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

Greenlake Management Pasco, LLC
Tri-Cities Assisted Living
4441 W. Airport FWY Ste 160
Irving, TX 75062

RE: Tri-Cities Assisted Living License # 2549

Dear Administrator:

This letter addresses Compliance Determination(s) 27026 (Completion Date 07/24/2023) and 23237 (Completion Date 05/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/24/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2160, WAC 388-78A-2600-2-I

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Tri-Cities Assisted Living

Provider Type: Assisted Living Facility

License/Cert.#: 2549

Intake ID: 80336

Compliance Determination #: 23237

Region/Unit #: RCS Region 1 / Unit G

Investigator: Melissa Milanez

Investigation Date(s): 05/01/2023 through 05/22/2023

Complainant Contact Date(s): 05/22/2023

Allegation(s):

1. A named resident was given the wrong dose of insulin.
2. A named resident's Hoyer lift has not been charged, and they were left in bed.
3. A named resident was soaked in urine, had not had a shower, and their nails hadn't been trimmed.
4. A named resident's room is dirty with feces on the floor and piles of dirty clothes left in their closet.
5. A named resident has no way of calling for help.

Investigation Methods:

Sample:	Total residents: 101 Resident sample size: 3 Closed records sample size:
Observations:	Environment, cares, residents, resident apartments, staff availability and response to resident's needs.
Interviews:	Residents, staff and others not associated with the facility.
Record Reviews:	Characteristic roster, resident records (assessments, care plans, temporary service plans, behavioral care plans, case manager's assessments, and doctor orders), resident shower schedules, incident investigations, staff schedules, staff phone list, and facility policies.

Investigation Summary:

1) Interviews and record reviews showed that the named resident received the wrong dose of insulin which caused a negative outcome. The facility failed to make all appropriate notifications.
2) Observations and Interviews showed that the named residents Hoyer lift was charged, and the facility had a backup battery if needed.
3,4) Record review and Interviews showed the named resident did not have a shower in the month of March. Observations showed the residents nails were trimmed, room was clean, and free of odors. Dirty linen hamper in closet was empty and clothes were put away in designated areas.
5) Interviews, observations, and record review showed that the resident is unable to

use the call light due to cognition and is on a two-hour safety check.
Failed practice identified.
Citation written for WAC 388-78A-2600 (2)(l), WAC 388-78A-2160, WAC 388-78A-2120 (1)(2)(a)(3)(a)(b)(4). Reference Statement of Deficiencies dated 05/22/2023.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Tri-Cities Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2549
Intake ID: 81037
Compliance Determination #: 23237
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 05/01/2023 through 05/22/2023
Complainant Contact Date(s): 05/22/2023

Allegation(s):
1) The named resident had a fractured arm.

Investigation Methods:

Sample:	Total residents: 101 Resident sample size: 3 Closed records sample size:
Observations:	Environment, cares, residents, resident apartments, staff to resident interactions, staff availability and response to resident's needs.
Interviews:	Residents, staff and others not associated with the facility.
Record Reviews:	Characteristic roster, resident records (assessments, care plans, temporary service plans, behavioral care plans, case manager's assessments, and doctor orders), resident shower schedules, incident investigations, staff schedules, staff phone list, and facility policies.

Investigation Summary:
Observations, interviews and record review showed that the named resident required a two-person transfer with the Hoyer lift. Facility staff failed to follow the named residents Negotiated Service Plan for transferring. The resident obtained a closed left humeral fracture and pain was not addressed and monitored appropriately. Failed practice identified. Citation written for WAC 388-78A-2160 and 388-78A- 2120. Reference Statement of Deficiencies dated 05/22/2023.

Conclusion / Action:

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

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 #: 2549	Compliance Determination # 23237
Plan of Correction	Tri-Cities Assisted Living	Completion Date
Page 1 of 9	Licensee: Greenlake Management Pasco, LLC	05/22/2023

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 05/01/2023 and 05/01/2023 of:

Tri-Cities Assisted Living
2000 N 22nd Ave
Pasco, WA 99301

This document references the following complaint number(s): 80336, 77940, 81037

The following sample was selected for review during the unannounced on-site visit: 3 of 101 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.

Gwin Kaercher
Residential Care Services

06/01/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) — Date: 6/6/2023

WAC 388 78A 2120 Monitoring residents' well being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to monitor and provide pain relief interventions when a resident exhibited pain for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 experiencing prolonged pain and psychological distress due to a fractured shoulder.

Findings included...

