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) 56198 (Completion Date 03/12/2025) and 50634 (Completion Date 01/13/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/12/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660-1, WAC 388-78A-2660-2, RCW 70.129.140.1, RCW 70.129.140.5.a, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, 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)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF 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: 155122
Compliance Determination #: 50634
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 11/21/2024 through 01/13/2025
Complainant Contact Date(s): 01/14/2025

Allegation(s):

1. Call lights not being answered within a timely manner.
2. Facility phone was not answered.
3. Resident representative not notified of hospital visit.
4. Identified resident was found soiled and staff refused to assist with cares.
5. Named residents blood pressure and blood sugars was not being monitored.
6. Caregiver jerked named residents' arm and caused pain.
7. Named residents phone charger was stolen and wheelchair missing.

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 6 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms (locked drawers, personal items) Staff to resident interactions Resident to resident interactions Call light response times
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Business office manager Activity Director
Record Reviews:	Hospital records Physician visit notes State reporting log Incident investigation Facility policies Staff patterns Resident records (care plans, TSP's, assessments, face

sheet, MARS, physician orders, home health notes)
Call light log
staff schedules
Staff roster
Policy's (medication administration policy, abuse/neglect policy, NSA policy)

Investigation Summary:

1. Staff interviews showed that the facility strives to answer call lights within fifteen minutes. Review of resident records showed that the identified resident required assistance with toileting and mobility and would call for help when needed. Review of call light records showed that the resident pushed there call light on multiple occasions and call light response time was over fifteen minutes. Failed practice identified under WAC 388-78a-2160.

2. Observations showed that facility phones were being answered in a timely manner. The Administrator and the Director of Operations stated that the ALF phones are set up to forward to the on-call cell phone if they are not answered at the facility. They stated they were not made aware of phones not being answered but would investigate the concern to ensure phones were working properly. Interviews with staff showed that phones are answered by front desk receptionist during the week and after hours, phone calls are forwarded to a cordless phone that staff are responsible for carrying around. No failed practice identified.

3. The facility had a policy for responding to emergencies and documentation. Interviews and record review showed that facility staff had received a call from the named resident's provider and had instructed the staff to send the resident to the hospital for an abnormal lab result. Interviews with facility staff showed that staff notified one of the named resident's emergency contacts. The facility provided an all-staff education on ensuring they document all notifications on their electronic health record. No failed practice was identified.

4. Interviews and record review showed that the identified resident required assistance with Activities of Daily Living (ADL's) and staff were to assist as needed. The identified resident stated that staff had refused to assist them with cares. Interview with facility staff showed that they were told by other staff not to assist with cares and that the identified resident needed to do things on their own. The Administrator stated that there was a failure in communicating the needs of the resident, and that they provided staff education on following the Negotiated Service Agreement. Failed practice identified under WAC 388-78a-2160.

5. Interviews with staff showed that the identified resident was obtaining blood sugar checks, but blood pressures were not being monitored. Record review showed that the identified resident had several high blood pressure readings at the facility and had been seen in the emergency room for high blood pressures. Additionally, the identified resident was prescribed three new blood pressure medications, and blood pressures were not being monitored. The facility failed to fulfill their responsibility to ensure the health and safety of the resident by failing to monitor a critical health condition. Failed practice identified under WAC 388-78a-2600.

6. Observations showed that staff to resident interactions were appropriate and respectful. Staff were observed providing cares in a respectful manner. Staff interviewed showed they were aware of what a mandated reporter was and how to make a report if they witness abuse or neglect. Facility administrator stated they were unaware of allegation and would do an investigation. Sampled resident

interviews showed that they felt safe in the facility. Identified residents was unable to state staff members name and stated that the staff were providing better cares. Facility was unable to substantiate allegations. No failed practice identified.

7. Identified resident stated they currently had their phone charger and a wheelchair. Interview with administrator showed that upon hearing about the missing items, the facility followed their policy, investigated and offered to replace missing item if not found. Observations showed the resident had their phone charger and no longer had concerns with missing items. Observations of resident's apartments showed that they had access to locked draws in their apartments. No failed practice identified.

