic health conditions.

Findings included...

In an interview on 03/19/2025 at 10:50 AM, Staff H, Medication Technician (MT), stated that if a vital sign was below the parameters ordered for a resident's medication, the medication would be held, and the doctor would be notified. Staff stated that the Medication Administration Records (MAR) would be marked as "drug not given" or something similar if the medication was held.

<Resident 1>

Review of Resident 1's full facility assessment, dated 12/11/2024, showed that the resident needed staff assistance with their medication. The assessment showed Resident 1 had a diagnosis of [redacted].

Review of Resident 1's Negotiated Service Agreement (NSA), dated 12/12/2024, showed that Resident 1 required medication assistance.

Review of Resident 1's doctor's orders, dated 12/24/2025, showed that the resident had an order for Losartan (to reduce blood pressure) once daily. The orders showed that the Losartan was to be held if Resident 1's pulse was less than 60 beats per minute (BPM) of if their systolic blood pressure (SBP, top number) was under 110.

Review of the facility's February 2025 vital signs records showed that Resident 1's pulse and/or SBP was below the prescribed parameters 11 times.

Review of Resident 1's February 2025 MARs showed that the resident's Losartan was given to them each of the 11 days when their pulse and/or SBP were below the prescribed parameters (Losartan was not held per order).

Review of the facility's March 2025 vital signs records showed that Resident 1's pulse and/or SBP was below the prescribed parameters 11 times.

Review of Resident 1's March 2025 MARs showed that the resident's Losartan was given to them each of the 11 days when their pulse and/or SBP were below the prescribed

parameters (Losartan was not held per order).

<Resident 2>

Review of Resident 2's full facility assessment, dated 11/29/2024, showed that the resident required staff administration of their medication. The assessment showed Resident 2 had a diagnosis of [redacted] ([redacted]).

Review of Resident 2's NSA, dated 11/29/2024, showed that the resident required nurse delegation for insulin (a medication used to control blood sugar) injections and capillary blood glucose testing (CBG testing, to monitor the levels of sugar in the blood stream).

Review of Resident 2's doctor's order, dated 12/09/2024, showed that the resident had an order for CBG testing three times per day. Resident 2's doctor's orders also showed that the resident had an order for Humalog (a type of insulin used to control blood sugar). The Humalog was to be held if Resident 2's CBG test result was less than 140.

Review of Resident 2's February 2025 vital signs records showed that Resident 2's CBG testing result was less than 140 on 54 occasions.

Review of Resident 2's February 2025 MAR showed that the resident's Humalog was administered to them each of the 54 occasions when their CBG testing was less than 140 (Humalog was not held per order).

Review of Resident 2's March 2025 vital signs records showed that Resident 2's CBG testing result was less than 140 on 22 occasions.

Review of Resident 2's March 2025 MAR showed that the resident's Humalog was administered to them each of the 22 occasions when their CBG testing was below the prescribed parameters (Humalog was not held per order).

In an interview on 03/19/2025 at 4:06 PM, Staff B, Licensed Practical Nurse/Health Services Director stated that they would expect to see documentation on the MAR to show that the medication was held when a vital sign was outside the prescribed parameter.

<Resident 4>

Review of Resident 4's full facility assessment, dated 11/07/2024, showed that the resident required assistance and administration of medications, given by a delegated MT. The assessment did not show that Resident 4 could take their oral medications

independently.

Review of Resident 4's NSA, dated 11/07/2024, showed that the resident required administration of insulin, CBG test and topical medications. The NSA showed that staff were to stay with the resident while medications were given to them, to ensure all medications were taken. The NSA showed that Resident 4's medications should never be left unattended.

Review of Resident 4's "Nurse Delegation: Nursing Visit" form, dated 8/14/2024, showed that nurse delegation was required for administration of all the resident's medications.

A medication pass observation on 03/20/2025 at 8:24 AM showed Staff H administered Resident 4's CBG test and their insulin injection. Staff H then left Resident 4's cup of oral pills on their TV stand. Staff H stated that Resident 4 took their pills on their own.

In an interview on 03/20/2025 at 1:18 PM, Staff B, stated that they were not aware staff were leaving Resident 4's pills in their room for self-administration. Staff B stated that they just performed a self-medication administration assessment with Resident 4. Resident 4 failed the assessment. Staff B stated that they put out a temporary service plan to direct staff to stay with Resident 4 until all medications were taken.

