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) 28063 (Completion Date 08/15/2023) and 24800 (Completion Date 06/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/15/2023 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-2210-2-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-b, WAC 388-78A-2260-2-c, WAC 388-78A-2260-2-d, WAC 388-78A-2260-1, WAC 388-78A-2930-1-a-ii, WAC 388-78A-2930-1-b-i, WAC 388-78A-2240

The Department staff who did the on-site verification:
Laurel Knight, 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: 83812
Compliance Determination #: 24800
Region/Unit #: RCS Region 1 / Unit G
Investigator: Gwin Kaercher
Investigation Date(s): 06/02/2023 through 06/27/2023
Complainant Contact Date(s): 06/02/2023

Allegation(s):

1. Identified resident is not getting their pain medications.
2. Identified resident is not getting cares and services as agreed upon.

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Staff Nursing staff Residents
Record Reviews:	Medical records including negotiated service agreements, medication administration records, physician orders. Incident investigation State reporting log

Investigation Summary:

1. Identified resident and their representative confirmed the resident had a broken arm and had pain medication ordered that they were not receiving due being unable to find it. Facility staff records showed the resident had not been getting their pain medication. Facility investigation showed the medication had been delivered and then it was unsure what happened after it was delivered. Facility staff interview confirmed the resident had not been receiving their pain medication as ordered. Deficient practice was identified, please see the statement of deficiency dated 07/10/2023 for failing to give medications as ordered 388-78a-2210 and failure to secure medications 388-78a-2260.
2. Facility staff interviews confirmed the resident had episodes of diarrhea and their bedding and clothing were changed when the staff became aware. Resident observation showed the resident was in clean clothing and had clean bedding. No

deficient practice was identified at the time of the department's visit.

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: 83459
Compliance Determination #: 24800
Region/Unit #: RCS Region 1 / Unit G
Investigator: Gwin Kaercher
Investigation Date(s): 06/02/2023 through 06/27/2023
Complainant Contact Date(s):

Allegation(s):
1. Identified resident's medications went missing.

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Staff Nursing staff Residents
Record Reviews:	Medical records including negotiated service agreements, medication administration records, physician orders. Incident investigation State reporting log

Investigation Summary:
1. Identified resident and their representative confirmed the resident had a broken arm and had pain medication ordered that they were not receiving due being unable to find it. Facility staff records showed the resident had not been getting their pain medication. Facility investigation showed the medication had been delivered and then it was unsure what happened after it was delivered. Facility staff interview confirmed the resident's medication was replaced after . Deficient practice was identified, please see the statement of deficiency dated 07/10/2023 for failing to give medications as ordered 388-78a-2210 and failure to secure medications 388-78a-2260.

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: 84573
Compliance Determination #: 24800
Region/Unit #: RCS Region 1 / Unit G
Investigator: Gwin Kaercher
Investigation Date(s): 06/02/2023 through 06/27/2023
Complainant Contact Date(s):

Allegation(s):

1. Identified resident is not getting their pain medications.
2. Memory care residents are not getting cares and services as agreed upon.
3. Identified staff are selling drugs.

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Staff Nursing staff Residents
Record Reviews:	Medical records including negotiated service agreements, medication administration records, physician orders. Incident investigation State reporting log

Investigation Summary:

1. Identified resident and their representative confirmed the resident had a broken arm and had pain medication ordered that they were not receiving due being unable to find it. Facility staff records showed the resident had not been getting their pain medication. Facility investigation showed the medication had been delivered and then it was unsure what happened after it was delivered. Facility staff interview confirmed the resident had not been receiving their pain medication as ordered. Deficient practice was identified, please see the statement of deficiency dated 07/10/2023 for failing to give medications as ordered 388-78a-2210 and failure to secure medications 388-78a-2260.
2. Resident interviews confirmed they were not hungry. Resident observation showed the resident was in clean clothing and had clean bedding and food was being served to

all residents. Staff interviews confirmed they did not have any concerns regarding resident condition or quantity of food available. No deficient practice was identified at the time of the department's visit.
3. Interviews with facility staff confirmed they had investigated alleged selling of street drugs and narcotic pain pills and had reported the missing narcotics to local law enforcment. Facility investigation and witness statements showed no knowledge or evidence of the Identified staff doing anything against their policy. No deficient practice identified.

