



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

01/30/2025

Greenlake Management Columbian, LLC
Royal Columbian Senior Living
5615 W Umatilla Ave
Kennewick, WA 99336

RE: Royal Columbian Senior Living # 2581

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 53648 (Completion Date 01/30/2025) and 51123 (Completion Date 12/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/30/2025 and found no deficiencies.

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

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

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

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

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

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

- (a) Orientation and safety;
- (b) Basic;
- (d) Cardiopulmonary resuscitation and first aid; and
- (e) Continuing education.

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

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

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

The Department staff who did the On Site verification:

Elizabeth Hall, AFH/ALF Licensors

Robin Rainville, Assisted Living Facility Licensors

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G

Residential Care Services



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

Statement of Deficiencies	License #: 2581	Compliance Determination # 51123
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 10	Licensee: Greenlake Management Columbian, LLC	12/12/2024

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

The department completed data collection for an unannounced on-site follow-up on 12/04/2024 and 12/04/2024 of:

Royal Columbian Senior Living
5615 W Umatilla Ave
Kennewick, WA 99336

This document references the following SOD dated: 12/12/2024

The following sample was selected for review during the unannounced on-site visit: 6 of 72 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Robin Rainville, Assisted Living Facility Licensors
Elaine Lopez, Licensors
Elizabeth Hall, AFH/ALF Licensors

From:

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

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

Laura Williams-Davis
Residential Care Services

12/24/2024

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.

This document was prepared by Residential Care Services for the Locator website.



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
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Residential Care Services

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Statement of Deficiencies	License #: 2581	Compliance Determination # 51123
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Administrator (or Representative)

12/31/24

Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

- (a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;
- (b) Complete an assessment specifically focused on a resident's identified problems and related issues:
 - (i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete accurate assessments for residents with identified issues for 2 of 6 residents (Resident 6 and 4). This failure placed the residents at risk of a decline in their chronic medical conditions and of unmet care needs.

Findings included...

Review of the Department of Social and Health Services Statement of Deficiencies, dated 10/10/2024, showed, "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. 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." The administrator section showed that Staff H, Administrator, signed the document on 10/30/2024. Staff H signed the "Plan/Attestation Statement" for all deficiencies cited that read, "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, [the facility] is or will be in compliance with this law and/or regulation on 11/15/2024."

<Resident 6>

Observation on 12/04/2024 at 2:13 PM showed that Resident 6 was seated in a motorized wheelchair. Resident 6 was observed to have their right leg amputated (surgical removal of a part of the body) above the knee.

Review of the facility's characteristic roster, undated, showed that Resident 6 had wounds and/or skin issues.

Administrator (or Representative)

Date

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<Resident 6>

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Review of the facility's characteristic roster, undated, showed that Resident 6 had wounds and/or skin issues.

Review of Resident 6's quarterly physician's orders signed 10/16/2024, showed an order, originally dated 10/28/2019, that the resident was prescribed, "weekly skin checks to be performed by a licensed nurse with emphasis on foot/toes/buttocks for skin breakdown."

Review of Resident 6's full facility assessment, dated 10/28/2024, showed that the resident had a diagnosis of [REDACTED]

and [REDACTED]

The assessment showed that the resident had, "no skin issues." The assessment did not show the resident's chronic skin ulcer to the left toe or the need for weekly skin checks by a licensed nurse. Additionally, the assessment did not show that Resident 6 had a leg amputation.

Review of Resident 6's November 2024 and December 2024 Medication Administration Records (MARs) showed an order, originally dated 10/24/2024, for staff to "keep area clean and dry, cleanse with wound cleaner or saline, pat dry then apply betadine daily" for a diagnosed [REDACTED].

Review of a progress note in Resident 6's record, dated 11/24/2024, showed that a Medication Technician (MT) had cleansed and bandaged the wound on Resident 6's toe.

In an interview on 12/04/2024 at 2:13 PM, Resident 6 stated that they had the right leg amputated around the year 2017. Resident 6 stated that they had a wound on the toe of their left foot that was painful at times. Resident 6 stated that no nurse from the facility had assessed the wound, and that the wound, "had a smell."

In an interview on 12/04/2024 at 3:59 PM, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that there was no documentation in Resident 6's record to show that a nurse had assessed Resident 6's wound to their left foot. Staff G stated that this was the first time they had learned that Resident 6 had a wound. Staff G also stated that they had been the nurse who updated Resident 6's full assessment on 10/28/2024.

<Resident 4>

Review of the facility's characteristic roster, undated, showed that Resident 4 required nursing services. The roster showed that Resident 4 had insulin dependent diabetes (a disease in which the body was unable to regulate sugar in the blood stream properly and required administration of an injected insulin to regulate the sugar levels).

Review of resident 4's nurse delegation nursing visit form, dated 08/12/2024, showed that the resident had a diagnosis of [REDACTED]. The form showed that Resident 4 required

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administration of insulin and finger stick blood sugar checks (a blood sample taken from the finger to test the levels of sugar in the blood) by a specially trained and delegated MT.

Review of Resident 4's quarterly physician's orders signed 10/09/2024, showed an order, originally dated 11/03/2023, that the resident was prescribed insulin injections with the dosage determined by the result of the blood sugar test.

Review of Resident 4's full facility assessment, dated 10/15/2024, showed that the resident required medication assistance only. The assessment showed that Resident 4 did not require medication administration. The assessment did not show that Resident 4 required administration of insulin and blood sugar checks by a delegated MT.

In an interview on 12/04/2024 at 9:45 AM, Staff H, Administrator, they and Staff G were responsible for reviewing all updated assessments and maintaining compliance with the regulation.

In an interview on 12/04/2024 at 3:45 PM, Staff B, Resident Care Coordinator, stated that delegated MTs did administer Resident 4's insulin injections and blood sugar checks.

This is an uncorrected deficiency previously cited on 10/10/2024 for subsection (2)(a) and a recurring deficiency previously cited on 02/21/2023 for subsection (2)(a).

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/23/25.

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



Administrator (or Representative)

12/31/24

Date

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

- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or

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Review of Resident 4's full facility assessment, dated 10/15/2024, showed that the resident required medication assistance only. The assessment showed that Resident 4 did not require medication administration. The assessment did not show that Resident 4 required administration of insulin and blood sugar checks by a delegated MT.

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Administrator (or Representative)

Date

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(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to evaluate a reoccurring condition experienced by 1 of 1 resident (Resident 6). This failure placed the resident at risk of complications from their chronic health condition.

Findings included...

Review of the Department of Social and Health Services Statement of Deficiencies, dated 10/10/2024, showed, "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. 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." The administrator section showed that Staff H, Administrator, signed the document on 10/30/2024. Staff H signed the "Plan/Attestation Statement" for all deficiencies cited that read, "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, [the facility] is or will be in compliance with this law and/or regulation on 11/15/2024."

Review of Resident 6's quarterly physicians orders signed 10/16/2024, showed an order, originally dated 10/28/2019, that the resident was prescribed weekly skin checks to be performed by a licensed nurse with emphasis on foot/toes/buttocks for skin breakdown.

Review of Resident 6's full facility assessment, dated 10/28/2024, showed that the resident had a diagnosis of [REDACTED] and [REDACTED]

[REDACTED] The assessment showed that the resident had, "no skin issues." The assessment showed that Resident 6 was not evaluated for the chronic skin ulcer to their left toe or the need for weekly skin checks to be done by a licensed nurse.

Review of Resident 6's progress notes, dated 11/20/2024 to 12/02/2024, showed no evaluation of the resident's skin performed by a licensed nurse.

In an interview on 12/04/2024 at 9:50am, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that if a resident had a change of condition a nurse would update the resident's assessment and care plan.

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In an interview on 12/04/2024 at 2:13 PM, Resident 6 stated that they had a wound on their left foot that had a foul odor. Resident 6 stated that they were told by their doctor that they may need surgery to amputate (surgical removal of a part of the body) the toe on the left foot due to the declining condition of the wound. Additionally, Resident 6 stated that no nurse from the facility had looked at their wound.

In an interview on 12/04/2024 at 3:03 PM, Staff G stated that they had completed Resident 6's full assessment, dated 10/28/2024. Staff G stated that they were not aware of Resident 6's wound. Staff G stated that they had missed the wound when they updated Resident 6's full assessment.

In an interview on 12/04/2024 at 3:59 PM, Staff G stated that there was no documentation in Resident 6's record to show that any facility nurse had evaluated the wound or performed weekly skin checks.

This is a repeated deficiency previously cited on 04/10/2024, 10/31/2023, 6/09/2023, and 04/04/2022 for subsections (3) and uncorrected deficiency previously cited on 10/10/2024 for subsections (3).

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) <u>11/23/25</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>12/31/24</u> Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

- (a) Orientation and safety;
- (b) Basic;
- (c) Cardiopulmonary resuscitation and first aid; and

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- (a) Orientation and safety;
- (b) Basic;
- (d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff received continuing education for 1 of 1 staff (Staff K). This failure placed residents at risk of being cared for by untrained staff.

Findings included...

Review of the Department of Social and Health Services Statement of Deficiencies, dated 10/10/2024, showed, "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. 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." The administrator section showed that Staff H, Administrator, signed the document on 10/30/2024. Staff H signed the "Plan/Attestation Statement" for all deficiencies cited that read, "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, [the facility] is or will be in compliance with this law and/or regulation on 11/15/2024."

Review of WAC 388-112A-0611 showed that staff were to obtain 12 hours of Continuing Education (CE) credits from birthday to birthday every year.