This is a recurring citation previously cited on the Statement of Deficiencies, dated 09/07/2022, for WAC 388-78A-2210(1)(b).

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Yonya Williams — Administrator (or Representative)

4/24/25 — Date

*WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14).

foodemployees shall clean their hands and exposed portions of their arms as specified under

*WAC 246-215-02305 **immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:**

(1) After touching bare human body parts other than clean hands and clean, exposed

portions of arms;

(4) Except as specified under WAC 246-215-02400 (2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;

(5) After handling soiled equipment or utensils;

(9) After engaging in other activities that contaminate the hands or gloves.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that staff washed their hands after using a tissue and touching soiled dishes for staff who worked in the kitchen, for 1 of 5 staff (Staff G). This failure placed the residents at risk of contracting food borne illnesses.

Findings included...

During the full kitchen service observation on 03/18/2025 from 11:12 AM through 12:29 PM, Staff G was never observed to wash or sanitize their hands, despite touching contaminated items multiple times.

Observation on 03/18/2025 in the facility kitchen showed the following activities when Staff G, Dishwasher, contaminated their hands then touched clean dishes:

- 11:37 AM Staff G removed gloves, blew and wiped their nose on a tissue, then placed the tissue in their pocket. Staff G then began putting clean dishes away. Staff G did not wash their hands.
- 11:38 AM Staff G put on gloves and continued to put clean dishes away.
- 11:39 AM Staff G rinsed dirty dishes and put them into the dishwashing machine.
- 11:41 AM with the same gloves on, Staff G retrieved a cleaning cloth out of the bucket of sanitizer liquid and wiped down the dish pit.
- 11:43 AM with the same gloves on, Staff G put away clean pots and pans from the dishwashing machine, carrying them with their fingers on the insides of the pans.
- 11:45 AM Staff G removed gloves, moved a large, uncovered wheeled garbage can by touching the top edge of the can, then put on new gloves.
- 11:50 AM Staff G changed gloves, rinsed the dish pit with the spray nozzle, then opened the kitchen entry door touching the doorknob.
- 11:52 AM with same gloves on, Staff G put away clean pans and utensils.
- 11:53 AM a resident handed Staff G a drinking glass and asked for ice. Staff G held the glass over the ice inside the bin to fill it with ice and handed it back to the resident.

- 12:17 PM Staff G entered the kitchen from the employee breakroom and put gloves on.
- 12:20 PM Staff G put away a small blender, using the same gloved hands to touch the inside parts of the cannister.

In an interview on 03/18/2205 at 4:30 PM, Staff A, Administrator, stated that they would need to provide additional training for the staff on proper handwashing expectations.

This is a repeat citation previously cited on the Statement of Deficiencies, dated 10/31/2022 for WAC 388-78A-2305(1).

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Tonya Williams — Administrator (or Representative)

4/24/25 — Date

***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.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that the registered nurse delegator assessed each resident who received delegated task assistance from staff every 90 days for 5 of 5 residents (Resident 1, 2, 4, 6 and 7). Additionally, the

facility failed to ensure that nurse delegated medication administration was performed by staff who were properly trained and/or credentialed to perform delegated tasks; for 2 of 2 staff (Staff C and D). These failures placed residents at risk of having their medications administered incorrectly.

Findings included...

Review of Washington Administrative Code (WAC) 246-840-930, titled, "Criteria for delegation," showed that the Registered Nurse Delegator (RND) was to reevaluate a resident receiving delegated nursing tasks for safe and effective services, and document their assessment at least every 90 days. The RND must also verify credentials and provide supervision of nurse delegated staff at least every 90 days. Additionally, the RND must ensure that each staff member was individually trained on each task specific to the residents' assessed delegation needs.

Review of the facility's policy, titled, "Nurse Delegation," dated 08/18/2021, showed that the RND was to reevaluate delegation and document their evaluation at least every 90 days.

Review of Resident 2, 4, 6, and 7's Nurse Delegation Nursing Visit summaries dated 08/14/2024 showed that Staff C and D had not been delegated to perform nursing tasks for those residents. Staff C and D were not properly trained to perform delegated tasks.

Review of the personnel file for Staff C, Medication Technician (MT) file showed that they were hired on 02/18/2025. Staff C's file showed that they did not have a valid credential needed to be delegated for nursing tasks.