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

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 06/02/2023 and 06/02/2023 of:

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

This document references the following complaint number(s): 84429, 83812, 83459, 83257, 84573

The following sample was selected for review during the unannounced on-site visit: 3 of 97 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, 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

07/11/2023
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)

7/18/2023
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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that their medication system provided a safe and effective delivery of resident medications for 2 of 3 residents (Residents 1,2). This failure resulted in Resident 1 missing scheduled and as needed medication doses ordered for pain and unclear orders. Additionally, the failure resulted in damaged and destroyed medications for Resident 2.

Findings included...

Record review of the facility's medication policy titled, "Med 02 – Medication Services" dated 08/10/21, showed that the Executive Director would ensure that medication related services required or requested by each resident was provided. All medication handled, stored, or assisted with would be documented on the Medication Assistance Record, (MAR) and in accordance with state regulations.

Resident 1
Review of Resident 1's record showed the resident was admitted to the ALF on [redacted]/2023. Their NSA dated 04/24/2023 showed the resident needed total assistance with medications, dressing, bathing, toileting, and transfers. Their diagnosis included [redacted] that was being treated with a sling and pain medications.

Review of the May 2023 Medication Administration Record (MAR) review showed the resident had an order for Oxycodone, (narcotic opioid pain medication) 20 mg, 1 tablet

three times daily ordered routinely by their doctor on 05/05/2023. MAR documentation showed the medication was not given for 20 consecutive doses starting on 05/17/2023. Staff initialed and circled scheduled doses to indicate it was not given due to non-availability of the medication. The scheduled pain medication order was discontinued on 05/23/2023. See WAC 388-78a-2240 non-availability of medication.

Resident 1 also had an order for Oxycodone 20 mg, 1 tablet every six hours as needed written on 05/05/2023. No as needed pain medication was documented as given to Resident 1 after 05/15/2023. The as needed pain medication order was discontinued on 05/23/2023.

Review of physician's order review showed on 05/23/2023 a new order was received for Oxycodone 15 mg 1 tab every six hours, not to exceed 45 mg per day. The May and June 2023 MARs showed the order was transcribed on the MAR as Oxycodone 15 mg, 1 tablet every six hours as needed for pain and not to exceed 45 mg per day. The facility made one attempt to clarify the order with no additional follow up or reply. There were no doses of pain medications documented as given after receiving the new order 05/23/2023.

On 06/02/2023 at 3:20 PM Resident 1 was observed with facial grimacing when repositioning in bed. They stated they had pain from their broken arm but "sometimes you just have to do what you have gotta do and pain is part of it."

On 06/02/2023 at 2:26 PM Staff E Medication Technician, (MT) stated that if a resident did not have pain medication in stock the usual process was to call the pharmacy to ask why. Staff E stated Resident 1 was "out of pain medications for maybe a week or so but that she didn't really scream or yell unless you turn her." Staff E stated that Resident 1 was "not really" able to ask for pain medications.

On 06/02/2023 at 2:30 PM Staff D, MT stated that Staff B, the Health and Wellness Director, (HWD) had run a narcotic audit report and discovered Resident 1 was not getting any pain medications. Staff D stated that they had followed up on the audit report the following night. Staff D stated Resident 1 said "oww" when they were turned, and the resident was able to say if they are having pain. Staff D stated that they had sent a fax one time on 05/23/2023 to clarify the order for pain medication to confirm it was an as needed pain medication and had not received clarification. The pain medication was entered onto the MAR as an as needed medication and no further attempts were made to clarify the order.