In an interview on 12/04/2024 at 10:15 AM, Staff H stated that to be back in compliance with the regulation, the facility had created a tracking sheet to monitor staff's completion of CEs every month. Staff H stated that they reminded staff during all staff meetings to complete their 12 CE hours before their birthday.

Review of the personnel file for Staff K, (Health Services Director), showed that they were hired on 01/16/2014. Staff K's file showed that they had completed zero hours of CE credits from their birthday in 2023 to their birthday in 2024.

In an interview on 12/04/2024 at 3:45 PM, Staff H confirmed that Staff K had not completed any CE credits for the year.

This is an uncorrected deficiency previously cited on 10/10/2024 for subsection 2e.

Plan/Attestation Statement

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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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 1/23/25.

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


 Administrator (or Representative)

12/31/24
 Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to inform each resident at least every twenty-four months in writing of the service items, charges, activities available in the facility, and the rules of the facility's operation for 3 of 3 residents (Residents 1, 2, and 6). This failure did not allow residents to make informed decisions regarding living choices at the facility.

Findings included...

Review of the Department of Social and Health Services Statement of Deficiencies, dated 10/10/2024, showed, "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. I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and

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(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

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In an interview on 12/04/2024 at 10:45 AM, Staff H stated that they had not been able to update twenty-four-month rental agreements for residents.

In an interview on 12/04/2024 at 3:25 PM, Staff I, Business Office Manager, stated that it was the responsibility of Staff J, Sales Specialist, to review the facility's full admission agreement, to inform residents of the available service items, charges, activities, and the rules of the facility's operation with residents.

Review of the facility's characteristic roster, undated, showed that Resident 1 moved into the facility on 08/26/2022. Resident 1's record showed the most current rental agreement was signed 08/16/2022. The record did not show that Resident 1 had been informed every twenty-four months of the facility's available service items, charges, activities, and the rules of the facility's operation.

Review of the facility's characteristic roster, undated, showed that Resident 2 moved into the facility on 12/18/2017. Resident 2's record showed the most current rental agreement was signed 02/18/2019. The record did not show that Resident 2 had been informed every twenty-four months of the facility's available service items, charges, activities, and the rules of the facility's operation.

Review of the facility's characteristics roster, undated, showed that Resident 6 moved into the facility on 12/30/2011. Resident 6's record showed the most current rental agreement was signed 02/30/2019. The record did not show that Resident 6 had been informed every twenty-four months of the facility's available service items, charges, activities, and the rules of the facility's operation.

This is an uncorrected deficiency previously cited on 10/10/2024 for subsection (1)(4).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/21/25.

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

regulations at all times.” The administrator section showed that Staff H, Administrator, signed the document on 10/30/2024. Staff H signed the “Plan/Attestation Statement” for all deficiencies cited that read, “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, [the facility] is or will be in compliance with this law and/or regulation on 11/15/2024.”

In an interview on 12/04/2024 at 10:45 AM, Staff H stated that they had not been able to update twenty-four-month rental agreements for residents.

In an interview on 12/04/2024 at 3:25 PM, Staff I, Business Office Manager, stated that it was the responsibility of Staff J, Sales Specialist, to review the facility’s full admission agreement, to inform residents of the available service items, charges, activities, and the rules of the facility’s operation with residents.

Review of the facility’s characteristic roster, undated, showed that Resident 1 moved into the facility on [REDACTED]/2022. Resident 1’s record showed the most current rental agreement was signed 08/16/2022. The record did not show that Resident 1 had been informed every twenty-four months of the facility’s available service items, charges, activities, and the rules of the facility’s operation.

Review of the facility’s characteristic roster, undated, showed that Resident 2 moved into the facility on [REDACTED]/2017. Resident 2’s record showed the most current rental agreement was signed 02/18/2019. The record did not show that Resident 2 had been informed every twenty-four months of the facility’s available service items, charges, activities, and the rules of the facility’s operation.

Review of the facility’s characteristics roster, undated, showed that Resident 6 moved into the facility on [REDACTED]/2011. Resident 6’s record showed the most current rental agreement was signed 02/30/2019. The record did not show that Resident 6 had been informed every twenty-four months of the facility’s available service items, charges, activities, and the rules of the facility’s operation.

This is an uncorrected deficiency previously cited on 10/10/2024 for subsection (1)(4).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Statement of Deficiencies	License #: 2581	Compliance Determination # 51123
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 10 of 10	Licensee: Greenlake Management Columbian, LLC	12/12/2024


Administrator (or Representative)

12/31/24
Date



Residential Care Services Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living	Provider Type: Assisted Living Facility
License/Cert.#: 2581	Intake ID: 148145
Compliance Determination #: 47766	Region/Unit #: RCS Region 1 / Unit G
Investigator: Robin Rainville	
Investigation Date(s): 09/30/2024 through 10/10/2024	
Complainant Contact Date(s): 09/30/2024	

Allegation(s):

Side effects from not receiving medication.

Investigation Methods:

Sample: Total residents: 69
Resident sample size: 9
Closed records sample size: 0

Observations: Residents
Medication administration
Medication carts and audits
Narcotic counts
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Kitchen
Food preparation
Dining Service
General facility environment

Interviews: Residents
Nursing staff
Family members
Maintenance staff
Business office manager
Kitchen staff
Administrator
Corporate staff

Record Reviews: Medical records- Face sheet, medication records, physician orders, care plans, progress notes, narcotic logs
Hospital records
Grievance log
Incident investigations

Investigation Summary:

Interviews and record review showed that as needed medications for constipation was not provided to the named resident by the facility. Interviews showed that the named resident had complications due to the constipation and was hospitalized. Failed practice was identified. Refer to Washington Administrative Code (WAC) 388-78A-2100(a)(b)(i) and WAC 388-78A-2210(1)(b)(2)(b).

Conclusion / Action:

- ☒ 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: Royal Columbian Senior Living

License/Cert.#: 2581

Compliance Determination #: 47766

Investigator: Robin Rainville

Investigation Date(s): 09/30/2024 through 10/10/2024

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 145824

Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1. Named resident missed 8 days of meds
2. The ALF borrowed meds from someone else to give to the named resident.
3. Many of the staff do not understand English which makes it hard for residents to communicate.

Investigation Methods:

Sample: Total residents: 69
Resident sample size: 9
Closed records sample size: 0

Observations: Identified resident
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Kitchen
Food preparation
Dining Service
General facility environment
Medication carts and audits
Narcotic counts

Interviews: Identified resident
Nursing staff
Residents
Family members
Maintenance staff
Business office manager
Kitchen staff
Administrator
Corporate staff

Record Reviews: Medical records- Medication records, physician orders, care plans, progress notes, narcotic logs
Hospital records
Grievance log
Incident investigations
Facility policies
Personnel files
Staff training records
Staff patterns
Resident characteristic roster
Resident council minutes

Investigation Summary:

1. Observation, interview and record review showed that medications on the Medication Administration Records (MARS) did not accurately reflect medications being given, many medications for the sampled residents were not available to be given, and/or medications were not being given as ordered. Failed practice identified. See the Statement of Deficiency dated 10/09/2025 for medication services, Washington Administrative Code (WAC) 388-78a-2210 and medications not available, WAC 388-78a-2240.
 2. Resident interviews showed this was a concern. Staff interviews and record reviews did not show evidence of residents being given other residents' medications. The MARS showed inconsistent documentation of medications not available. Allegation unsubstantiated, no failed practice identified.
 3. Observation showed staff speaking to and around residents in English. Resident council meeting minutes showed this issue was brought to management. Interviews showed it was facility policy to speak English when near residents. No failed practice identified.
-

Conclusion / Action:

- ☒ 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: Royal Columbian Senior Living	Provider Type: Assisted Living Facility
License/Cert.#: 2581	Intake ID: 149177
Compliance Determination #: 47766	Region/Unit #: RCS Region 1 / Unit G
Investigator: Robin Rainville	
Investigation Date(s): 09/30/2024 through 10/10/2024	
Complainant Contact Date(s): 10/09/2024	

Allegation(s):

1. Medications given late.
 2. Care not being provided timely.
 3. Medications given without water.
 4. Personal care provided in public areas.
-

Investigation Methods:

Sample:	Total residents: 69 Resident sample size: 9 Closed records sample size: 0
Observations:	Activities Dining Resident rooms Resident care equipment Staff to resident interactions Resident to resident interactions Medication administration Kitchen Food preparation
Interviews:	Nursing staff Residents Family Members Caregivers Maintenance staff
Record Reviews:	Resident Records (face sheet, assessment, care plan, progress notes, home health notes) Grievance log Incident investigation Facility policies Personnel files Staff training records

Investigation Summary:

1. Record review, interview and observation showed that the Assisted Living Facility (ALF) staff administered the named resident's medication more than an hour after the scheduled time. Failed practice was identified. Refer to Washington Administrative Code (WAC) 388-78A-2210(1)(b)(2)(b)
2. Interview with staff showed that the resident received timely care. Observation showed that the named resident received care timely, was appropriately dressed, well-groomed and staff interactions with the resident were respectful. No failed practice identified.
3. Interview showed that ALF staff had water and cups available on the medication carts for medication administration. Observation showed that the named resident had juice and water available when staff administered their medications. No failed practice identified.
4. Interview showed that ALF staff could not provide personal care in a public areas for privacy reasons and showed that staff directed the named resident to a bathroom or their room to complete care. Observation showed staff completed the named resident's care and medication treatment in their bedroom for privacy. No failed practice identified.