Review of the Resident 1's record showed they were admitted to the facility on [redacted]/2023 with diagnoses which included [redacted], and [redacted]. The resident's Negotiated Service Agreement (NSA), dated on 04/24/2023 showed that the resident was fully dependent on staff with transfers, repositioning, and incontinence care. The NSA showed the resident required the use of a Hoyer (mechanical lift) for all transfers. Additionally, the NSA showed Resident 1 was able to tell staff when they were in pain, and staff were to notify the Licensed Nurse (LN) if severe pain complaints persisted.

Review of the facility's 02/27/2023 pre-admission assessment (a tool to determine resident's care needs) showed that prior to Resident 1's admission to the ALF the resident was being treated at the hospital for pain to their hips and back.

Resident 1 was observed in their room on 05/01/2023 at 11:18 AM. Upon entering the resident's room, the resident was observed yelling out that they needed help, and that they were in pain. The resident stated they needed assistance to get up and go home. They were observed with their left hand clenched tightly and leaning towards the right side.

On 05/01/2023 at 11:23 AM Resident 1 stated they had pain to their back and their

bottom. When the resident attempted to raise their left hand, the resident yelled, "No, no, no, don't touch my hand, it hurts." The resident stated they could not raise their arm because it hurt to move it.

On 05/01/2023 at 11:31 AM Staff G, Medication Technician when informed that Resident 1 was in pain, stated that they did not think the resident had anything prescribed for pain but would check the medication record.

During a concurrent observation and interview on 05/01/2023 at 11:55 AM Staff B, Resident Care Manager, Staff C and D, Shower Aides, and two unidentified care staff were observed transferring Resident 1 with the Hoyer lift from their recliner to their bed. During the transfer the resident was yelling for help, "Mama wait, hello mama, don't do it, it hurts.... I'm scared to death." The resident apologized for yelling, stated they were in a lot of pain and that they were fearful because they had been dropped on a concrete floor. Staff continued to transfer the resident and stated that it was the resident's normal response to yell out in pain, and that Resident 1 was afraid of the Hoyer lift. After being transferred to their bed, staff removed the resident's brief to provide incontinent care. Resident 1 was observed to have a Stage 2 pressure injury (partial thickness loss of dermis (the inner layer of the two main layers of the skin) presenting as a shallow open ulcer with a red or pink wound bed) to left buttocks and a scratch to the back side of the left lower thigh. While in the room, Staff B stated they had not been notified of the pressure injury or the scratch. Staff C notified Staff B that they had observed a bruise to the residents left shoulder during the shower earlier that morning.

Review of a chart note dated 05/01/2023 at 2:00 PM showed that staff noted a large bruise to Resident 1's left shoulder that extended to the elbow. The record showed the bruise was identified during the shower and reported to Staff B.

During a telephone interview on 05/02/2023 at 12:53 PM, Resident 1's Collateral Contact (CC1) Representative and Durable Power of Attorney stated that the facility notified them Resident 1 would be transferred to the hospital for complaints of left shoulder pain, and that the injury was related to a staff transfer. CC1 stated this was the first notification they had of the resident's bruising and increased pain. During the same interview CC2 stated Resident 1 had been on routine narcotics for knee pain in the past, but stated they were not aware of why they were not taking pain medications since admission to the ALF.

Review of a chart note dated 05/02/2023 at 1:41 PM, showed that Resident 1 was crying out in pain while staff attempted to provide care. Resident 1 requested to go the hospital. Paramedics were called, they came to the facility and administered pain medications before transporting the resident to the hospital for further evaluation.

Review of Resident 1's record showed no documentation of any action or response to Resident 1's pain for more than 24 hours, after the facility's acknowledgment of increased pain and bruising to Resident 1's left shoulder.

Review of Resident 1's record from 05/01/2023 to 05/02/2023 (before the resident was sent to the hospital) did not show an assessment of the injury, attempts to provide treatment, pain relief interventions or monitoring. The record showed no changes to directives for transfers or repositioning Resident 1.

On 05/03/2023 at 11:00 AM, Staff C and D, stated they regularly provided showers for Resident 1. Both Staff C and D stated that every time the resident had a shower, they complained of pain. Staff D stated the resident had complained of pain for a while, and that even when lifting Resident 1's legs was painful for them. Staff C and D stated they reported the complaints of pain to Staff B, but "nothing" had been done. Staff C and D stated that on the morning of 05/01/2023, when preparing the resident for a shower they observed a large size bruise to Resident 1's left shoulder. Staff C stated the resident showed discomfort, was complaining of left shoulder pain, and was leaning to the right side. Staff C and D noticed that Resident 1 was experiencing more pain than usual, so they chose to use the Hoyer lift for the transfer into the shower chair. Staff C and D stated the resident complained of pain while being transferred with the lift, but continued to use it because they were told by the ALF's administrative staff that the resident "Had to have a shower."

