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
2000 N 22nd Ave
Pasco, WA 99301

RE: Tri-Cities Assisted Living License # 2549

Dear Administrator:

This letter addresses Compliance Determination(s) 47640 (Completion Date 09/25/2024) and 44171 (Completion Date 07/31/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/25/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-4, WAC 388-78A-2371, WAC 388-78A-2600-1, WAC 388-78A-2600-1-b

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

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, 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: 138665
Compliance Determination #: 44171
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 07/16/2024 through 07/31/2024
Complainant Contact Date(s): 07/31/2024

Allegation(s):
The named resident was found to have multiple bruises on their body.

Investigation Methods:

Sample:	Total residents: 86 Resident sample size: 3 Closed records sample size: 2
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Business office manager Home Health Nurse.
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:
Interviews with facility staff showed that not all the staff were aware of the extent of bruising on the named resident. Interviews also showed that the facility failed to thoroughly investigate how the named resident's bruises occurred and failed to implement preventative measures to protect the named resident. Failed practice

identified in the Statement of Deficiencies (SOD) dated 07/31/2024, under WAC 388-78a-2371.

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: 137093
Compliance Determination #: 44171
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 07/16/2024 through 07/31/2024
Complainant Contact Date(s):

Allegation(s):
Fall with injury.

Investigation Methods:

Sample:	Total residents: 86 Resident sample size: 3 Closed records sample size: 2
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Resident mobility devices Tripping hazards
Interviews:	Identified staff Nursing staff Residents Family members Business office manager
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:
Observations, interviews and record reviews showed that the facility failed to follow their policy and procedures when responding to falls. The facility failed to summon immediate assistance for the identified resident after the fall and failed to notify the responsible party the day of the fall. The identified resident was taken to the hospital the next day and was diagnosed with a [redacted]. Failed practice

identified. WAC 388-78A-2600. Reference statement of deficiencies dated 07/31/2024.

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 07/16/2024 and 07/16/2024 of:

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

This document references the following complaint number(s): 138665, 137093, 137148

The following sample was selected for review during the unannounced on-site visit: 3 of 86 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

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

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Michelle Closner
Residential Care Services

08/05/2024
Date

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

Administrator (or Representative)

4-6-24
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to investigate, determine the circumstances of an event, and protect all residents during the investigation of allegations of abuse for 1of 3 residents (Resident 1). This failure placed the residents at risk of harm and at risk of further incidents of abuse.

Findings included...

Record review of the facility's policy titled, "Elder Abuse, Neglect, and Exploitation" dated 08/10/2021 showed that facility staff was to immediately report any form of possible symptoms of abuse or neglect to the Department according to state requirements. A thorough investigation would be conducted by the Director (HWD) or Executive Director.

Record review of the ALF's policy titled, "Internal Incident Report and State Incident Report", dated 08/10/2021 showed that the ALF must investigate and document investigative findings for any suspected abuse. The policy showed the ALF must determine the circumstances of events. Furthermore, the policy stated that the ALF must document the date and time each individual was contacted and the relationship of the individual to the resident.

Review of the ALF's Guidebook showed that all alleged incidents of abuse, neglect, abandonment, significant injuries of unknown source must be thoroughly investigated. A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abandonment, abuse, neglect or misappropriation of resident property occurred, and how to prevent further occurrences. Critical components of any investigation include: the objectivity of the investigator, the timeliness of the initiation of the investigation, and the thoroughness of the investigation.

Resident 1

Resident 1's Negotiated Service Agreement (NSA) dated on 08/24/2023 showed that the resident had diagnosis of [redacted]) with [redacted]). The NSA showed that the resident required two-person assistance with all transfers.