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: 156806
Compliance Determination #: 50634
Region/Unit #: RCS Region 1 / Unit G
Investigator: Melissa Milanez
Investigation Date(s): 11/21/2024 through 01/13/2025
Complainant Contact Date(s): 01/14/2025

Allegation(s):

1. Unknown staff refuse to help named resident with cares.
2. Family not able to get in touch with the facility staff.
3. Facility administering wrong medication dose.

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 6 Closed records sample size:
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Staff patterns Medications Administration Records Physician Orders

Investigation Summary:

1. Interviews and record review showed that the identified resident required assistance with Activities of Daily Living (ADL's) and staff were to assist as needed.

The identified resident stated that staff had refused to assist them with cares. Interview with facility staff showed that they were told by other staff not to assist with cares and that the identified resident needed to do things on their own. The Administrator stated that there was a failure in communicating the needs of the resident, and that they provided staff education on following the Negotiated Service Agreement. Failed practice identified under WAC 388-78a-2160.

2. Observations showed that the front desk receptionist was answering the phones during the onsite visit. Interviews showed that care staff are responsible for carrying a cordless phone after hours. The Administrator stated that phone calls not answered after business hours would be re-directed to the Administrator or the Director of Nursing. No failed practices identified.

3. Record review of the residents after visit summary showed that there was a new order to increase the medication dosage per the physician's orders. Interview with staff showed that they were aware of the new dosage changes but acknowledged that they had not administered the new dose. Review of the Medication Administration Record failed to show new medication dosage. Failed practice identified under WAC 388-78a-2210. Medication services.

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 11/21/2024 of:

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

This document references the following complaint number(s): 155043, 155122, 155461, 155805, 156587, 156806, 156815

The following sample was selected for review during the unannounced on-site visit: 6 of 85 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

Statement of Deficiencies	License #: 2549	Compliance Determination #506534
Plan of Correction	Tri-Cities Assisted Living	Completion Date
Page 2 of 12	Licensee: Greenlake Management Pasco, LLC	01/13/2026

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

01/28/2025
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.

Administrator (or Representative)

2.19.25
Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that residents were treated with respect and dignity related to assisting resident with care and services and answering call light responses for 1 of 6 sample residents (Resident 1). This failure resulted in undignified staff responses to Resident 1 and contributed to delayed cares and services for a resident who was experiencing pain and increased health issues.

Findings included...

Review of the ALF's policy "Personal Rights" dated 08/10/2021 showed that the facility must promote care of residents in a manner and in an environment that maintains or

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

01/28/2025
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.

Administrator (or Representative)

Date

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(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that residents were treated with respect and dignity related to assisting resident with care and services and answering call light responses for 1 of 6 sample residents (Resident 1). This failure resulted in undignified staff responses to Resident 1 and contributed to delayed cares and services for a resident who was experiencing pain and increased health issues.

Findings included...

Review of the ALF's policy "Personal Rights" dated 08/10/2021, showed that the facility must promote care of residents in a manner and in an environment that maintains or

enhances each resident's dignity and respect in full recognition of his or her individuality. The ALF's policy also showed that within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; the resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident, and the resident has the right to receive services in the facility with reasonable accommodation of individual needs and preferences.

Review of the ALF's policy "Dignity" dated 08/10/2021, showed that each resident has the personal right to be accorded dignity in their personal relationships with staff, residents, and other persons and that staff is to be respectful and courteous in all interactions with residents.

Review of the ALF's policy "Resident Assessment and Negotiated Service Agreement" dated 02/15/2024, showed that the facility will provide care as agreed upon by the community and resident or resident's authorized representative in the Negotiated Service Agreement.

Review of Resident 1's NSA, dated 10/26/2024, showed that staff were to assist with escorts to and from meals and activities. The NSA also showed that the resident required one-person total assistance from staff with toileting, required ambulation assistance or wheelchair escort due to resident having a broken right shoulder and a history of falls. Staff were to assist them as needed and the resident would use there call light to ask for assistance.