Review of Resident 1's record showed upon admission to the ALF ([redacted]2023) the resident had an order for a pain patch (Lidocaine), the record showed no other pain medications or any other type of intervention since the resident's admission. Resident 1's record showed no monitoring or assessments of the Resident 1's pain until 05/02/2023 when the resident returned to the ALF with a fractured arm.

Resident 1 was observed in their room on 05/03/2023 at 10:33 AM, the resident was lying in bed and wearing a brace to the left arm, they had a large size bruise to her their left shoulder that extended down their arm and behind the armpit area. The bruise was a light-yellowish color in the shoulder area and a greenish-yellowish color in the arm. The bruise measured approximately 5 inches in length and 4.5 inches in width. The resident stated they had 10 out of 10 pain (scale of 1 to 10 with 10 being the greatest pain) to their left arm, they yelled out "please don't touch it, it hurts a lot, I want a shot for the pain."

On 05/05/2023 at 8:32 AM Staff H, Regional Nurse Consultant stated that they would be providing a 30-day notice for discharge due to Resident 1 needing a higher level of care then their facility could provide, that they were not aware of why Resident 1's pain had not been addressed since admission, and they did not understand why the Resident 1 had been admitted into their memory care unit. Staff H stated they would now be responsible for screening all new potential admits into their buildings to ensure that their facilities would be able to safely meet residents' needs.

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, Tri-Cities Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/6/2023 .

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

Administrator (or Representative) 6/6/2023 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a mechanical lift equipment (Hoyer) with two or more staff was used for transfers as agreed upon in the resident's Negotiated Service Agreement (NSA) for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 experiencing pain after sustaining a left humeral fracture (a break in the bone in the upper arm).

Findings included...

Record review of the facility's policy titled, "Resident Assessment and Negotiated Service Agreement" dated 08/10/2021, showed that the ALF must provide the care services as agreed upon in the NSA to each resident unless a deviation from the NSA is mutually agreed upon between the assisted living facility and the resident or resident's representative at the time the care or services are scheduled.

Record review of the facility's policy titled, "Use of Mechanical Lifts" dated 08/10/2021, showed residents always have the right to refuse the use of a mechanical lift. If this is the case, the Wellness Director will consult with a medical professional to determine alternative methods to transfer the resident.

Review of Resident 1's pre-admission assessment dated 02/27/2023 showed that the resident was to be transferred by the Hoyer lift for all transfers.

Facility record review showed Resident 1 was admitted to the facility on [redacted]/2023. They had a diagnosis, including [redacted]

[redacted]. Resident 1's NSA dated 04/24/2023 showed that the resident required assistance of two staff members for all transfers with the Hoyer lift.

On 05/02/2023 at 12:53 PM Resident 1's Collateral Contact (CC1), Representative and Durable Power of Attorney stated that she had "just got off the phone" with the facility and that they notified her that Resident 1 was being sent to the hospital due to complaints of left shoulder pain. CC1 stated that the Staff B told them that they believed the pain to the resident's left shoulder could have come from when the staff transferred the resident onto the shower chair without the Hoyer lift, sometime last week. CC1 asked Staff B why Resident 1 had been transferred without the Hoyer lift, Staff B stated to CC1 that they had to do a two-person transfer to be able to shower the resident without the sling.

On 05/02/2023 at 5:27 PM, CC1 stated that they called the facility to get an update on Resident 1, they stated the facility communicated to them that Resident 1 was diagnosed with [redacted] and would be returning to the facility.

Record review of the investigation completed on 05/02/2023 showed that on 04/26/2023 staff were preparing to assist Resident 1 with a shower and noted that they were unable to use the provided Hoyer sling due to not having the correct type for showering the resident. Staff then completed a two-person transfer of the resident from their bed into their wheelchair, they were taken upstairs, staff transferred them into the shower chair, then transferred back into their wheelchair via a 2-person transfer, then taken to their apartment; it was concluded in the investigation completed by Staff B that the resident had obtained the bruising and fracture due to the transfer that occurred on 04/26/2023.

During an interview on 05/03/2023 at 10:25 AM with Staff B, Health and Wellness Director, stated "It is not very often that they do not use the sling, I can't say for sure how often they do it."

Resident 1 was observed in their room on 05/03/2023 at 10:33 AM, the resident was lying in bed and wearing a brace to the left arm, they had a large size bruise to her their left shoulder that extended down their arm and behind the armpit area. The bruise was a light-yellowish color in the shoulder area and a greenish-yellowish color in the arm. The bruise measured approximately 5 inches in length and 4.5 inches in width. The resident stated they had 10 out of 10 pain (scale of 1 to 10 with 10 being the greatest pain) to their left arm, they yelled out "please don't touch it, it hurts a lot, I want a shot for the pain."