Review of the personnel file for Staff D, MT, showed that they were hired as a MT on 10/07/2024.

Staff C and D were hired after the RND had last reviewed delegation at the facility for Resident 2, 4, 6, and 7, on 08/14/2024.

On 03/17/2025 at 10:01 AM, Staff A, Administrator, stated that the facility provided nurse delegation of tasks which included medication administration and capillary blood glucose testing (CBG testing, to monitor the levels of sugar in the blood stream).

<Resident 1>

Review of the characteristic roster showed that Resident 1 moved into the facility on [redacted]/2024.

Resident 1 moved into the facility after the RND had last reviewed delegation at the facility on 08/24/2024.

Review of the facility's nurse delegation paperwork binder showed that Resident 1 had not been assessed for the need for nurse delegation.

Review of a doctor's order, dated 12/30/2024, showed that Resident 1's medications were to be crushed.

Review of Resident 1's progress notes, dated 01/12/2025, showed that the resident was combative and spit out their morning pill which had been placed in pudding by the MT.

Review of Resident 1's January 2025, February 2025 and March 2025 Medication Administration Records (MARs) showed that Staff C, and Staff D, MT, frequently administered the resident's medication.

In an interview on 03/20/2025 at 2:30 PM, Staff J, Resident Care Coordinator, stated that Resident 1 required their medication to be crushed, placed in food and spoon fed to them (this task would require the supervision of an RND).

<Resident 2>

Review of Resident 2's full facility assessment, dated 11/29/2024, showed that Resident 2 had a diagnosis of [redacted]. The assessment showed that Resident 2 required nurse delegation for insulin (injected medication to regulate excess sugar in the blood stream) administration, CBG testing, eye drops and topical medications.

Review of Resident 2's January 2025 MAR showed that Staff D administered the resident's insulin, CBG test, prescribed topical ointment and eye drops on 01/30/2025.

Review of Resident 2's February 2025 and March 2025 MAR showed that Staff C frequently administered the resident's insulin, CBG test, prescribed topical ointments and eye drops.

Review of Resident 2's nurse delegation paperwork showed that the resident's assessment for delegation had last been documented on a "Nurse Delegation: Nursing Visit" form, dated 08/14/2024. The form showed that the next nurse delegation assessment and review was to be done by 11/14/2024. There were no additional nurse delegation documents to show that Resident 2's nurse delegation had been reviewed every 90 days as required. Additionally, the form did not list Staff C or Staff D as qualified MTs that were delegated to perform Resident 2's medication administration.

<Resident 4>

Review of Resident 4's full facility assessment, dated 11/07/2024, showed that Resident 4 had a diagnosis of [redacted]. The assessment showed that Resident 4 required nurse delegation for insulin administration and CBG testing.

Review of Resident 4's January 2025 MAR showed that Staff D administered the resident's insulin and CBG test on 01/30/2025.

Review of Resident 4's February 2025 and March 2025 MAR showed that Staff C frequently administered the resident's insulin and CBG tests.

Review of Resident 4's nurse delegation paperwork showed that the resident's assessment for delegation had last been documented on a "Nurse Delegation: Nursing Visit" form, dated 08/14/2024. The form showed that the next nurse delegation assessment and review was to be done by 11/14/2024. There were no additional nurse delegation documents to show that Resident 4's nurse delegation had been reviewed every 90 days as required. Additionally, the form did not list Staff C or Staff D as qualified MTs that were delegated to perform Resident 4's medication administration.

Observation on 03/20/2025 at 8:24 AM showed Staff H, MT, administering Resident 4's CBG test and their insulin injection.

<Resident 6>

Review of Resident 6's full facility assessment, dated 11/22/2024, showed that Resident 6 had a diagnosis of [redacted]. The assessment showed that Resident 6 required nurse delegation for the administration of their oral and inhaled medications.

Review of Resident 6's January 2025 MAR showed that Staff D administered the resident's medications to them on 01/30/2025.

Review of Resident 6's February 2025 and March 2025 MARs showed that Staff C and Staff D frequently administered the resident's medication.

In an interview on 03/19/2025 at 3:13 PM, Resident 6 stated that the staff crushed their oral medications and spooned them into the resident's mouth.