Per Resident 1's records of three Emergency Department (ED) visits on 10/20/2024, 11/05/2024, and 11/23/2024 noted Resident 1's ED visits were due to low blood sugar, high potassium, high blood pressure, weakness, lower extremity edema, leg pain, lower bilateral dermatitis.

Review of a progress note, dated 11/01/2024, showed the resident was assessed by the physical therapist from an outside agency and confirmed that the resident had complaints of pain to the left arm, and blood pressure was 208/97.

Review of Resident 1's progress note, dated 11/05/2024, showed that Resident 1 was seen by the occupational therapist on 11/04/2024 for an evaluation. Resident 1 required wheelchair transfers with maximum assist, and the resident had reported pain.

Review of a progress note, dated 11/21/2024, showed the home health Registered Nurse assessed Resident 1, and noted "four wounds were present, and appeared to be traumatic in nature, resident reported 5/10 pain with activity, had 1+edema to bilateral lower extremities, and staff were to help elevate lower extremities."

Review of a progress note, dated 11/21/2024, showed a note from physical therapy stating, "patient reported to much pain to attempt ambulation today."

Review of Resident 1's November's Medication Administration Record (MAR), showed that the resident weighed 135 pounds on 11/22/2024.

Review of a progress note, dated 11/26/2024, showed the resident was seen by the physical therapist. The noted stated, "resident completed sit to stands with moderate assist, resident reported achy all over. Resident gained weight and was now 151 pounds (sixteen-pound weight gain in four days)."

Review of Resident 1's Assessment, dated 12/03/2024 (after ER visits, and after on-site visit), showed that the resident had a diagnosis of [redacted].

On 11/25/2024 at 9:56 AM Collateral Contact 1 (CC1), Resident Representative, stated that they were concerned that Resident 1 was not receiving adequate care with activities of daily living, and staff were refusing to help them with cares. In addition, CC1 stated that Resident 1's call light was ignored on multiple occasions, including an incident when the resident was left on the commode for forty minutes without receiving assistance. CC1 also stated that on one other occasion, they visited the resident and found them sitting in their wheelchair in the bathroom, soiled and surrounded by a puddle of urine. CC1 stated the resident had pushed their call button and no one had come to help them. CC1 stated that on 11/23/2024 they called the facility to try and get Resident 1 assistance with toileting, and was unable to get in contact with anyone at the facility. They stated that they instructed Resident 1 to push their call button and waited on the phone with them until someone came to assist. CC1 stated that an unknown staff member refused to provide cares and refused to assist the resident to the dining area for lunch. CC1 stated that the unknown staff member told the resident that they had to figure out how to get to the dining room for lunch and that they were not allowed to use their wheelchair. CC1 stated that on the same day, Resident 1 pushed their call button again, they were on the phone and had requested to talk to the staff member who entered. CC1 stated they spoke to a caregiver, and the caregiver told them that they were aware of the cares that Resident 1 needed but had been instructed by other caregivers not to assist Resident 1.

On 11/25/2024 at 12:14 PM, Resident 1 was observed in their apartment on the second floor sitting in their wheelchair. The resident had edema (swelling) of both lower legs, feet, ankles, and hands. Additionally, there were dressings noted to both lower leg extremities from below the knee to the ankle that were wrapped with Kerlix (a type of gauze roll used for wound care and absorbing drainage) that was visibly soiled and damp with yellow discoloration around the edges.

On 11/25/2024 at 12: 16 PM Resident 1, stated that they had pain to their right arm, their legs, and had a history of a fractured shoulder. They stated that it was difficult to receive assistance from staff and that staff were refusing to help them with cares. Resident 1 stated they required help with escorting to and from meals, as well as with showering and toileting assistance. Resident 1 stated that staff were instructed not to assist them with care needs, forcing them to struggle with daily tasks alone. They stated that despite expressing severe pain in their legs and arms, staff reportedly refused to provide care. Resident 1 stated that on one occasion, an unknown staff member had told them, "Have fun getting back to your room." Resident 1 also stated that they had experienced significant delays in response to their call light, often waiting extensive periods for assistance. In multiple instances, they were left on the commode for over forty minutes. They stated it was too difficult for them to wheel themselves in their wheelchair due to pain in their legs and arms.