Conclusion / Action:

- ☒ 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

Licensee: Greenlake Management Columbian, LLC
Royal Columbian Senior Living
5615 W Umatilla Ave
Kennewick, WA 99336

RE: Royal Columbian Senior Living License # 2581

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 10/10/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
 - o Mail the Plan/Attestation Statement and report with original signatures to:

Greenlake Management Columbian, LLC
Royal Columbian Senior Living # 2581
10/10/2024
Page 2 of 49

Stephanie Jenks, Field Manager
Residential Care Services
Region 1, Unit G
1200 Alder Street
Union Gap, WA 98903

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
 - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit G
Residential Care Services

Enclosure

10.23.2024 15:37:21

State of Washington



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 #: 2581	Compliance Determination # 47786
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 3 of 49	Licensee: Greenlake Management Columbian,	10/10/2024

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

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 09/30/2024, 10/01/2024, 10/02/2024, 10/03/2024 and 10/04/2024 of:

Royal Columbian Senior Living
5615 W Umatilla Ave
Kennewick, WA 99336

This document references the following complaint numbers: 148145, 145824, 149177.

The following sample was selected for review during the unannounced on-site visit: 9 of 69 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Tracy Ramirez, Assisted Living Facility Licenser
Elaine Lopez, Licenser
Elizabeth Hall, AFH/ALF Licenser
Jessica Clapp, Assisted Living Facility Licenser
Anna Cairns, ALF Long Term Care Surveyor
Robin Rainville, Assisted Living Facility Licenser

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.

This document was prepared by Residential Care Services for the Locator website.



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 #: 2581	Compliance Determination # 47766
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 3 of 49	Licensee: Greenlake Management Columbian,	10/10/2024

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

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 09/30/2024, 10/01/2024, 10/02/2024, 10/03/2024 and 10/04/2024 of:

Royal Columbian Senior Living
5615 W Umatilla Ave
Kennewick, WA 99336

This document references the following complaint numbers: 148145, 145824, 149177.

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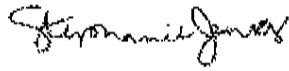
From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

10.23.2024 15:37:21

State of Washington

Statement of Deficiencies	License #: 2581	Compliance Determination # 47766
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 4 of 49	Licensee: Greenlake Management Columbian,	10/10/2024



10/23/2024

Residential Care Services

Date

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



Administrator (or Representative)

10/30/24

Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

- (1) Individual's recent medical history, including, but not limited to:
 - (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;
 - (2) Currently necessary and contraindicated medications and treatments for the individual, including:
 - (c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.
- (3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete a full assessment addressing the required elements for 2 of 2 residents (Residents 3 and 8). This failure placed the residents at risk of having unmet care needs.

Findings included...

<Resident 3>

Review of Resident 3's Department of Social and Health Services (DSHS) assessment, dated 01/05/2024, showed that the resident had diagnoses of [REDACTED]



10/23/2024

Residential Care Services

Date

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

Administrator (or Representative)

Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

- (1) Individual's recent medical history, including, but not limited to:
 - (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;
 - (2) Currently necessary and contraindicated medications and treatments for the individual, including:
 - (c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.
- (3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete a full assessment addressing the required elements for 2 of 2 residents (Residents 3 and 8). This failure placed the residents at risk of having unmet care needs.

Findings included...

<Resident 3>

Review of Resident 3's Department of Social and Health Services (DSHS) assessment, dated 01/05/2024, showed that the resident had diagnoses of [REDACTED]

[REDACTED]. The DSHS assessment showed that Resident 3 took medication for seizures and neuropathy.

In an interview on 10/02/2024 at 9:43 AM, Resident 3, stated that they had a history of a stroke, seizures, and neuropathy and took medications for both. Resident 3 stated that they have had increased seizures since moving into the ALF.

Review of Resident 3's physician visit note, dated 06/03/2024, showed that the resident had a seizure episode that week and, "a lot of pain in their legs."

Review of Resident 3's facility's progress note, dated 08/27/2024, showed that the resident had, "tremors."

Review of Resident 3's facility's progress note, dated 08/31/2024, showed that the resident had a seizure in their room and was given an as needed medication for seizures.

Review of Resident 3's facility's progress note, dated 09/05/2024, showed the resident had, "an episode (seizure)."

Review of Resident 3's full facility assessment, dated 06/29/2024, showed that the resident had a diagnosis of [REDACTED]. The facility's assessment did not include Resident 3's diagnoses of [REDACTED] and [REDACTED].

<Resident 8>

Review of Resident 8's July 2024, August 2024, and September 2024 Medication Administration Records (MARs) showed that the resident had diagnoses of [REDACTED] and [REDACTED]. The MARs showed that Resident 6 required insulin and blood sugar checks.

Review of Resident 8's nurse delegation nursing visit form, dated 08/12/2024, showed that the resident had nurse delegation for medication administration, blood sugar checks, and insulin (medication to control blood sugar levels) injections.

Observation on 10/01/2024 at 11:10 AM, showed Resident 8 sitting in their chair, with leg braces on their legs and orthopedic shoes on their feet. Resident 8 had their feet propped up on the seat of their electric wheelchair.

10.23.2024 15:37:21

State of Washington

Statement of Deficiencies	License #: 2581	Compliance Determination # 47766
Plan of Correction	Royal Columbian Senior Living	Completion Date
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Review of Resident 8's full facility assessment, dated 08/19/2024, showed it did not include the resident's diagnoses, that they had leg braces or orthotic shoes, that they used an electric wheelchair for ambulation, or that they had nurse delegation for their medications, insulin, and blood sugar checks.

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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



Administrator (or Representative)

10/30/24

Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

- (a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;
- (b) Complete an assessment specifically focused on a resident's identified problems and related issues;
- (i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to complete assessments for residents who had self-directed medication administration, mobility devices, significant diagnoses, and medications for 4 of 7 residents (Residents 1, 2, 7, and 9). This failure placed the residents at risk of unmet care needs and a decline of chronic medical conditions.

Findings included...

<Resident 1>

Observation on 10/01/2024 at 11:18 AM showed that Resident 1 walked with a walker with their right foot dragging slightly and their right hand contracted (a tightening and shortening of the muscles).

Review of Resident 8's full facility assessment, dated 08/19/2024, showed it did not include the resident's diagnoses, that they had leg braces or orthotic shoes, that they used an electric wheelchair for ambulation, or that they had nurse delegation for their medications, insulin, and blood sugar checks.

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

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

Administrator (or Representative)

Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to complete assessments for residents who had self-directed medication administration, mobility devices, significant diagnoses, and medications for 4 of 7 residents (Residents 1, 2, 7, and 9). This failure placed the residents at risk of unmet care needs and a decline of chronic medical conditions.

Findings included...

<Resident 1>

Observation on 10/01/2024 at 11:18 AM showed that Resident 1 walked with a walker with their right foot dragging slightly and their right hand contracted (a tightening and shortening of the muscles).

In an interview on 10/01/2024 at 11:25 AM, Resident 1 stated that they could not use their right hand, and the right side of their body had numbness due to a stroke (an interruption to the blood supply causing damage to the brain).

Review of Resident 1's full facility assessment, dated 04/08/2024, showed that the resident had not been assessed for their stroke and their right sided numbness and weakness.

<Resident 2>

Review of Resident 2's Department of Social and Health Services (DSHS) assessment, dated 01/05/2024, showed that the resident had diagnoses of [REDACTED] and [REDACTED]. The DSHS assessment showed that Resident 2 had a history of constipation and received multiple medications for constipation.

Review of Resident 2's full facility assessment, dated 08/19/2024, showed that it did not include Resident 2's diagnoses of [REDACTED] or [REDACTED].

In an interview on 10/01/2024 at 2:39 PM, Collateral Contact 2 (CC2), representative for Resident 2, stated that they felt it was important for the facility to assess Resident 2's bowel movements related to their chronic constipation issues and hospitalizations.

<Resident 7>

Review of Resident 7's demographic sheet, undated, showed that the resident moved into the facility on [REDACTED]/2023.

Behavioral Management

Review of Resident 7's DSHS assessment, dated 08/07/2024, showed that the resident had diagnoses that included [REDACTED] and [REDACTED]. The assessment showed that Resident 7 required a behavioral management plan.

Review of Resident 7's progress notes dated July 2024 – September 2024, showed that the resident had behaviors that included aggression, alcohol use, smoking in undesignated areas and demanding staff do their care immediately.

Review of Resident 7's full facility assessment, dated 10/07/2023, showed that it the resident's behaviors had not been assessed.

Observation on 10/02/2024 at 12:34 PM, showed that Resident 7 was agitated and demanded that their lunch meal be served immediately. Resident 7 yelled at staff and stated that they had ordered their lunch first and that other residents were served before them.

In an interview on 10/02/2024 at 10:14 AM, Staff C, Medication Technician (MT), stated that Resident 7 was impatient and that they wanted their care completed immediately after asking.

Dentures

In an interview on 10/02/2024 at 9:07 AM, Resident 7 stated that they could not wear their dentures and that their dentures had been broken since they moved into the facility.

Observation on 10/02/2024 at 09:07 AM, showed that Resident 7 had upper and lower dentures (artificial replacements for missing teeth) and that that the lower denture was broken in half. Observation showed that the breakfast meal delivered to the resident's room included crisp bacon.

In an interview on 10/03/2024 at 9:37 AM, Resident 7 stated that it was difficult for them to eat regular textured foods and that they needed food to be soft.

Review of Resident 7's full facility assessment, dated 10/07/2023, showed that the resident required cut up foods. The assessment did not show that Resident 7 had dentures.