On 07/16/2024 at 1:23 PM, Resident 1 was observed laying on their bed. Due to the resident's cognitive deficits, they were unable to state what staff helped them with. Resident 1 was observed with a dark, blue, purple bruise to their right upper ear measuring 4 centimeters (cm) by 3 cm. Observations also showed a red bruise to the left side of the neck measuring 4 cm by 3 cm, a dark red bruise to the right side of Resident 1's underarm, two yellow bruises noted to right side of rib area measuring 2.5 cm by 2 cm, dark blue bruising to left arm, and various small size bruises to both knees and lower extremities. Also noted were two small sized abrasions to the right knee and one small abrasion to the left knee that had been scabbed over.

Resident 1's record review of Physician's Orders for July 2024 showed that they were on a blood thinning medication which has a side effect of causing increased risk of bruising.

Review of a 07/11/2024 incident report showed staff had found discoloration to the right ear and upon investigation staff did not know how the discoloration happened.

On 07/16/2024 at 12:40 PM, Staff A, Concierge, stated that the Administrator was out on vacation and that they were assisting with the Administrator duties until the end of the month. Staff A stated they were not aware of any current or pending open investigations related to abuse. Staff A stated that Resident 1 had been sent out to the hospital for a fall and complaints of pain and they had not been aware of any bruising.

On 07/16/2024 at 12:53 PM, Staff B, Licensed Practical Nurse (LPN), stated they were not aware of Resident 1 ever falling and it was unknown how the bruises happened but did not feel they needed to conduct an investigation to rule out abuse. Staff B stated, "older people sometimes they bang themselves on stuff and my mind just doesn't go directly to abuse." Staff B stated they did not interview other residents during the investigation of the bruises found on Resident 1, to see if anyone else had been potentially abused.

On 07/16/2025 at 1:18 PM, Staff A, and investigator entered Resident 1's room. Staff A stated they were not made aware of any bruising to Resident 1. Staff A observed Resident 1 and noted several bruises to their body. Staff A stated, "these are not normal bruises, especially the one to the neck, we should have started an immediate investigation to rule out abuse." Staff A stated they were not sure why this did not happen.

On 07/16/2024 at 1:20, Staff C, Business Office Manager (BOM), stated they were assisting with Administrator duties while the current Administrator was out on vacation. Staff C stated that they were not made aware of any bruises. Staff C entered Resident 1's room and stated that the bruises noted on Resident 1 were not normal bruises and they would have expected staff to do an investigation, and they were not sure why this did not happen.

On 07/16/2024 at 2:22 PM, Staff D, Area Operations Support, stated that it was their policy to conduct an investigation for any suspicious bruising and that they would be providing additional training to staff on investigations to rule out abuse and neglect.

This is a repeated deficiency previously cited on the Statement of Deficiency dated on 09/14/2023.

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) 9/13/24 .

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

Administrator (or Representative) — Date: 8.16.24

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure staff followed their fall response policies and procedures for 1 of 3 residents (Resident 3). This failure caused the resident to have prolonged pain, a delay in medical care, and placed the resident at risk of additional injuries and unmet care needs.

Findings included...

Record review of the facility's policy titled "Fall Response Procedures" dated 12/15/2021

showed that should a resident fall the responsible party is notified immediately and Resident Care Assistants are instructed to summon immediate assistance from the Wellness Director or Nurse/Medical Technician on duty. Resident Care Assistants do not move the resident, except to protect against further injury, as in the case of a dangerous environment.

Record review of the facility assessment dated 07/17/2024, showed Resident 3 resided in the Memory Care Unit, was at risk for falls and had a diagnosis of [redacted] ([redacted]).

Review of Resident 3's Negotiated Service Agreement (NSA) dated 05/30/2024 showed that the resident was at risk for falls due to cognition, diagnosis and medications. The NSA also showed that staff were to report falls/injuries verbally to the licensed nurse/delegated aid and complete a first responder form if a fall were to occur.

Review of a Resident Care In-Service form dated 06/28/2024 showed that if a resident had a fall staff were to notify either the delegated aid or nurse to look over/assess for injuries and staff were instructed to not move the resident until this had been completed.