Review of Resident 6's nurse delegation paperwork showed that the resident's assessment for delegation had last been documented on a "Nurse Delegation: Nursing Visit" form, dated 08/14/2024. The form showed that the next nurse delegation assessment and review was to be done by 11/14/2024. There were no additional nurse delegation documents to show that Resident 6's nurse delegation had been reviewed every 90 days as required. Additionally, the form did not list Staff C or Staff D as qualified MTs that were delegated to perform Resident 6's medication administration.

<Resident 7>

Review of Resident 7's full facility assessment, dated 11/14/2024, showed that Resident 7 had a diagnosis of [redacted]. The assessment showed that Resident 7 required nurse delegation for the administration of all medications by a delegated MT.

Review of Resident 7's January 2025 MAR, showed that Staff D administered the resident's medications including insulin and CBG test on 01/30/2025.

Review of Resident 7's February 2025 and March 2025 MARs showed Staff C frequently administered the resident's insulin, CBG test and oral medications.

Review of Resident 7's nurse delegation paperwork showed that the resident's assessment for delegation had last been documented on a "Nurse Delegation: Nursing Visit" form, dated 08/14/2024. The form showed that the next nurse delegation assessment and review was to be done by 11/14/2024. There were no additional nurse delegation documents to show that Resident 7's nurse delegation had been reviewed every 90 days as required. Additionally, the form did not list Staff C or Staff D as qualified MTs that were delegated to perform Resident 7's medication administration.

This is a recurring citation previously cited on the Statement of Deficiencies, dated 10/17/2023, for WAC 388-78a-2320(2)(b), and on the Statement of Deficiencies, dated 09/07/2022, for WAC 388-78a-2320(2)(b).

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Administrator (or Representative) Tonya Williams Date 4/24/25

*** WAC 388-78A-2420 Record retention.**

(1) The assisted living facility must maintain on the assisted living facility premises in a resident's active record(s) all relevant information and documentation necessary for meeting a resident's current assessed needs.

(4) All active, inactive, and closed resident records must be available for review by department staff and other authorized persons.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that active resident record information was retained on the premises and available for the department to review for 7 of 7 residents (Resident 1, 2, 3, 4, 5, 6 and 7). This failure limited the department from having the ability to review portions of resident's records relevant to ensuring regulatory requirements were met.

Findings included...

The department entered the facility to begin the full licensing inspection on 03/17/2025. The facility was advised that a sample of residents' records would be reviewed with a minimum of a three-month look back period.

In the entrance interview on 03/17/2025 at 9:54 AM, Staff A, Administrator, stated that the facility had switched Electronic Health Record (EHR) systems for resident records as of January 1st, 2025.

Review of Medication Administration Records (MARs) for Residents 1, 2, 3, 4, 5, 6 and 7 showed that documentation of medications given to each resident was only available starting from January 27, 2025. Additionally, the MARs did not show number of units of insulin (an injected medication to regulate blood sugar) that were given in accordance with the results of their blood sugar tests, for Residents 2 and 4.

Review of progress notes for Residents 1, 2, 3, 4, 5, 6 and 7 showed that documentation was only available starting from December 30th, 2024.

In an interview on 03/19/2025 at 2:25 PM, Staff J, Resident Care Coordinator, stated that the facility could not access residents' progress notes prior to January 2025.

In an interview on 03/19/2025 at 3:58 PM, Staff J stated that they did not have the ability to view residents' weights documented prior to switching EHR systems in January 2025. Staff J stated that they had been told the old system information would translate over into the new EHR system when the change took effect. Staff J stated the information did not transfer into the new system.

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Administrator (or Representative) Tonya Williams Date 4/24/25

***WAC 388-78A-2450 Staff.**

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff received facility orientation for 3 of 5 staff (Staff B, C and D). This failure placed residents at risk of being cared for by untrained staff.

Findings included...

Review of the personnel file for Staff B, Licensed Practical Nurse/Health Services Director, showed that they were hired on 01/03/2025. Staff B's file did not show that they had received facility orientation.

Review of the personnel file for Staff C, Medication Technician (MT), showed that they were hired on 10/07/2024. Staff C's file did not show that they had received facility orientation.

Review of the personnel file for Staff D, MT, showed that they were hired on 02/18/2025. Staff D's file did not show that they had received facility orientation.

In an interview on 03/19/2025 at 1:33 PM, Staff I, Business Office Manager, stated that they were not aware facility orientation was required for Staff B, C, and D.