In an interview on 10/03/2024 at 10:47 AM, Staff K, Health Services Director, stated that they did not know Resident 7 had dentures.

<Resident 9>

Review of Resident 9's DSHS assessment, dated 03/24/2024, showed that the resident had diagnoses of [REDACTED], and [REDACTED]. Additionally, the assessment showed that Resident 9 had a history of seizures, required administration of medications, pain management, and dietary supplement drinks.

10.23.2024 15:37:21

State of Washington

Statement of Deficiencies	License #: 2581	Compliance Determination # 47766
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 9 of 49	Licensee: Greenlake Management Columbian,	10/10/2024

Review of Resident 9's doctor's order, dated 08/21/2024, showed that the resident was prescribed weekly weights to be done by the facility and supplemental drinks with meals, three times a day.

Review of Resident 9's progress notes, dated 09/02/2024, showed that the resident had an open blister on their bottom and that the resident had requested wound care.

Review of Resident 9's doctor's order, dated 09/09/2024, showed that home health nursing for wound care was prescribed.

Review of Resident 9's progress notes, dated 09/16/2024, showed that a home health nurse measured the resident's wound and encouraged more protein intake and pressure offloading.

Review of Resident 9's, home health document titled, "Outside Health Services Coordination of Care Form," dated 09/26/2024, showed that there were instructions for staff to assist with toileting and cleansing after bowel movements and that, "Dressings are rolling up and stool getting into wound."

Observation on 10/03/2024 at 9:20 AM, showed that Resident 9's electric wheelchair was next to their bed and that they had a rail on the left side of their bed. Resident 9 stated, "That's mine, I put it on myself," when asked about the rail on their bed.

Interview on 10/03/2024 at 12:15 PM, Staff G acknowledged that there was not a bed rail assessment in Resident 9's record. Staff G stated that, "If it's not in the record, it has not been done."

Review of Resident 9's full facility assessment, dated 03/24/2024, did not include diagnoses of [REDACTED], and their history of seizures. Additionally, the assessment did not show the resident required weekly weights, the need for supplemental drinks, the need for skin assessments, wound care by home health, or their use of a bed rail.

This is a recurring deficiency previously cited on 02/21/2023 for subsection (2) (a).

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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

Review of Resident 9's doctor's order, dated 08/21/2024, showed that the resident was prescribed weekly weights to be done by the facility and supplemental drinks with meals, three times a day.

Review of Resident 9's progress notes, dated 09/02/2024, showed that the resident had an open blister on their bottom and that the resident had requested wound care.

Review of Resident 9's doctor's order, dated 09/09/2024, showed that home health nursing for wound care was prescribed.

Review of Resident 9's progress notes, dated 09/16/2024, showed that a home health nurse measured the resident's wound and encouraged more protein intake and pressure offloading.

Review of Resident 9's, home health document titled, "Outside Health Services Coordination of Care Form," dated 09/26/2024, showed that there were instructions for staff to assist with toileting and cleansing after bowel movements and that, "Dressings are rolling up and stool getting into wound."

Observation on 10/03/2024 at 9:20 AM, showed that Resident 9's electric wheelchair was next to their bed and that they had a rail on the left side of their bed. Resident 9 stated, "That's mine, I put it on myself," when asked about the rail on their bed.

Interview on 10/03/2024 at 12:15 PM, Staff G acknowledged that there was not a bed rail assessment in Resident 9's record. Staff G stated that, "If it's not in the record, it has not been done."

Review of Resident 9's full facility assessment, dated 03/24/2024, did not include diagnoses of [REDACTED], and their history of seizures. Additionally, the assessment did not show the resident required weekly weights, the need for supplemental drinks, the need for skin assessments, wound care by home health, or their use of a bed rail.

This is a recurring deficiency previously cited on 02/21/2023 for subsection (2) (a).

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

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

10.23.2024 15:37:21

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Rachael Stross
Administrator (or Representative)

10/30/24
Date

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

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(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

(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 evaluate, monitor and take action for changes of condition experienced by 2 of 2 residents (Resident 1 and 9). This failure contributed to Resident 9 having weight loss and Resident 1 experiencing pain, and placed residents at risk of complications from their chronic health conditions.

Findings included, .

<Resident 9>

Review of Resident 9's Department of Social and Health Services (DSHS) assessment, dated 03/20/2024, showed that the resident had diagnoses of [REDACTED]

and [REDACTED].

Review of Resident 9's doctor's order, dated 08/21/2024, showed that the resident was prescribed weekly weights to be done by the facility and a supplemental nutrition drink with meals, three times a day.

Review of Resident 9's full facility assessment, dated 03/26/2024, showed that the resident was not evaluated for the need for a supplemental nutrition drink with each meal or weight to be monitored. Resident 9's assessment showed that the resident had

Administrator (or Representative)

Date

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

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(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

(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 evaluate, monitor and take action for changes of condition experienced by 2 of 2 residents (Resident 1 and 9). This failure contributed to Resident 9 having weight loss and Resident 1 experiencing pain, and placed residents at risk of complications from their chronic health conditions.

Findings included...

<Resident 9>

Review of Resident 9's Department of Social and Health Services (DSHS) assessment, dated 03/20/2024, showed that the resident had diagnoses of [REDACTED]

[REDACTED], and [REDACTED].

Review of Resident 9's doctor's order, dated 08/21/2024, showed that the resident was prescribed weekly weights to be done by the facility and a supplemental nutrition drink with meals, three times a day.

Review of Resident 9's full facility assessment, dated 03/26/2024, showed that the resident was not evaluated for the need for a supplemental nutrition drink with each meal or weight to be monitored. Resident 9's assessment showed that the resident had

a regular diet.

Review of Resident 9's July 2024, August 2024 and September 2024 MAR showed that it did not include a supplemental drink that the resident's doctor had ordered.

Review of Resident 9's facility monthly weight log showed that the log did not include weekly weights for Resident 9. The log showed that Resident 9 weighed 36 pounds less in September 2024 than they did when their DSHS assessment was completed on 03/20/2024.

In an interview on 10/02/2024 at 9:55 AM, Resident 9 stated that they had, "Lost so much body weight."

In an interview on 10/04/2024 at 9:10 AM, Resident 9 stated that they had not received a supplemental drink with their dinner the night before. Additionally, Resident 9 stated that they had not been getting the supplemental drinks consistently with their meals.

Observation on 10/04/2024 at 9:30 AM showed a staff member dropped off a disposable container for Resident 9's breakfast which did not include a supplemental drink.

Review of Resident 9's record showed that the facility did not contact the resident's provider when the resident had significant weight loss. Further review of the documentation showed no action was taken by the facility for the resident's weight loss.

<Resident 1>

In an interview on 10/01/2024 at 11:25 AM, Resident 1 stated that staff managed their medication. Resident 1 stated that they missed a week of medication including pain medication, anti-depressant and blood pressure medication. Resident 1 stated they were in pain when the medications were missed.

Review of Resident 1's August 2024 and September 2024 MARs showed that the resident missed the following medication doses:

- August 2024 MAR showed that they had an order for a nerve pain medication to be given twice daily until 08/27/2024. The MAR showed that the medication was not given for 18 out of 53 doses.
- August 2024 MAR showed that the resident had an order for a medication to elevate mood, to be given daily at bedtime. The MAR showed that the medication was not given on 08/16/2024, 08/17/2024, and 08/22/2024, 08/23/2024, 08/24/2024 and 08/25/2024.
- September 2024 MAR showed that the resident had an order for a medication to treat muscle spasms and pain three times a day. The MAR showed that Resident 1 was not

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given their medication for muscle spasms and pain for 17 out of 90 doses.

-September MAR showed that the resident had an order for a medication to be given three times daily to reduce nerve pain. The MAR showed that Resident 1 missed the medication twice on 09/26/2024 and twice on 09/27/2024.

Review of Resident 1's record showed that they had not been evaluated or monitored for the effects of missing their pain, nerve and mood medications in August 2024 and September 2024. Further review of the documentation showed no action was taken by the facility for the resident's missed medications.

In an interview on 10/01/2024 at 1:43 PM, Staff K, Health Services Director, stated that the missed medications were not identified. Staff K further stated that when a resident missed medications, the resident should have been placed on alert charting to be monitored for the effects of missed medications.

This is a recurring deficiency previously cited on 04/10/2024 for subsections (3) (a) (4), 10/31/2023, 6/09/2023 for subsections (3) (a) (4), and 04/04/2022.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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


 Administrator (or Representative)

10/30/24
 Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the negotiated service agreement was agreed to and signed by the resident, their representative, and or the facility for 6 of 9 residents (Resident 1, 4, 5, 6, 8, and 9). This

given their medication for muscle spasms and pain for 17 out of 90 doses.

-September MAR showed that the resident had an order for a medication to be given three times daily to reduce nerve pain. The MAR showed that Resident 1 missed the medication twice on 09/26/2024 and twice on 09/27/2024.

Review of Resident 1's record showed that they had not been evaluated or monitored for the effects of missing their pain, nerve and mood medications in August 2024 and September 2024. Further review of the documentation showed no action was taken by the facility for the resident's missed medications.

In an interview on 10/01/2024 at 1:43 PM, Staff K, Health Services Director, stated that the missed medications were not identified. Staff K further stated that when a resident missed medications, the resident should have been placed on alert charting to be monitored for the effects of missed medications.

This is a recurring deficiency previously cited on 04/10/2024 for subsections (3) (a) (4), 10/31/2023, 6/09/2023 for subsections (3) (a) (4), and 04/04/2022.