On 11/25/2024 at 12:28 PM Collateral Contact 2 (CC2), Physical Therapist, stated that they had been providing physical therapy services to Resident 1. CC2 stated that the resident would require assistance with escorts downstairs and would not be able to do so on their own safely due to their current condition.

On 11/25/2024 at 1:05 PM, Staff D, Caregiver, stated that Resident 1 required assistance with escorts, toileting, changing their clothes and taking vital signs. Staff B stated that on Saturday 11/23/2024 another caregiver (one that only works on weekends) told them that Resident 1 needed to be using their walker to come down for meals and that they could do it by themselves. Staff B stated that they did not think the resident could do this on their own and knew that the resident was unable to walk due to their condition and helped them downstairs. Staff B stated that the resident had told them that a night shift caregiver also refused to help them to the bathroom and told them they had to do it themselves. Staff B stated that it is their policy to answer call lights as soon as they can but no later than fifteen minutes.

On 11/25/2024 at 1:57 PM Staff A, Administrator stated that Resident 1 required assistance with escorts and toileting and would call for help when needed. Staff A stated that they try to keep the facility's call light response time to under 15 minutes.

Review of Resident 1's call light event report dated 11/01/2024-11/26/2024, showed that there were 157 times the call light had been pushed with the longest response time being 252 minutes.

Call light response times included on:

- 11/01/2024 occurred at 7:56 AM and staff responded at 8:13 AM- waterproof pendent 1 push- 17 minutes
- 11/01/2024 occurred at 8:55 AM and staff responded at 9:23 PM-waterproof pendent 2 pushes- 28 minutes
- 11/01/2024 occurred at 5:35 PM and staff responded at 5:55 PM- waterproof

pendent 4 pushes-19 minutes
- 11/03/2024 occurred at 11:31 AM and staff responded at 12:22 PM-waterproof pendent 2 pushes- 51 minutes
- 11/04/2024 occurred at 2:31 PM and staff responded at 2:51 PM-waterproof pendent 2 pushes- 19 minutes
- 11/04/2024 occurred at 11:34 AM and staff responded at 11:55 AM-waterproof pendent 5 pushes- 20 minutes
- 11/08/2024 occurred at 8:52 PM and staff responded at 9:47 PM-waterproof pendent 1 push- 55 minutes
- 11/9/2024 occurred at 8:04 AM and staff responded at 8:37 AM-waterproof pendent 2 pushes- 32 minutes
- 11/09/2024 occurred at 5:01 PM and staff responded at 12:40 PM-waterproof pendent 1 push- 59 minutes
- 11/09/2024 occurred at 7:15 PM and staff responded at 7:50 PM-waterproof pendent 3 pushes- 35 minutes
- 11/10/2024 occurred at 6:16 AM and staff responded at 6:44 AM-waterproof pendent 3 pushes- 28 minutes
- 11/10/2024 occurred at 12:11 PM and staff responded at 12:49 PM-waterproof pendent 2 pushes- 37 minutes
- 11/10/2024 occurred at 9:22 PM and staff responded at 9:51 PM-waterproof pendent 1 push- 29 minutes
- 11/11/2024 occurred at 11:57 AM and staff responded at 12:25 PM-waterproof pendent 8 pushes- 28 minutes
- 11/12/2024 occurred at 9:33 PM and staff responded at 10:19 PM-waterproof pendent 6 pushes- 46 minutes
- 11/17/2024 occurred at 5:53 AM and staff responded at 7:00 AM-waterproof pendent 3 pushes- 66 minutes
- 11/17/2024 occurred at 11:56 AM and staff responded at 12:53 PM-waterproof pendent 1 push- 57 minutes
- 11/17/2024 occurred at 1:01 PM and staff responded at 1:29 PM-waterproof pendent 2 pushes- 27 minutes
- 11/17/2024 occurred at 5:04 PM and staff responded at 5:38 PM-waterproof pendent 2 pushes- 34 minutes
- 11/17/2024 occurred at 8:44 PM and staff responded at 10:03 PM-waterproof pendent 4 pushes- 78 minutes
- 11/18/2024 occurred at 6:32 PM and staff responded at 7:05 PM-waterproof pendent 2 pushes- 32 minutes
- 11/18/2024 occurred at 7:22 PM and staff responded at 10:02 PM-waterproof pendent 8 pushes- 159 minutes
- 11/20/2024 occurred at 10:48 AM and staff responded at 3:01 PM-waterproof pendent 4 pushes- 252 minutes
- 11/20/2024 occurred at 6:56 PM and staff responded at 8:29 PM-waterproof pendent 5 pushes- 93 minutes
- 11/20/2024 occurred at 10:19 PM and staff responded at 10:46 PM-waterproof pendent 3 pushes- 27 minutes
- 11/21/2024 occurred at 7:00 PM and staff responded at 7:55 PM-waterproof pendent 2 pushes- 54 minutes
- 11/22/2024 occurred at 8:40 PM and staff responded at 9:07 PM-waterproof pendent 7 pushes- 27 minutes
- 11/24/2024 occurred at 9:27 AM and staff responded at 9:57 PM-waterproof pendent 25 pushes- 30 minutes