During an interview on 05/03/2023 at 10:48 AM, Staff C and D, Shower Aids, stated they provided a bed bath to Resident 1 on 04/24/2023 because they did not have the proper sling to transfer the resident into the shower chair. Staff C and D communicated to Staff B, Health and Wellness Director/Licensed Nurse that they would need a different sling to be able to safely transfer the resident into the shower chair and that they were not provided with one. They were told by Staff B that they were not to continue to give Resident 1 a bed bath and that the resident needed to be transferred onto the shower chair and taken upstairs into the shower room to receive a proper shower. Staff C and D then called for

Staff B to come into the resident's room and observe the difficulties they were having when transferring Resident 1 without the Hoyer lift. Staff C and Staff D stated that during the transfer Resident 1 was screaming that they were in pain, but their pain was not addressed at that time, and they continued to transfer the resident.

During an interview on 05/03/2023 at 10:54 PM Staff E, Caregiver, stated that there was a time that they could recall that the shower aids transferred Resident 1 without the Hoyer lift from their wheelchair to the shower chair, and then from the shower chair to the recliner. Staff E stated the resident has been complaining of pain for a while.

During an interview on 05/03/2023 at 11:03 AM Staff D, shower aid, stated that every time they use the Hoyer lift on Resident 1, the resident states they are fearful of it because they have been dropped hard and slammed on the cement. Both Staff C and D stated the NSA showed they are to use the Hoyer lift for all transfers, including showers.

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, Tri-Cities Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/6/2023

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

Administrator (or Representative) 6/6/2023 Date

WAC 388-78A-2600 Policies and procedures.

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

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their medication policy to ensure resident received prescribed medication and accurate doses for 1 of 3 residents (Resident 1) who required assistance with medications. This failure resulted in Resident 1 receiving the wrong dose of insulin (medication to control amount of glucose (sugar) in the bloodstream) which contributed to a drop in the resident's blood sugar levels requiring interventions of staff to normalize the resident's blood

sugars.

Findings included....

Record review of the facility's policy titled; "Signing of Medications" dated 08/10/2023 showed that when assisting the resident with medication administration, the Medication Technician (MT) will: check and compare the information on the medication label with the MAR, check the six rights: right resident, right medication, right time, right dosage, right route, and right documentation.

Record review showed the Resident 1 was admitted to the facility on [redacted]/2023. The resident had a diagnosis of [redacted]. Resident 1 required assistance with their medications.

Review of Resident 1's physician orders dated 05/01/2023 showed Resident 1 had prescribed orders for Humalog (rapid acting insulin) inject 10 units 3 times daily before meals and Lantus (long-acting insulin to treat Diabetes) inject 50 units 2 times daily.

Review of the facility's Medication Error Incident report dated on 04/12/2023 showed that Resident 1 was given Humalog 50 units instead of the prescribed order Humalog 10 units, due to a miscommunication between two MTs.

Review of Resident 1's Progress Note dated on 04/12/2023 at 8:30 AM showed that during the breakfast treatment pass, a MT gave Resident 1 the wrong dosage of their insulin. Resident 1 was then given orange juice and food to increase the residents blood sugar levels.

Review of a Progress Note on 04/12/2023 at 11:46 AM showed that the Licensed Nurse (LN) assessed the Resident 1 due to an insulin medication error, and Glucagon (used to treat severe low blood sugars) was given due to blood sugar being at 88.

During an interview with Staff F on 05/01/2023 at 12:50 PM stated Resident 1 had an order for Lantus 50 units two times daily and an order to for Humalog 10 units three times daily before meals. Staff F was training a newly hired MT on the morning of 04/12/2023. They both entered Resident 1's room and noted that the resident needed assistance with incontinence care. While Staff F provided care to the resident, the unidentified MT asked Staff F how many units of Humalog they needed to give the resident. Staff F communicated to the MT that it was 50 units of Humalog that needed to be administered. After the unidentified MT injected the resident with insulin, Staff F realized that they had communicated to the MT the wrong dose of insulin. Staff F acknowledged the facility policy and procedure had not been followed.

Staff F then notified the facility's administrator and the physician. Staff F gave the resident orange juice and food, and which were ordered by the physician. Staff F confirmed that the resident's blood sugar dropped down to 88 (low) and that Staff A, Administrator/Licensed Nurse administered the ordered Glucagon to help raise the blood sugar.

This is a recurring deficiency previously cited on 02/10/2023.

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, Tri-Cities Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/6/2023

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

Administrator (or Representative) — Date: 6/6/2023