Plan/Attestation Statement

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Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the negotiated service agreement was agreed to and signed by the resident, their representative, and or the facility for 6 of 9 residents (Resident 1, 4, 5, 6, 8, and 9). This

failure placed residents at risk of unmet care needs and receiving services that were not agreed upon.

Findings included...

<Resident 1>

Review of the facility's resident characteristic roster showed that Resident 1's move in date was [REDACTED]/2022.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/08/2024, showed that the signature lines were blank.

<Resident 4>

Review of the facility's resident characteristic roster showed that Resident 4's move in date was [REDACTED]/2023.

In an interview on 10/01/2024 at 10:52 AM, Resident 4 stated that they could not remember signing their NSA with an ALF staff member. Resident 4 stated that they thought maybe it was signed when they had moved in and not since then.

Review of Resident 4's NSA, dated 08/19/2024, showed that the signature lines were blank.

<Resident 5>

Review of the facility's resident characteristic roster showed that Resident 5's move in date was [REDACTED]/2023.

In an interview on 10/02/2024 at 9:00 AM, Resident 5 stated, "I have never signed anything, my sister would have."

In an interview on 10/07/2024 at 2:23 PM Collateral Contact 1 (CC1), representative for Resident 5, stated that they signed an NSA when the resident moved in and had not received and/or signed any documents from the facility since then.

Review of Resident 5's NSA, dated 10/29/2023, showed that the signature lines were

blank.

<Resident 6>

Review of the facility's resident characteristic roster showed that Resident 6's move in date was [REDACTED]/2024.

Review of Resident 6's NSA, dated 08/27/2024, showed that the signature lines were blank.

<Resident 8>

Review of the facility's resident characteristic roster showed that Resident 8's move in date was [REDACTED]/2024.

Review of Resident 8's NSA, dated 02/12/2024, showed that the signature lines were blank.

<Resident 9>

Review of the facility's resident characteristic roster showed that Resident 9's move in date was [REDACTED]/2023.

In an interview on 10/02/2024 at 9:50 AM, Resident 9 stated that about a month after they had moved into the facility, staff brought in just the signature page for them to sign and it did not include the care services outlined in the NSA.

Review of Resident 9's NSA, dated 03/26/2024, showed that the signature lines were blank.

In an interview on 10/01/2024 at 3:08 PM, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that if the NSA's provided were not signed then the ALF did not have them signed as required, and they should have.

In an interview on 10/08/2024 at 5:00 PM, Staff H, Director of Sales and Marketing, stated that the ALF did not have an official policy on having care plan signed.

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



Administrator (or Representative)

10/30/24
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 medication was given as prescribed and failed to develop and ensure a safe medication system was in place for residents who required assistance and administration with their medication for 4 of 8 residents (Residents 1, 6, 7, and 9). These failures resulted in wrong medications being administered to Resident 1, 7 and 9, late medication administration for Resident 7 and Resident 9, and medications errors for Resident 9, which placed the residents at risk for health complications.

Findings included...

Review of the ALF's policy titled, "Medication Management," revised 02/15/2024, showed that medications brought in at the time of move in were to be examined by the nurse to verify they were properly labeled and in the correct container. The policy showed that medications were to be administered at the times ordered by the physician and according to the pharmacy label on the package. The policy showed that staff were to verify that the medication label matched the Medication Administration Record (MAR)

Plan/Attestation Statement

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Administrator (or Representative)

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 medication was given as prescribed and failed to develop and ensure a safe medication system was in place for residents who required assistance and administration with their medication for 4 of 8 residents (Residents 1, 6, 7, and 9). These failures resulted in wrong medications being administered to Resident 1, 7 and 9, late medication administration for Resident 7 and Resident 9, and medications errors for Resident 9, which placed the residents at risk for health complications.

Findings included...

Review of the ALF's policy titled, "Medication Management," revised 02/15/2024, showed that medications brought in at the time of move in were to be examined by the nurse to verify they were properly labeled and in the correct container. The policy showed that medications were to be administered at the times ordered by the physician and according to the pharmacy label on the package. The policy showed that staff were to verify that the medication label matched the Medication Administration Record (MAR)

at the time medications were dispensed to a resident.

<Resident 1>

In an interview on 10/01/2024 at 11:25 AM, Resident 1 stated that staff managed their medication for them. Resident 1 stated that staff had told them that they were given another resident's medication when they were out of their own at times.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/08/2024, showed that they had been assessed to need assistance from the ALF staff with ordering, storing and administration of their medication.

Review of Resident 1's September 2024 MAR showed an order for baclofen (a strong muscle relaxer for muscle spasms and pain) to be given three times daily.

Observation on 10/03/2024 at 10:46 AM, during a medication cart audit of Resident 1's available medications, showed that baclofen was not available for the resident. The audit showed that a bubble pack of cyclobenzaprine (a lower strength muscle relaxer) was available, with instructions on the package to give the medication once daily at bedtime. The bubble pack showed that the medication had expired in August 2024. Resident 1's MARs did not show that they had an order for cyclobenzaprine.

In an interview on 10/03/2024 at 10:52 AM, Staff C, Medication Technician (MT), stated that they gave Resident 1 cyclobenzaprine instead of baclofen because the resident's pharmacy told them that was the medication to give. Staff C stated that they signed for the baclofen each day despite that not being the medication they were giving to Resident 1.

<Resident 6>

Review of Resident 6's demographic sheet, undated, showed that the resident moved into the facility on [REDACTED]/2024.

Review of Resident 6's NSA, dated 09/12/2024, showed that the resident had diagnoses that included [REDACTED], and [REDACTED]. The NSA showed that Resident 6 required assistance from staff for medication administration.

Observation on 10/04/2024 at 1:35 PM of a medication cart audit, showed that Resident 6 had five prescription medication bottles. Observation showed that one bottle was marked with the medication name, benazepril, and there were pills in the bottle that were two different colors; some of the pills were white and the others were purple.

In an interview on 10/04/2024 at 1:35PM, Staff C stated that the prescription bottles came with Resident 6 when they moved into the facility from their home. Staff C stated that they were instructed to use the medications in the bottles before using the medication cards provided by the facility's pharmacy. Staff C stated that they looked up the medication, benazepril, on their cellular phone to determine which color of pill in the bottle of mixed pills to give to the resident.

<Resident 7>

Review of Resident 7's demographic sheet, undated, showed that the resident moved into the facility on [REDACTED]/2023.

Review of Resident 7's NSA, dated 09/21/2023, showed that the resident had diagnoses that included [REDACTED] and [REDACTED]. The assessment showed that Resident 7 required to have their medications administered by facility staff.

<Late medication administration>

In an interview on 10/02/2024 at 9:30 AM, Resident 7 stated that they had medications that were to be administered three times daily at specific times. Resident 7 stated that their medications were often brought to them late.

Observation on 10/02/2024 at 9:55 AM, showed Staff C came to Resident 7's room with the resident's medications that were scheduled to be given at 8:00 AM.

In an interview on 10/02/2024 at 10:14 AM, Staff C stated that Resident 7 had medications that were ordered to be given at scheduled times. Staff C stated that they were late administering medications two to three times per week.

Review of Resident 7's doctor's orders showed that the resident received medications for anxiety, depression, PTSD, high blood pressure and pain. The document showed that Resident 7's medications were scheduled to be given at 8:00 AM, 12:00 PM, 5:00 PM and 8:00 PM.

In an interview on 10/04/2024 at 12:29 PM, Staff G stated that medications with scheduled times could be administered one hour before or after the scheduled time.

Review of Resident 7's report of medication administration times for July 2024, August

2024 and September 2024 showed the following:

- Hydroxyzine (medication used for anxiety) was given outside the medication window (one hour before or after the scheduled time) 34 times.
- Lidocaine Patch (medication used for pain) was given outside the medication window 20 times.
- Methocarbamol (medication for muscle spasms) was given outside of the medication window 32 times.
- Metoprolol succinate (medication used for high blood pressure) was given outside the medication window 24 times.
- Naproxen (medication used for pain) was given outside the medication window 27 times.
- Pregabalin (medication used for pain) was given outside the medication window 43 times.
- Sertraline (medication used for depression) was given outside the medication window 27 times.

<Wrong medication>

Observation on 10/03/2024 at 11:01 AM, during a medication cart audit of Resident 7's available medications, showed that the resident had a bubble pack with a label that read, "Metoprolol Tartrate" (for blood pressure), with a dose of 25 mg, give a half tablet to equal 12.5 mg, twice daily. The tablets in each bubble pack were cut in half.

Review of Resident 7's MAR for September 2024, showed that the resident was prescribed metoprolol succinate 25mg to be given daily. The MAR did not show a prescription for the metoprolol tartrate.

In an interview on 10/03/2024 11:10 AM, Staff B, Resident Care Coordinator, stated that they were not aware that staff were signing for a different metoprolol than what they were giving to Resident 7.

<Resident 9>

Review of Resident 9's Department of Social and Health Services (DSHS) assessment, dated 03/20/2024, showed that the resident had diagnoses of [REDACTED]

[REDACTED], and [REDACTED].

Review of Resident 9's NSA, dated 03/24/2024, showed that they had been assessed to need assistance from the ALF staff with ordering, storing and administration of their medication.

<Wrong medication>

Review of Resident 9's doctor's orders, dated 10/02/2024, showed that the resident required medications for pain, COPD, Parkinson's disease, hypertension, anxiety, and sleep.