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Tonya Williams — Administrator (or Representative)

4/24/25 — Date

* **WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that**

the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

(3) Has received three positive references for the person;

(4) Does not allow the person to have unsupervised access to any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to submit a Washington state name and date of birth background check to the department within one business day after hire for 2 of 6 staff (Staff E and F). Additionally, the facility failed to ensure that three positive references were obtained for 1 of 5 staff (Staff C). These failures placed the residents at risk of being cared for by disqualified staff. These failures placed the residents at risk of being cared for by disqualified staff.

Findings included...

Review of the personnel file for Staff E, Housekeeper, showed that they were hired on 08/18/2022. Staff E's file showed that their Washington state name and date of birth (WNDOB) background check was submitted on 09/26/2023 (405 days after their hire date).

Review of the personnel file for Staff F, Caregiver, showed that they were hired on 10/16/2023. Staff F's file showed that their WNDOB background check was submitted on 11/16/2023 (31 days after their hire date).

In an interview on 03/19/2025 at 1:56 PM, Staff I, Business Office Manager, stated that they were unaware of the reason Staff E and F's WNDOB background checks were submitted more than one day after hire.

Review of the personnel file for Staff C, Medication Technician, showed that they were hired on 02/18/2025. Staff C's file showed a WNDOB background check which was submitted on 02/18/2025.

Review of the personnel file for Staff C showed that the facility did not obtain three positive references prior to hiring or pending the results of the WNDOB background check until the results were received on 02/26/2025.

Review of the facility "As Worked" staff schedule dated February 2025 showed that Staff C worked two days from 2/18/2025 to 02/26/2025, unsupervised.

This is a repeat deficiency previously cited on the Statement of Deficiencies dated 10/31/2022 for WAC 388-78A-2468(1) (3) (4).

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25.

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

Administrator (or Representative) Tonya Williams Date 4/24/25

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a review to determine if staff with non-disqualifying background check results had the Character, Competence, and Suitability to work with the vulnerable adults, for 3 of 3 staff (Staff A, B and C). This failure placed residents at risk from being cared for by staff members who were potentially not suitable to work with vulnerable adults.

Findings included...

Review of the personnel file for Staff A, Administrator, showed that they were hired on 04/17/2023. The file showed that Staff A had a Washington state name and date of birth (WNDOB) background check result dated 04/06/2023, which indicated that a Character, Competency and Suitability (CCS) review was required. Additionally, the file showed that Staff A had a fingerprint background check result dated 06/30/2023 which indicated that a CCS review was required. Staff A's file showed that no CCS review had been completed until 01/25/2024.

Review of the personnel file for Staff B, Licensed Practical Nurse/Health Services Director, showed that they were hired on 01/03/2025. The file showed that Staff B had a WNDOB background check result dated 01/03/2025, which indicated that a CCS review

was required. Additionally, the file showed that Staff B had a fingerprint background check result dated 02/03/2025 which indicated that a CCS review was required. Staff B's file showed that a CCS review had not been completed when both of Staff B's background check results indicated that a CCS review was required.

Review of the personnel file for Staff C, Medication Technician, showed that they were hired on 02/18/2025. The file showed that Staff C had a WNDOB background check result dated 02/26/2025, which indicated that a CCS review was required. Staff C's file showed a CCS had been completed 03/13/2025, 15 days after the WNDOB results were received. Additionally, the file showed that Staff C had a fingerprint background check result dated 03/18/2025 which indicated that a CCS review was required. Staff C's file showed that a CCS review had not been completed for the fingerprint background check result.

In an interview on 03/19/2025 at 1:17 PM, Staff I, Business Office Manager, did not know that a CCS was required with each background check result.

In an interview on 03/19/2025 at 1:44 PM, Staff I stated that there had been a lot of staff turnover, and the facility had been busy hiring people, that is why the CCS was late for Staff C.

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Tonya Williams — Administrator (or Representative)

4/24/25 — Date

***WAC 388-78A-2480 Tuberculosis Testing Required.**

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were screened for tuberculosis within three days of hired for 2 of 5 staff (Staff B and F). This failure placed residents at risk of being exposed to a communicable disease.

Findings included...