On 06/02/2023 at 2:32 PM Staff B stated that the pharmacy had told them a new pain medication order was needed because they were out of stock. Staff B stated that Resident 1's primary care provider had ordered a pain medication as needed. Staff B stated they were unsure why a resident in the dementia unit would have an as needed pain medication ordered because "they were not a prescriber" of medication. Staff B stated they did not know if Resident 1 was able to remember they had a pain medication available and put on the call light to ask for it.

On 06/02/2023 at 2:40 PM Collateral Contact 1, (CC1) stated they had evaluated Resident 1 due to the arm fracture and changed the pain medication order to Oxycodone 15 mg 1 tab every six hours, not to exceed 45 mg per day on 05/23/2023. They stated they had not ordered a pain medication on an as needed basis for Resident 1 and were not aware the resident was not getting the medication as ordered.

On 06/02/2023 at 4:00 PM Staff A stated they were not sure why the order was entered as needed on the MAR.

Resident 2

Review of Resident 2's record showed the resident was admitted to the ALF for assistance due to their general decline from neurological diseases (affecting the nervous system). Their NSA dated 11/15/2022 showed the resident needed total assistance with medications, dressing, bathing, catheter care, and transfers. Their diagnoses included [redacted] and [redacted].

On 06/02/2023 at 4:12 PM Resident 2 stated they depend on the Hydrocodone (pain medication) ordered daily. Resident 2 stated "when I run out, I am miserable without it."

On 06/02/2023 at 4:00 PM Staff A stated that there was a recent incident in which two cards (prepackaged sealed single dose medications) containing thirty individual doses per card of hydrocodone that were damaged and destroyed for Resident 2.

See WAC 388-78a-2260 for storing and securing medication.

~~Per telephone call on 07/18/2023, with facility administrator: Laura Samuel, BIC date changed to 08/11/2023. 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, Tri-Cities Assisted Living is or will be in compliance with this law and / or regulation on (Date) ~~8/11/2023~~ ~~08/11/2023~~ 7/28/2023

Per facility administrator, Laura Samuel, via 7/20/2023 email, BIC date changed to: 7/28/2023. cw

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

L Samuel — Administrator (or Representative)

7/18/2023 — Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(c) Separate from food or toxic chemicals;

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were properly stored in a locked mobile medication cart with a secondary locked narcotic, (opioid pain medication) compartment only accessible to medication delivery staff for 2 of 2 residents (Residents 1& 2). This resulted in Resident 1 missing multiple consecutive doses due to theft and errors in medication administration. Additionally, this placed Resident 2 at risk for not receiving their pain medications due to food spills that caused medication destruction.

Findings included...

Review of the facility policy titled "Med 04-Medication Storage of Centrally Stored Medications" dated 08/10/2021 showed the facility should store medications in a manner that ensures maintenance of both the integrity of the medication and the safety of all residents residing in the community. All medications should be kept in locked storage at all times and away from food or toxic chemicals. Medications should be in a locked compartment that is accessible to only designated responsible staff persons.

Resident 1

During an interview on 06/02/2023 at 4:00 PM with Staff A, Executive Director, stated that they had discovered a theft of two cards (prepackaged sealed single dose medications, 60 tablets) of Resident 1's oxycodone 20 mg, (narcotic pain medication) during a routine narcotic audit. Staff A stated that the cards had been received from the pharmacy delivery staff by Staff F, Medication Technician. Staff A stated that their investigation showed Staff F did not enter the cards into the narcotic log or secure them in the medication cart as per facility policy. The medications were not available as ordered for the resident.

Review of Resident 1's medication administration records, (MAR) showed the resident did not have pain medication available between 05/17/2023 and 05/23/2023 for a total of 20 missed doses.