In an interview on 10/04/2024 at 9:42 AM, Staff K stated, "Maybe staff are giving the PRN [as needed medication]," when notified that Resident 9 had stated that they were continuing to receive their routine pain medication. Staff K stated that the resident had orders for two different types of the oxycodone pain medication, one for routine administration and one for use as needed. Additionally, Staff K stated that the routine oxycodone/APAP pain medication had been suspended on the September 2024 MAR by a staff member and there was no discontinue order from the doctor.

In an interview on 10/03/2024 at 11:19 AM, Staff K, stated that they did not know why Resident 9's oxycodone/APAP was not in the cart or why their routine oxycodone was suspended.

<Medication errors>

Review of Resident 9's narcotic book, dated 10/02/2024, showed that the resident had been given their as needed oxycodone 5mg, two doses at the same time. Further review of the narcotic book showed oxycodone was order for one tab three times a day (TID, eight hours between doses).

In an interview on 10/04/2024 at 12:20 PM, Staff K, stated that Resident 9's as needed oxycodone was given by a MT two times because the resident had asked for it and the MT had given them, "An extra one to have." Staff K stated that they did not have orders for giving the medication twice.

In an interview on 10/04/2024 at 10:03 AM, Staff H, Director of Sales and Marketing, stated that during the medication cart audit the facility was currently performing, they would expect major medication errors with Resident 9's medications. Staff H stated that Resident 9's routine oxycodone was, "Probably suspended without doctor knowledge." Staff H stated that Resident 9's medication audit was, "One of the biggest mess ups with meds." Additionally, Staff H stated that they had, "Found a bunch of meds" for Resident 9 that were not on their orders.

Review of Resident 9's July 2024 MAR showed that the resident was prescribed alprazolam (anxiety medication) to be given, "One tab by mouth every day as needed." Resident 9's MAR showed that they were given two doses on 07/25/2024 and 07/31/2024.

Review of Resident 9's August MAR showed that the resident was prescribed alprazolam to be given "One tab by mouth every day as needed." Resident 9's MAR showed that they were given two doses on 08/03/2024, 08/16/2024, 08/26/2024, 08/30/2024, and 08/31/2024.

Review of Resident 9's September 2024 MAR showed that the resident was prescribed alprazolam to be given "One tab by mouth every day as needed." Resident 9's MAR showed that they were given two doses on 09/06/2024, 09/07/2024, 09/08/2024, 09/09/2024, 09/12/2024, three doses on 09/19/2024, and two doses 09/22/2024, 09/29/2024, and 09/30/2024.

In an interview on 10/03/2024 at 12:13 PM, Staff G stated that Resident 9's alprazolam was to be given only once a day as needed.

Late medication administration

Review of Resident 9's report of medication administration times for July 2024 through September 2024 showed the following:

- Carbidopa (Parkinson's medication) given outside of the medication window 23 times.
- Escitalopram (anxiety medication) given outside of the medication window 15 times.
- Hydrochlorothiazide (high blood pressure medication) given outside of the medication window 15 times.
- Methocarbamol (medication for muscle spasms) given outside of the medication window 38 times.
- Mirtazapine (depression medication) given outside of the medication window 15 times.
- Oxycodone/APAP (pain medication) given outside of the medication window 38 times.
- QVAR inhaler (COPD medication) given outside of the medication window 25 times.
- Amlodipine (high blood pressure medication) given outside of the medication window 12 times.
- Alprazolam (anxiety medication) given outside of the medication window 31 times.

Safe medication delivery

Observation on 10/03/2024 at 1:20 PM of a medication pass, showed that Staff C walked out of one resident's room after giving them their medication, and proceeded to walk to the other end of the hallway without stopping at the medication cart. Staff C went directly into a second resident's room to give them their medications. Observation showed that there were multiple white, oval pills laying on the floor by the resident's recliner. Staff C was observed to acknowledge the pills lying on the floor and left the room.

In an interview on 10/03/2024 at 1:20 PM, Staff C stated that they kept one medication cup in each hand as they went to the rooms, to identify which cup belonged to which

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resident. Staff C showed the two small medication cups, and they were not labeled with the name or room number of either resident that she had taken the medications to.

This is a recurring deficiency previously cited on 06/09/2023 for subsections (1)(b), 11/17/2022 for subsections (2)(a) and 04/04/2022 for subsections (1)(b)(2).

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) <u>11/15/24</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>10/30/24</u> _____ Date

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 observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that residents' medications were obtained when staff were responsible to order medications, for 4 of 8 residents (Residents 1, 2, 7, and 9). This failure resulted in the residents not receiving their prescribed medication, contributed to a hospitalization for Resident 2 due to worsening constipation, and placed the residents at risk of complications with their health conditions secondary to missed medications.

Findings included...

Review of the facility policy titled, "Medication Non-Availability," revised 02/15/2024, showed that medication not on an automatic refill from the facility's preferred pharmacy would be reordered when there was a ten-day supply remaining. The policy showed that staff assisting with medication administration for a resident were responsible to request medication refills when needed, or to notify the appropriate staff member to do so.

<Resident 1>

resident. Staff C showed the two small medication cups, and they were not labeled with the name or room number of either resident that she had taken the medications to.

This is a recurring deficiency previously cited on 06/09/2023 for subsections (1)(b), 11/17/2022 for subsections (2)(a) and 04/04/2022 for subsections (1)(b)(2).

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

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

Administrator (or Representative)

Date

WAC 388-78A-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 observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that residents' medications were obtained when staff were responsible to order medications, for 4 of 8 residents (Residents 1, 2, 7, and 9). This failure resulted in the residents not receiving their prescribed medication, contributed to a hospitalization for Resident 2 due to worsening constipation, and placed the residents at risk of complications with their health conditions secondary to missed medications.

Findings included...

Review of the facility policy titled, "Medication Non-Availability," revised 02/15/2024, showed that medication not on an automatic refill from the facility's preferred pharmacy would be reordered when there was a ten-day supply remaining. The policy showed that staff assisting with medication administration for a resident were responsible to request medication refills when needed, or to notify the appropriate staff member to do so.

<Resident 1>

In an interview on 10/01/2024 at 11:25 AM, Resident 1 stated that staff managed their medication. Resident 1 stated that they missed a week of medication including pain medication, anti-depressant and blood pressure medication. Resident 1 stated that they were in pain when the medications were missed. Resident 1 stated that they had considered taking control of their medications back from the ALF. Resident 1 also stated that staff had told them they were given another resident's medication when they were out of their own at times.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/08/2024, showed that they had been assessed to need assistance with their medication ordering, storing and administration from the ALF staff.

Review of Resident 1's September 2024 Medication Administration Record (MAR) showed an order for baclofen (a strong muscle relaxer for muscle spasms and pain) to be given three times daily. The MAR showed that Resident 1 was not given baclofen for 17 out of 90 doses. The MAR showed reasons the medication was not given included, "order change," "waiting for refill," "no meds," and "waiting on med."

Observation during a medication cart audit of Resident 1's available medications on 10/03/2024 at 10:46 AM, showed that baclofen was not available for the resident.

Review of Resident 1's August 2024 MAR showed that they had an order for amitriptyline (medication for mood) to be given twice daily until 08/27/2024, for nerve pain. The MAR showed that the medication was not given for 18 out of 53 doses. The MAR showed reasons the medication was not given included, "waiting on pharmacy," "resident needs to see the doctor," "not in yet," and "waiting on med."

Review of Resident 1's September 2024 MAR showed that they had an order for a pregabalin to be given three times daily to reduce nerve pain. The MAR showed that Resident 1 missed the medication twice on 09/26/2024 and twice on 09/27/2024. The MAR showed reasons the medication was not given included, "waiting for new prescription," "waiting for response from [pharmacy]," "no meds," and "waiting on med."

Review of Resident 1's September 2024 MAR showed that they had an order for a medication to elevate mood, to be given daily at bedtime. The MAR showed that the medication was not given on 09/16/2024, 09/17/2024, 09/23/2024, 09/24/2024 and 09/25/2024. The MAR showed reasons the medication was not given included, "waiting on pharmacy," "resident needs to see the doctor," "not in yet," and "waiting on med."

In an interview on 10/01/2024 at 1:43 PM, Staff K, Health Services Director, stated that they were not aware that Resident 1 missed medications. Staff K stated that the Medication Technicians (MTs) were supposed to let the resident care coordinator know if there were medications not available, so that a hold order could be obtained.

In an interview on 10/03/2024 at 11:34 AM, Staff K stated that the MTs didn't tell the management when residents ran out of medications, so they could be obtained. Staff K stated that the facility did not audit the MARs for missed doses of medication.

<Resident 2>

Review of Resident 2's Department of Social and Health Services (DSHS) assessment, dated 01/05/2024, showed that the resident had aphasia (inability to communicate clearly) due to a stroke (an interruption in the blood supply to the brain causing damage) and used the word "pain" to communicate. The DSHS assessment showed that the ALF was responsible for medication management for Resident 2. The DSHS assessment showed that the resident had a history of constipation and received multiple medications for constipation. The DSHS assessment showed that Resident 2 had right sided hemiplegia (paralyzed on one side of the body).

Review of Resident 2's full facility's assessment, dated 08/19/2024, showed that the resident had a diagnosis of [REDACTED] and [REDACTED]. The assessment showed staff were to ask Resident 2 yes and no questions. Resident 2's assessment showed that the ALF was responsible for medication management and for administering the medications.

Review of Resident 2's NSA, dated 01/08/2024, showed the resident had a diagnosis of [REDACTED] and [REDACTED].

Review of Resident 2's facility's progress note, dated [REDACTED]/2024 at 6:00 AM, showed that the resident had shortness of breath, did not feel well, was constipated, and had pain.