Statement of Deficiencies	License #: 2549	Compliance Determination #:50634
Plan of Correction	Tri-Cities Assisted Living	Completion Date
Page 7 of 12	Licensee: Greenlake Management Pasco, LLC	01/13/2025

On 12/13/2024 at 11:51 AM Staff A, stated that they do not have a policy on call light response times, but they strive to get them answered within fifteen minutes. They stated that after reviewing the call light response times, they acknowledged that they could be better and would be providing an in-service to staff on call light response times.

On 12/19/2024 at 11:55 AM, Staff C, Health and Wellness Director, stated acknowledged observing other residents assisting Resident 1 with wheelchair mobility.

On 01/13/2025 at 3:62 PM, Staff A, stated that they believe the staff were misinformed by a delegated aid regarding to not assist Resident 1. They stated that there had been a note from a physical therapist that showed the resident was encouraged to walk with rest breaks if able. They stated that during their investigation, the Business Office Manager (BOM) reported overhearing a caregiver (one that only works at the facility part-time) instruct another that Resident 1 needed to be coming down to the dining room by themselves. Staff A stated that the BOM told the caregivers, that that was not true, and that staff needed be helping the resident with cares. Staff A also stated they provided an in-service to staff on the importance of following the residents care plans and that they should not be forcing residents to do anything they cannot do.

This is a reoccurring citation previously cited on 12/27/2023 for WAC 388-78a-2660 (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, Tri-Cities Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/14/25 2/27/25

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

Administrator (or Representative) 2/19/25 Date

WAC 388-78A-2210 Medication services.

(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

On 12/13/2024 at 11:51 AM Staff A, stated that they do not have a policy on call light response times, but they strive to get them answered within fifteen minutes. They stated that after reviewing the call light response times, they acknowledged that they could be better and would be providing an in-service to staff on call light response times.

On 12/19/2024 at 11:55 AM, Staff C, Health and Wellness Director, stated acknowledged observing other residents assisting Resident 1 with wheelchair mobility.

On 01/13/2025 at 3:52 PM, Staff A, stated that they believe the staff were misinformed by a delegated aid regarding to not assist Resident 1. They stated that there had been a note from a physical therapist that showed the resident was encouraged to walk with rest breaks if able. They stated that during their investigation, the Business Office Manager (BOM) reported overhearing a caregiver (one that only works at the facility part-time) instruct another that Resident 1 needed to be coming down to the dining room by themselves. Staff A stated that the BOM told the caregivers, that that was not true, and that staff needed be helping the resident with cares. Staff A also stated they provided an in-service to staff on the importance of following the residents care plans and that they should not be forcing residents to do anything they cannot do.