Resident 2

Staff A stated that there was also another incident in which two cards, of Hydrocodone 7.5/325 mg, (narcotic pain medication) 60 tablets, belonging to Resident 2 were damaged and destroyed. Staff A further stated that Staff J, Resident Care Coordinator (RCC), spilled coffee on the cards while conducting a narcotic audit. The cards were destroyed by staff due to the coffee spill.

Record review of the facility investigation dated 06/09/2023 showed that Staff J and Staff E, Medication Technician destroyed the cards due to the coffee spill. The facility staff reordered the medication.

During a telephone interview on 06/22/2023 at 3:18 PM Staff C, Eastern Area Regional Clinical Services Director was asked about their narcotic medication management system, they stated that when staff received the medication from pharmacy delivery personnel they locked them in the medication cart and had the oncoming staff shift sign them off. ~~Per telephone call on 07/18/2023, with facility administrator: Laura Samuel, BIC date changed to 08/11/2023. ME~~

Plan/Attestation Statement

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

Per facility administrator, Laura Samuel, via email on 7/20/2023, BIC date changed to: 07/28/2023. ME

L Samuel
Administrator (or Representative)

7/18/2023
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility, (ALF) failed to ensure that residents had a method of asking for help from staff for 2 of 2 residents (Residents 1 & 5) residing in the memory care unit. This failure resulted in Residents 1 & 5 and other memory care unit residents at risk of not being able to have their needs met when they were not able to call for assistance.

Findings included...

Review of the resident characteristic roster dated 06/02/2023 showed 22 licensed beds in the memory care unit.

Resident 1

Review of Resident 1's record showed the resident was admitted to the ALF on [redacted]/2023. Their negotiated service agreement (NSA), dated 04/24/2023 showed the resident needed total assistance with dressing, bathing, toileting every two hours and required a mechanical lift for transfer. The resident required assistance with meals, medications, and housekeeping.

Residents 5 and 1 were observed on 06/02/2023 at 3:25 PM in their shared room. Resident 1 had multiple bruises on their left arm and a sling partially in place. Resident 1 stated that they recently had a broken arm. No functional call lights or wireless communication devices were observed in the residents' sleeping room. Resident 1 stated that they would wait for someone to check on them or "holler" if they needed help.

On 06/02/2023 at 2:32 PM Staff B, Health and Wellness Director stated that they were unsure if Resident 1 could use the call lights. They stated there were not any call lights in the memory care unit.

~~Per telephone call on 07/18/2023, with facilty administrator: Laura Samuel, BIC date changed to 08/11/2023. ME~~

Plan/Attestation Statement

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

Per facility administrator, Laura Samuel, via 7/20/2023 email, BIC date changed to: 7/28/2023. LW

Administrator (or Representative) — Date: 7/18/23

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure 1 of 2 residents (Resident 1) had the ordered medication available to be given when the facility provided medication service. This failure resulted in Resident 1 missing pain medication doses due to the medication not being in the facility.

Findings included...

Review of Resident 1's record showed the resident was admitted to the ALF on [redacted]/2023. Their negotiated service agreement (NSA) dated 04/24/2023 showed the resident needed total assistance with medications, dressing, bathing, toileting, and transfers. Their diagnosis included a [redacted] that was being treated with an arm sling and pain medications.

Review of the May 2023 Medication administration record (MAR) showed the resident had an order for Oxycodone, (narcotic opioid pain medication) 20 mg, 1 tablet three times daily ordered routinely on 05/05/2023. MAR documentation showed the medication was not given for 20 consecutive doses starting on 05/17/2023. Staff initialed and circled scheduled doses to indicate it was not given due to non-availability of the medication.

On 06/02/2023 at 2:30 PM Staff D, MT stated that Staff B, the Health and Wellness Director, had run a narcotic audit report and discovered Resident 1 was not getting any pain medications. Staff D stated that they had followed up on the audit report the following night.

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

Per facility administrator Laura Samuel, via 7/20/2023 email, BIC date changed to: 7/28/2023. ME

Administrator (or Representative)

7/18/2023
Date