Review of Resident 2's facility's progress note, dated [REDACTED]/2024 at 9:52 AM, showed that the resident had pain, nausea, and low oxygen levels.

Review of Resident 2's facility's progress note, dated [REDACTED]/2024 at 3:47 PM, showed that the resident was admitted to the hospital due to severe constipation and needed medical intervention to empty their bowels.

Review of Resident 2's MARs showed that for July 2024, August 2024, and September 2024 the ALF had not offered and/or given any of the resident's as needed medication for constipation.

Review of Resident 2's hospital notes, dated [REDACTED]/2024, showed that the resident was brought in for abdominal pain and admitted for abdominal distention (swollen beyond

normal size) and obstipation (a severe form of constipation, where a person cannot pass stool or gas). The hospital notes showed that Resident 2's abdomen had significant stool impaction (stool is trapped in the colon). Resident 2's hospital notes further showed that the resident had a history of constipation, stroke and was nonverbal. Resident 2's hospital note showed that they had a continuous tube placed inside the body to suction gas out for bowel decompression.

Review of Resident 2's records did not show that the resident was offered or provided as needed medication for constipation.

In an interview on 10/01/2024 at 10:45 AM, Staff M, MT, stated that caregivers were supposed to notify them if Resident 2 had no stools. Staff M stated that they did not offer as needed medications for constipation and would instead let the following shift know if the resident had no stool on their shift. Staff M stated that Resident 2 had a long-known history of constipation and that when they were hired at the ALF it was stressed to them to be alert to the resident's constipation.

Observation on 10/01/2024 at 10:55 AM, with Staff M, of the medication cart showed that Resident 2 was out of three of their four as needed medications ordered for constipation. Staff M stated that Resident 2 had been hospitalized in the past for constipation.

In an interview on 10/01/2024 at 2:39 PM, Collateral Contact 2 (CC2), representative for Resident 2, stated that they had requested that the facility monitor Resident 2's bowel movements related to their chronic constipation issues. CC2 stated that they felt this was very important to do, so that staff would know when to give Resident 2 their as needed medications for constipation, which may have prevented the current hospitalization.

In an interview on 10/01/2024 at 1:55 PM, CC3, healthcare professional, stated that Resident 2 had not been eating very well while at the hospital due to their circumstances. CC3 stated that they were considering giving Resident 2 Total Parenteral Nutrition (TPN) (intravenously administered nutrition when it is needed for the only source of nutrition and to allow the bowel to rest).

In an interview on 10/03/2024 at 8:47 AM, CC4, charge healthcare professional, stated that Resident 2 had been admitted to the hospital on [REDACTED]/2024 and there was no plan for a discharge. CC4 stated that Resident 2 had multiple procedures to decompress both the stomach and the colon due to the severe constipation. Furthermore, CC4 stated that Resident 2 would be started on TPN and that it appeared the resident had gone without a bowel movement for about a week prior to admission at the hospital.

<Resident 7>

Review of Resident 7's full facility assessment, dated 10/07/2023, showed that the resident required assistance with managing their medications.

Review of Resident 7's physician's orders, dated 10/02/2024, showed that the resident received 15 medications that were given daily. The document showed that Resident 7 received medications to treat insomnia (inability to get restful sleep), high cholesterol, high blood pressure, digestive problems and pain.

Review of Resident 7's August 2024 MAR showed that the resident did not have the following routine medications available for administration:

- Melatonin (for sleep) was not given on 08/16/2024, 08/17/2024, 08/21/2024, 08/23/2024, 08/24/2024, 08/25/2024 and 08/30/2024. The MAR showed reasons the medication was not given included, "not in yet," "not available," and "out of med."
- Metoprolol succinate (to regulate blood pressure) was not given on 08/16/2024. The MAR showed the reason the medication was not given was, "not in yet."
- Sumatriptan succinate (for migraines) was not given on 08/16/2024, 08/21/2024, 08/23/2024, 08/26/2024 and 08/30/2024. The MAR showed reasons the medication was not given included, "not in yet" and "not available."
- Atorvastatin (for cholesterol) was not given on 08/21/2024, 08/23/2024, 08/26/2024 and 08/27/2024. The MAR showed reasons the medication was not given included, "not in yet" and "not available."
- Loperamide (for loose stools) was not given on 08/21/2024. The MAR showed reason the medication was not given was, "not in yet."
- Pregabalin (for nerve pain) was not given on 08/23/2024, 08/24/2024 and 08/25/2024. The MAR showed reasons medication was not given was, "med not available" and "not in yet."

Review of Resident 7's September 2024 MAR showed that the resident did not have the following routine medications available for administration:

- Loratadine (for allergies) was not given on 09/27/2024, 09/28/2024 and 09/30/2024. The MAR showed reasons the medication was not given included, "out of med" and "waiting on med."
- Sumatriptan succinate was not given on 09/28/2024 and 09/29/2024. The MAR showed the reason the medication was not given was, "waiting on med".
- Loperamide was not given on 09/28/2024. The MAR showed the reason the medication was not given was, "waiting on med."

<Resident 9>

In an interview on 10/02/2024 at 9:50 AM, Resident 9 stated that they had run out of their routine pain medication in September and that they had been out of it recently. Resident 9 stated that their pain medication had, "Showed up this morning."

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Review of Resident 9's NSA, dated 03/24/2024, showed that they had been assessed to need assistance with their medication ordering, storing and administration from the ALF Staff.

Review of Resident 9's July 2024 MAR showed that they had an order for oxycodone/APAP 5-325 mg to be given three times daily. Resident 9's MAR showed that the noon and evening doses of the medication were not given on 07/08/2024. The MAR showed that the resident did not receive one dose of the medication on 07/09/2024, 07/12/2024, 07/13/2024, 07/14/2024, 07/15/2024 and 07/16/2024. The MAR showed reasons the medication was not given included, "last dose taken this morning," "out of med," and "waiting on medication."

Review of Resident 9's August 2024 MAR showed that they had an order for zolpidem (a sleep aide) to be given at bedtime. Resident 9's MAR showed that the medication was not given 08/15/2024, 08/16/2024, 08/19/2024, 08/20/2024, 08/27/2024, 08/30/2024, and 08/31/2024. The MAR showed reasons the medication was not given included, "out of med," "waiting on pharmacy," "awaiting delivery," and "med not in yet."

Review of Resident 9's September 2024 MAR showed that they had an order for oxycodone /APAP (pain medication) 5-325 milligrams (mg) to be given three times daily. Resident 9's MAR showed that one dose on 09/17/2024, all doses 09/18/2024, one dose 09/19/2024, one dose on 09/23/2024, one dose 09/24/2024, and one dose on 09/25/2024 were not given. The MAR showed reasons the medication was not given included, "MD notified," "not in yet," "waiting on med," "discontinued for oxy 5 mg tabs," and "discontinued."

Review of Resident 9's September 2024 (Treatment Administration Record) TAR showed that the resident was prescribed dronabinol (medication for nausea) to be taken two times daily. The TAR showed that they had not been given the medication on 09/19/2024, 09/23/2024, 09/24/2024, 09/27/2024, 09/28/2024, 09/29/2024 and 09/30/2024. The TAR showed reasons the medication was not given included, "med arrived around 10:30 am," "waiting on med," and "does not have."

This is a recurring deficiency previously cited on 08/08/2023.

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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

Review of Resident 9's NSA, dated 03/24/2024, showed that they had been assessed to need assistance with their medication ordering, storing and administration from the ALF Staff.

Review of Resident 9's July 2024 MAR showed that they had an order for oxycodone/APAP 5-325 mg to be given three times daily. Resident 9's MAR showed that the noon and evening doses of the medication were not given on 07/08/2024. The MAR showed that the resident did not receive one dose of the medication on 07/09/2024, 07/12/2024, 07/13/2024, 07/14/2024, 07/15/2024 and 07/16/2024. The MAR showed reasons the medication was not given included, "last dose taken this morning," "out of med," and "waiting on medication."

Review of Resident 9's August 2024 MAR showed that they had an order for zolpidem (a sleep aide) to be given at bedtime. Resident 9's MAR showed that the medication was not given 08/15/2024, 08/16/2024, 08/19/2024, 08/20/2024, 08/27/2024, 08/30/2024, and 08/31/2024. The MAR showed reasons the medication was not given included, "out of med," "waiting on pharmacy," "awaiting delivery," and "med not in yet."

Review of Resident 9's September 2024 MAR showed that they had an order for oxycodone /APAP (pain medication) 5-325 milligrams (mg) to be given three times daily. Resident 9's MAR showed that one dose on 09/17/2024, all doses 09/18/2024, one dose 09/19/2024, one dose on 09/23/2024, one dose 09/24/2024, and one dose on 09/25/2024 were not given. The MAR showed reasons the medication was not given included, "MD notified," "not in yet," "waiting on med," "discontinued for oxy 5 mg tabs," and "discontinued."

Review of Resident 9's September 2024 (Treatment Administration Record) TAR showed that the resident was prescribed dronabinol (medication for nausea) to be taken two times daily. The TAR showed that they had not been given the medication on 09/19/2024, 09/23/2024, 09/24/2024, 09/27/2024, 09/28/2024, 09/29/2024 and 09/30/2024. The TAR showed reasons the medication was not given included, "med arrived around 10:30 am," "waiting on med," and "does not have."

This is a recurring deficiency previously cited on 08/08/2023.