This is a reoccurring citation previously cited on 12/27/2023 for WAC 388-78a-2660 (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, Tri-Cities Assisted 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-2210 Medication services.

(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 facility failed to ensure residents who required medication assistance, received their medications as prescribed for 1 of 6 residents (Resident 1). This failure contributed to Resident 1's discomfort, swellings of legs and untreated edema from high potassium.

Findings included...

Review of Resident 1's Negotiated Service Agreement (NSA), dated 02/23/2024, showed the resident had a diagnosis of [redacted], and was receiving medication assistance including re-ordering of medications through RX [prescription] pharmacy by the Medication Aid or Licensed Nurse.

Review of Resident 1's Patient Summary Emergency Room (ER) visit note, dated 11/23/2024, showed that the resident was seen in the ER for edema (general swelling throughout the body) and hyperkalemia (too much potassium in your blood, which can cause muscle weakness, irregular heartbeat, or in severe cases, even life-threatening arrythmias if left untreated). Additional instructions included were that the resident had been prescribed Furosemide (medication to reduce fluid retention) and was to take 40 milligrams (mg) in addition to the Furosemide 20 mg they were currently taking. After the seven days the resident was to continue with their previous dose of 20 mg daily.

Review of Resident 1's Progress Notes, dated 11/23/2024 at 9:49 PM, showed that the resident returned from the hospital after being seen for edema and hyperkalemia. Resident returns with new order for medication Furosemide 40 mg to take in addition to already prescribed Lasix 20 mg.

Review of Resident 1's Medication Administration Record (MAR) for November 2024, showed the resident did not receive furosemide of 40 mg from the 24th-26th (3 days).

In an interview on 11/25/2024 at 9:56 AM, Collateral Contact 1 (CC1), Resident Representative stated that they received a call from the ER staff informing them that Resident 1 was at the hospital and was being treated for high potassium. CC1 stated that Resident 1's legs were swollen and "liquid was coming out of their legs." They stated that the resident was supposed to be receiving Furosemide 40 mg per the hospitals discharge orders but had called the facility and was told they were only administering 20 mg of Furosemide.

On 11/25/2024 at 12: 16 PM Resident 1, stated that they had pain to their right arm, their legs, and had a history of a fractured shoulder.

On 11/25/2024 at 12:39 PM, Resident 1 was observed sitting in their wheelchair. The resident had edema (swelling) of both lower legs, feet, ankles, and hands. Additionally, there were dressings noted to both lower leg extremities from below the knee to the ankle that were wrapped with Kerlix (a type of gauze roll used for wound care and absorbing drainage) that was visibly soiled and damp with yellow discoloration around the edges.

In an interview on 11/25/2024 at 1:31 PM, Staff B, Medication Technician (MT), stated that they had the hospital discharge paperwork dated on 11/23/2024 indicating that the resident was to receive Furosemide 40mg (a medication that helps remove excess fluid from the body, reducing swelling in the legs, ankles, and feet) for seven days, but acknowledged that they had not administered the prescribed dose for the last two days that they had worked. Staff B stated the new order had not been in the MAR, and that they were not sure if the new orders were sent to the pharmacy. Staff B stated the process for residents retuning back from the hospital was to review the discharge paperwork for new orders and fax them to the pharmacy. Staff B stated their protocol required stamping the paperwork and initialing to confirm completion of tasks, including inputting new orders into the MAR and faxing order to the pharmacy. However, Staff B noted that the paperwork lacked initials confirming these tasks had been completed.

In an interview on 11/25/2024 at 1:57 PM, Staff A, Administrator, stated that they were not aware of the medication changes for Resident 1's furosemide order on 11/23/2024. Staff A stated that the facility's process for medication orders was for the Med Tech to update the MAR and send the new order to the pharmacy. Staff A stated that the pharmacy delivers medication on the weekends and was not sure why it had not arrived.

In an interview on 11/25/2024 at 1:59 PM, Staff C, Health and Wellness Director stated they were not aware that Resident 1 had returned from the hospital or were unaware of any medication changes.