Review of the personnel file for Staff B, Licensed Practical Nurse/Health Services Director, showed that they were hired on 01/03/2025. Staff B's file showed an initial tuberculosis (TB) screening test was conducted on 02/03/2025 (31 days after their hire date).

In an interview on 03/19/2025 at 1:31 PM, Staff I, Business Office Manager, stated that Staff B had started the facility's two-step TB screening but was unable to complete it and had to start over.

Review of the personnel file for Staff F, Caregiver, showed that they were hired on 10/16/2023. Staff F's file showed an initial TB screening test was conducted on 11/16/2023 (31 days after their hire date).

In an interview on 03/19/2025 at 2:13 PM, Staff I, Business Office Manager, stated that they did not know why the TB screenings were late for Staff F.

This is a repeat deficiency previously cited on the Statement of Deficiencies dated 10/31/2022 for WAC 388-78A-2480 (1).

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Tonya Williams — Administrator (or Representative)

4/24/25 — Date

✶ **WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:**

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that pets living on the premises had regular examinations and immunizations for 1 of 3 pets (Pet 3). This failure put residents at risk for contact with pets who may have transmissible diseases. [redacted]

Findings included...

Review of the facility's policy titled, "Pet Policy," undated, showed that pets must have current vaccination records on file with the facility. The policy showed that management staff would regularly review a resident's ability to maintain responsibility of a pet.

In an interview on 03/20/2025 at 12:24 PM, Staff I, Business Office Manager, stated that there were no pet records for Pet 3 (a dog).

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, Three Rivers Place Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/24/25 .

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

Administrator (or Representative) Tonya Williams Date 4/24/25

Greenlake SENIOR LIVING

2140

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 4/4/25
Complaint Citation Certification Citation	
WAC 388-78A-2140	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. Dementia screening assessment and slums form completed on 3/25/25 2. Staff in-service training conducted on resident behaviors and re-direction. 3. NSA updated to include interventions
How will you apply the correction to all clients you support?	1. Staff to monitor and report any behavioral changes of residents to Hwd. 2. Additional staff training will be assigned as needed. 3. All residents with behavioral changes will be assessed for needs.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. HWD 2. RCC
Additional Information:	
In-Service/Training:	All staff In-Service cconducted on 3/25/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:
3/25/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/25

2210

Greenlake SENIOR LIVING

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 4/18/25
Complaint Citation Certification Citation	
WAC 388-78A-2210	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1.LPN assessedappropriate residents for self medication requirements for all mentioned residents. 2. LPN audited all residents charts of self medication residents and assessed them to ensure they were appropriate to self medicate.
How will you apply the correction to all clients you support?	1. All self medication residents evaluation will be in move process. 2. 2. LPN to evaluate residents every 6 mos or with significate change. 3. LPN created resident self medication binder for all appropriate residents to ensure compliance.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. LPN 2. ED to follow-up
Additional Information:	
In-Service/Training:	1. Med Tech in-service on 4/18/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:
4/18/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/23

2305/ 2310

Greenlake SENIOR LIVING

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 3/19/25
Complaint Citation Certification Citation	
WAC 388-78A-2305 / WAC 388-78A-2310	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1.Handwashing In-Service on 3/19/25 (see attached) 2. Employee verbal/written counseling 3. Posted 3 additional handwashing diagrams.
How will you apply the correction to all clients you support?	1. All Employee yearly handwashing In-Service to ensure compliance. 2. All employees to be assigned hand washing training.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. BOM to assign trainings 2. ED to administer In-Service yearly
Additional Information:	
In-Service/Training:	1. All staff In-Service conducted on 3/19/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:
3/21/25	3/25/25		

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/25

2320

Greenlake

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 4/15/25
Complaint Citation Certification Citation	
WAC 388-78A-2320	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. Employee submitted NAR certification/fee paid 2. LPN/RCC to administer meds 3. LPN/RCC did audit of med cart and mars for medication accuracy.
How will you apply the correction to all clients you support?	1. NAR med requirements added to employee matrix for compliance. 2. LPN to assist employees in optaining credentials. 3. LPN to ensure delegator has delegated all med tech task and proper training has taken place.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. LPN 2. Bom 3. ED
Additional Information:	
In-Service/Training:	LPN/RCC training on med tech requirements. 3/26/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:
4/15/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/15