Review of Resident 3's Incident/Injury Report dated 06/29/2024 (a day after the fall) at 1:00 PM showed that a caregiver walked into the resident's room and found the resident on the floor. The incident report also showed that the unidentified caregiver was told by Resident 3's roommate (who also has Dementia and is not a good historian) that the resident had slid out of their chair. The caregivers assisted the resident up from the floor without notifying the delegated aid or the nurse.

Review of the facilities request for Non-Emergency Communication form dated 06/29/2024 and singed by Staff E, Medication Technician (MT), showed that the resident was sent to the hospital at 6:00 AM because night shift staff reported that the resident cried out in pain all night. The form also showed that the resident was diagnosed with a [redacted] at the hospital.

Review of an investigation report undated and not signed showed that staff reported the resident had slipped out of the chair. The report also showed that the resident's roommate told staff that the resident had slipped out of the chair. The caregiver assisted the resident up in the chair and did not wait for the delegated staff to assess the resident before assisting them back to the chair.

Review of the Emergency Room (ER) Report dated [redacted]/2024 showed that Resident 3 presented to the ER for evaluation of left hip bruising. Brusing had been noted by the Power of Attorney (POA) at the memory care facility. Staff were unsure of how the bruise took place, and the resident was sent to the ER for evaluation. The resident was unable to participate in their history due to cognitive impairment. The ER report also showed the resident was diagnosed with an [redacted] ([redacted])

[redacted]) and the plan was to transition to comfort care with a scheduled Hospice evaluation on 06/30/2024.

On 07/16/2024 at 12:40 PM, Staff A, Concierge/Interim Business Office Manager, stated that Resident 3 no longer resided at the facility and that family had moved them out into an Adult Family Home.

On 07/16/2024 at 1:41 PM, Staff E, Medication Technician, stated that they arrived to work on 06/29/2024 (the day after the fall) at 5:50 AM and the night shift caregiver told them that the resident needed to be sent out to the ER due to them screaming in pain all night. Staff E stated that they were told that Resident 3 had a bruise to their leg and had been crying. Staff E also stated that their fall policy stated that staff need to notify the delegated aid or nurse of any falls and need to complete an incident report, they stated this did not happen. Staff E stated that the incident report was not completed until the next day. Staff E also stated Resident 1's daughter had not been notified about the fall until the next day after the fall.

On 07/16/2024 at 1:47 PM, Staff F, Caregiver, stated they entered Resident 3's room and found Resident 3 on the floor. Staff F stated the fall was not witnessed by staff, they did not do an incident report or notify the nurse due to them thinking that the resident had just slid out of their chair. Staff F was unsure if the POA had been notified.

On 07/22/2024 at 3:45 PM, Collateral Contact 1 (CC1), Resident 3's representative stated that they were not notified about the resident having a fall until the following day when they received a phone call from the facility and were told that Resident 3 had been crying in pain throughout the night and was found to have a bruise to their hip. CC1 stated that the facility transferred the resident to the hospital where they had been diagnosed with an [redacted].

Interview on 07/31/2024 at 3:15 PM with Staff B, Health and Wellness Director, Licensed Practical Nurse, stated that they received a phone call from Staff E on 06/29/2024 at 6:00 AM (a day after the fall) stating that the resident had been complaining of pain all night and that they had a bruise to their leg. Staff B stated that they were told at that time by Staff E that the resident had slipped out of their chair the day before, but staff had not reported the incident. Staff B also stated they did not believe the residents daughter had been notified about the fall. Staff B stated that there is signage posted at the facility that staff are to complete an incident report if the resident falls or slides, but acknowledged that this did not happen in this case.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2549	Compliance Determination # 44171
Plan of Correction	Tri-Cities Assisted Living	Completion Date
Page 7 of 7	Licensee: Greenlake Management Pasco, LLC	07/31/2024

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) 9/13/24.

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

Administrator (or Representative) — Date: 8.6.24