In an interview on 12/31/2024 at 9:32 AM, Collateral Contact 3 (CC3), Primary Care Provider stated that it is their expectation that when a resident returns from the hospital, the facility should follow the discharge orders until they see the patient. CC3 stated the facility can reach them or their staff at any time of the day and seven days a week for questions or concerns.

Statement of Deficiencies	License #: 2549	Compliance Determination #506534
Plan of Correction	Tri-Cities Assisted Living	Completion Date
Page 10 of 12	Licensee: Greenlake Management Pasco, LLC	01/13/2025

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, Tri-Cities Assisted Living is or will be in compliance with this law and / or regulation on (Date) 3/4/25 2/27/25

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

Administrator (or Representative) 2-19-25 Date

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 interviews and record review the Assisted Living Facility (ALF) failed to fully implement their policy on alert charting when a resident's condition required heightened blood pressure monitoring for effectiveness of newly prescribed blood pressure medications for 1 of 6 Residents (Resident 1). This failure placed the resident at risk for serious health complications, including uncontrolled hypertension (high blood pressure) and contributed to the resident requiring emergency medical interventions.

Findings included...

Review of the ALF's policy "Alert Charting" dated 02/15/2024, showed that alert charting would be implemented when a resident's condition requires increased monitoring and observation for a limited period of time, or until the condition is resolved. Additionally, the policy showed that unless otherwise directed by the Licensed Nurse or Health Services Director, conditions or events that require alert charting include, but are not limited to: New Medications-any obvious side effect. Staff are to look up each new medication in medication book. Check to see if medication is having the desired effect (ex. sedative-improved sleep, antihypertensive-lower blood pressure).

Review of Resident 1's Assessment, dated 12/03/2024, showed that the resident had a diagnosis [redacted], and [redacted]

Plan/Attestation Statement

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_____ _____
Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

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Based on interviews and record review the Assisted Living Facility (ALF) failed to fully implement their policy on alert charting when a resident's condition required heightened blood pressure monitoring for effectiveness of newly prescribed blood pressure medications for 1 of 6 Residents (Resident 1). This failure placed the resident at risk for serious health complications, including uncontrolled hypertension (high blood pressure) and contributed to the resident requiring emergency medical interventions.

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Review of the ALF's policy "Alert Charting" dated 02/15/2024, showed that alert charting would be implemented when a resident's condition requires increased monitoring and observation for a limited period of time, or until the condition is resolved. Additionally, the policy showed that unless otherwise directed by the Licensed Nurse or Health Services Director, conditions or events that require alert charting include, but are not limited to: New Medications-any obvious side effect. Staff are to look up each new medication in medication book. Check to see if medication is having the desired effect (ex: sedative-improved sleep, antihypertensive-lower blood pressure).

Review of Resident 1's Assessment, dated 12/03/2024, showed that the resident had a diagnosis [redacted] ([redacted]), and [redacted] ([redacted]).

On 11/25/2024 at 9:56 AM, Collateral Contact 1 (CC1), stated that they were concerned that Resident 1's blood pressure was not being monitored at the facility, despite multiple hospital visits and a follow up appointment with the Orthopedic doctor, during which high blood pressures were noted. CC1 informed the facility that both the orthopedic doctor and the hospital nurse had advised close monitoring of the resident's blood pressure. However, the facility refused to check the blood pressure without orders from the resident's primary care provider.

On 11/25/2024 at 12: 16 PM Resident 1, stated that the facility had not been checking their blood pressure, despite being informed by the emergency room that their blood pressure was high and needed close monitoring. Resident 1 stated they only recently began checking their blood pressure after their sister repeatedly called the facility.

Review of Resident 1's ER visit report dated 10/20/2024, showed that the resident presented to the ER for seizure-like activity. The resident was found to be hypoglycemic (low blood sugars) with a blood sugar of 56 (normal 80-130). Resident 1 also was also found to have a high Potassium level of 7.5 (normal range 3.5-4.9), and a high blood pressure of 238/98 (normal blood pressure 120/80). The ER visit note also showed that this is thought to have caused their seizure-like activity.