Greenlake SENIOR LIVING

2420

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 4/15/25
Complaint Citation Certification Citation	
WAC 388-78A-2420	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. Corporate office contacted to retrieve resident information from previous network program 2. Printed out all resident information for a temporary paper file. 3. Nurse to audit weekly until problem is solved.
How will you apply the correction to all clients you support?	1. Back up system in place to store resident files. 2. If shuting system down print off all resident files for back up. 3. Store files on an approved, existing, protected, program to comply with access regulations.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. LPN,HSD 2. RCC 3. ED
Additional Information:	
In-Service/Training:	LPN/RCC training on resident files and access. 3/27/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:
4/15/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/25

2450

Greenlake

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 4/16/25
Complaint Citation Certification Citation	
WAC 388-78A-2450	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. Staff training on Orientation and safety completed 3/25/25 2. New forms for documentation introduced for Bom files. 3. BOM training on 3/20/25 on documentation and training.
How will you apply the correction to all clients you support?	1. Orientation/Safety training added to employee matrix to ensure compliance. 2. Bom added orientation/safety form to new hire paperwork. 3. ED/BOM will audit employee files monthly.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. BOM 2. EED
Additional Information:	3/25/25
In-Service/Training:	BOM training regarding orientation and safety compliance on 3/20/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:
4/16/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/25

2468

Greenlake SENIOR LIVING

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 4/16/25
Complaint Citation Certification Citation	
WAC 388-78A-2468	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. Audit was performed on all employee records to identify any potential negative outcomes. 2. BOM had trainings on receiving 3 positive references obtained prior to hire. 3. All backgrounds will be submitted prior to employment.
How will you apply the correction to all clients you support?	1. All areas of interest will be monitored strictly per regulations. 2. All employees will be added to the matrix at hire to ensure compliance. 3. Ed will check all new employee files as needed.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. BOM 2. ED
Additional Information:	
In-Service/Training:	BOM training

Completion Date:	Completion Date:	Completion Date:	Completion Date:
4/16/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/25

2470

Greenlake

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 4/16/25
Complaint Citation Certification Citation	
WAC 388-78A-2470	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. All missing Characteristic and background forms were completed and added to employee files immediately. 2. Audit was completed on all employee backgrounds for disqualifying crimes that needed a characteristic form attached to ensure resident safety.
How will you apply the correction to all clients you support?	1. Initial fingerprints, annual checks and characteristic forms added to employee matrix. 2. ED to audit all employee files for compliance and completion. 3. Bom added new steps to employee matrix to ensure compliance.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. BOM 2. ED
Additional Information:	
In-Service/Training:	BOM training regarding background checks on 3/26/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:

3/26/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/26

2480

Greenlake SENIOR LIVING

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 3/26/25
Complaint Citation Certification Citation	
WAC 388-78A-2480	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. Audit of TB records. 2. All TBs are up to date. 3. New facility LPN has been doing them since she started to keep us on track.
How will you apply the correction to all clients you support?	1. Immediately upon hire TB will be administered by LPN at facility and read within an appropriate time period. 2. LPN to update TB book and keep a calendar of dates on her desk for 2nd step dates to ensure it is within the time period allotted by the regulations. 3. Bom to monitor TB process to help comply with accurate time periods.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. LPN 2. ED 3. BOM
Additional Information:	
In-Service/Training:	HSD training 3/26/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:

3/26/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/25

2620

Greenlake SENIOR LIVING

Plan of Correction

Agency Name Licensing	Citation Date
Three Rivers Place	04/14/25
Submitted By	Date of POC Submission 4/24/25
Tonya Williams	Compliance Date 3/24/25
Complaint Citation Certification Citation	
WAC 388-78A-2620	

Citation:	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	1. Resident son took his dog home told the dog could not be left overnight with resident unless we have vet records from him. 2. BOM updated pet binder to include visiting pets.
How will you apply the correction to all clients you support?	1. All pet owners on premises will provide copies of vaccanations records. 2. Pet vaccination documentation will be provided for any pet who is here overnight. 3. All pet information will be stored in the pet binder and updated as needed.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	1. BOM 2. ED 3. AD
Additional Information:	
In-Service/Training:	BOM,AD training 3/27/25

Completion Date:	Completion Date:	Completion Date:	Completion Date:

3/27/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates. 2.

2.Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to Regional Director of Operations, and Clinical Director.

Executive Director Name: Tonya Williams Signature: Tonya Williams Date: 4/24/25