Review of a progress note dated 11/05/2024 at 4:18 AM, showed that the physical therapist reported to staff an increased blood pressure of 168/84.

Review of a progress note dated 11/05/2024 at 2:13 PM, showed that the resident was taken to the emergency room, per the primary care provider's request.

Review of Resident 1's second ER visit report dated 11/05/2024 showed that the resident presented to the ED due to a hypertensive urgency (elevated blood pressure readings) causing pulmonary edema (fluid buildup in the lungs). Review of Resident 1's discharge summary dated [redacted]/2024, showed that the resident was to follow up with their primary care provider as soon as possible, and was to start taking the following new medications: Clonidine, Amlodipine, and Hydralazine (all used to treat high blood pressure).

Review of Resident 1's Medication Administration Records (MAR's) for October and November, showed no additional blood pressure monitoring beyond the once-a-month check.

Review of a progress note dated 11/01/2024 at 6:13 PM, showed that the physical therapist reported to staff an increased blood pressure of 208/97, no additional monitoring of blood pressures reported or documented by the facility.

Review of a progress note dated 11/12/2024 at 5:42 AM, showed that the resident was seen by the physical therapist who reported an increased blood pressure reading to the facility of 177/84. No additional blood pressures were documented or reported by the facility.

Review of Resident 1's ER visit report dated 11/23/2024, showed that the resident was taken to the ER and evaluated for complaints of lower extremity edema and reports of Hyperkalemia (high potassium). Resident 1 complained of bilateral lower extremity leg pain and was noted to have bilateral lower extremity swelling and bilateral stasis dermatitis (skin inflation in the lower legs caused by fluid buildup). Further physical exam notes from the hospital records showed that the resident had a blood pressure of 213/87 at 12:34 PM, 173/87 at 2:41 PM, 188/87 at 3:35 PM, and 171/91 at 5:25 PM.

On 11/26/2024 at 1:31 PM, Staff B, Medication Technician (MT), stated that the resident had returned from the hospital and when asked if their blood pressure was being monitored, they confirmed that they were not.

On 1/13/2024 at 3:52 PM, Staff A stated that the staff does not need an order to monitor blood pressures and acknowledged that it was their policy to check blood pressures if a resident has a newly prescribed antihypertensive medication. Staff A stated they would be providing education on the need for monitoring blood pressures when a resident is put on alert charting for new blood pressure medications. Staff A acknowledged that this should have been done in this case.

This is a reoccurring citation previously cited on 09/25/2024 for WAC 388-78a-2600 (1).

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Administrator (or Representative) — Date: 2.19.25

Review of a progress note dated 11/12/2024 at 5:42 AM, showed that the resident was seen by the physical therapist who reported an increased blood pressure reading to the facility of 177/84. No additional blood pressures were documented or reported by the facility.

Review of Resident 1's ER visit report dated 11/23/2024, showed that the resident was taken to the ER and evaluated for complaints of lower extremity edema and reports of Hyperkalemia (high potassium). Resident 1 complained of bilateral lower extremity leg pain and was noted to have bilateral lower extremity swelling and bilateral stasis dermatitis (skin inflation in the lower legs caused by fluid buildup). Further physical exam notes from the hospital records showed that the resident had a blood pressure of 213/92 at 12:34 PM, 173/82 at 2:41 PM, 188/87 at 3:35 PM, and 171/91 at 5:25 PM.

On 11/25/2024 at 1:31 PM, Staff B, Medication Technician (MT), stated that the resident had returned from the hospital and when asked if their blood pressure was being monitored, they confirmed that they were not.

On 1/13/2024 at 3:52 PM, Staff A stated that the staff does not need an order to monitor blood pressures and acknowledged that it was their policy to check blood pressures if a resident has a newly prescribed antihypertensive medication. Staff A stated they would be providing education on the need for monitoring blood pressures when a resident is put on alert charting for new blood pressure medications. Staff A acknowledged that this should have been done in this case.

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Administrator (or Representative) Date