Plan/Attestation Statement

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

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Administrator (or Representative)

10/30/24

Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(v) Provide a variety of foods; and

(vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

(b) Prescribed nutrient concentrates and supplements when prescribed in writing by a health care practitioner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that menu items were not repeated for at least three weeks and failed to serve prescribed diets that utilized a diet manual approved and reviewed by a dietitian every five years for 1 of 3 residents (Resident 9). These failures resulted in resident placed residents at risk of having decreased quality of life by not receiving a variety of foods every three weeks and them not receiving their prescribed diets, which resulted in Resident 6 losing an excessive amount of weight.

Findings included...

Review of the facility menu, dated 09/09/2024 thru 09/29/2024, showed that residents were served the same menu items for lunch and dinner on 09/10/2024, 09/11/2024, 09/12/2024, 09/13/2024, 09/14/2024, 09/15/2024, 09/24/2024, 09/25/2024, 09/26/2024, 09/27/2024, 09/28/2024, and 09/29/2024 (13 meals that were repeated within three weeks).

_____ Administrator (or Representative)	_____ Date
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WAC 388-78A-2300 Food and nutrition services.

- (1) The assisted living facility must:
 - (c) Ensure all menus:
 - (v) Provide a variety of foods; and
 - (vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.
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 - (a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:
 - (i) Available to and used by staff persons responsible for food preparation;
 - (ii) Approved by a dietitian; and
 - (iii) Reviewed and updated as necessary or at least every five years.
 - (b) Prescribed nutrient concentrates and supplements when prescribed in writing by a health care practitioner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that menu items were not repeated for at least three weeks and failed to serve prescribed diets that utilized a diet manual approved and reviewed by a dietician every five years for 1 of 3 residents (Resident 9). These failures resulted in residentplaced residents at risk of having decreased quality of life by not receiving a variety of foods every three weeks and them not receiving their prescribed diets, which resulted in Resident 6 losing an excessive amount of weight.

Findings included...

Review of the facility menu, dated 09/09/2024 thru 09/29/2024, showed that residents were served the same menu items for lunch and dinner on 09/10/2024, 09/11/2024, 09/12/2024, 09/13/2024, 09/14/2024, 09/15/2024, 09/24/2024, 09/25/2024, 09/26/2024, 09/27/2024, 09/28/2024, and 09/29/2024 (13 meals that were repeated within three weeks).

10.23.2024 15:52:03

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Review of the facility Disclosure of Services showed that the facility provided prescribed general low sodium diets, general diabetic diets, and mechanical soft diets (food items that required little chewing). The facility disclosure showed that the facility provided nutritional supplements for residents needing additional nutrition.

Review of the facility diet manual, dated 09/12/2018, showed that the manual had not been reviewed, signed, or updated since that date, which was over six years.

Review of Resident 9's Home and Community Services assessment, dated 03/20/2024, showed that the resident had diagnoses of [REDACTED] and [REDACTED]. The assessment showed the resident's weight was 180 pounds.

Review of Resident 9's physician order, dated 08/21/2024, showed that the resident was prescribed weekly weights to be done by the facility and supplemental nutritional shakes with meals, three times a day.

Review of the facility's September monthly log showed that Resident 9's weight was 144 pounds (36-pound loss in six months).

In an interview on 10/02/2024 at 10:29 AM, Staff C, Medication Technician stated that there was no nutritional shake included on the resident's Medication Administration Record.

Observation on 10/02/2024 at 11:22 AM showed that the diet board posted in the main kitchen did not include Resident 9's supplemental nutritional shake.

This is a reoccurring deficiency previously cited on 02/21/2023 subsections (1)(c)(vi).

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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

Review of the facility Disclosure of Services showed that the facility provided prescribed general low sodium diets, general diabetic diets, and mechanical soft diets (food items that required little chewing). The facility disclosure showed that the facility provided nutritional supplements for residents needing additional nutrition.

Review of the facility diet manual, dated 09/12/2018, showed that the manual had not been reviewed, signed, or updated since that date, which was over six years.

Review of Resident 9's Home and Community Services assessment, dated 03/20/2024, showed that the resident had diagnoses of [REDACTED], and [REDACTED]. The assessment showed the resident's weight was 180 pounds.

Review of Resident 9's physician order, dated 08/21/2024, showed that the resident was prescribed weekly weights to be done by the facility and supplemental nutritional shakes with meals, three times a day.

Review of the facility's September monthly log showed that Resident 9's weight was 144 pounds (36-pound loss in six months).

In an interview on 10/02/2024 at 10:29 AM, Staff C, Medication Technician stated that there was no nutritional shake included on the resident's Medication Administration Record.

Observation on 10/02/2024 at 11:22 AM showed that the diet board posted in the main kitchen did not include Resident 9's supplemental nutritional shake.

This is a reoccurring deficiency previously cited on 02/21/2023 subsections (1)(c)(vi).

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

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

10.23.2024 15:52:03

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Administrator (or Representative)

10/30/24

Date

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

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that the registered nurse delegator assessed each resident who received delegated task assistance from staff, provided specific direction for delegated tasks to each staff member, and verified the staff members' credentials and competency for 2 of 2 residents (Resident 1 and 8). These failures placed residents at risk of their needs not being met and delegated tasks performed incorrectly.

Findings included...

Review of Washington Administrative Code (WAC) 246-840-930, titled, "Criteria for delegation," showed that the Registered Nurse Delegator (RND) was to assess the resident for the need and appropriateness for each delegated task and obtain written consent from the resident or their representative for the delegation. Additionally, the RND had to provide training and direction to qualified and properly credentialed staff.

In an interview on 09/30/2024 at 9:55 AM, Staff A, Administrator, stated that they used an outside company that was new to the facility, for their nurse delegation. Staff A stated that the facility provided nurse delegation for blood glucose testing (a blood test to check levels of sugar in the blood, performed by either a nurse or a delegated Medication Technician [MT]), insulin (injected medication to regulate blood sugars, performed either by a nurse or by a delegated MT), and medication administration for residents.

<Resident 1>

Review of Resident 1's full facility assessment, dated 04/08/2024, showed that the resident had a diagnosis of [REDACTED]. The assessment showed that Resident 1 required administration of their medications.

Administrator (or Representative)

Date

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

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that the registered nurse delegator assessed each resident who received delegated task assistance from staff, provided specific direction for delegated tasks to each staff member, and verified the staff members' credentials and competency for 2 of 2 residents (Resident 1 and 8). These failures placed residents at risk of their needs not being met and delegated tasks performed incorrectly.

Findings included...

Review of Washington Administrative Code (WAC) 246-840-930, titled, "Criteria for delegation," showed that the Registered Nurse Delegator (RND) was to assess the resident for the need and appropriateness for each delegated task and obtain written consent from the resident or their representative for the delegation. Additionally, the RND had to provide training and direction to qualified and properly credentialed staff.

In an interview on 09/30/2024 at 9:55 AM, Staff A, Administrator, stated that they used an outside company that was new to the facility, for their nurse delegation. Staff A stated that the facility provided nurse delegation for blood glucose testing (a blood test to check levels of sugar in the blood, performed by either a nurse or a delegated Medication Technician [MT]), insulin (injected medication to regulate blood sugars, performed either by a nurse or by a delegated MT), and medication administration for residents.

<Resident 1>

Review of Resident 1's full facility assessment, dated 04/08/2024, showed that the resident had a diagnosis of [REDACTED]. The assessment showed that Resident 1 required administration of their medications.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/08/2024, showed that the resident required nurse delegation for their insulin and for their fingerstick blood sugar testing.

In an interview on 10/01/2024 at 11:18 AM, Resident 1 stated that the MTs checked their blood sugars via fingerstick twice daily and administered their insulin injections to them.

Review of the delegation paperwork for Resident 1 showed that there was no nursing assessment of the delegated tasks needed. There were no records to show that a RND had visited and assessed Resident 1 to evaluate and determine the plan necessary for delegation of tasks. The records did not show which tasks were to be delegated or to whom. The records showed that the staff credential checklists were blank. The records showed that staff credentials had not been verified to show that they were qualified and competent to complete the delegated tasks for Resident 1.

Review of Resident 1's, "Nurse Delegation: Consent for delegation," form, undated, did not include the resident's diagnosis, name of their primary provider, or the current RND signature. Further review showed that Resident 1 signed the form where the RND signature box was and there was no date on the form.

<Resident 8>

In an interview on 10/01/2024 at 11:45 AM, Resident 8 stated that staff administered their insulin and blood sugar tests.

Review of Resident 8's July 2024, August 2024 and September 2024 Medication Administration Records (MARs) showed that the resident had diagnoses of [REDACTED]. The MARs showed Resident 8 required insulin and blood sugar checks.

Review of Resident 8's NSA, dated 02/12/2024, showed that the resident required administration of their medication.

Review of Resident 8's, "Nurse Delegation: Consent for delegation," form, undated, showed it did not include the resident's diagnosis or the RND signature. Further review showed Resident 8 signed the form where the RND signature box was and dated the form.

Review of Resident 8's, "Nurse Delegation: Nursing Visit," form, dated 08/12/2024, showed that the resident required delegation for medications, blood glucose checks, and insulin. Resident 8's record did not show specific tasks for administering their medication, monitoring blood sugars and administering insulin.

10.23.2024 15:52:03

State of Washington

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Review of the delegation paperwork for Resident 8 showed that there was no nursing assessment of the delegated tasks needed. There were no records to show that a RND had visited and assessed Resident 8 to evaluate and determine the plan necessary for delegation of tasks. The records did not show which tasks were to be delegated or to whom. The records showed that the staff credential checklists were blank. The records showed staff credentials had not been verified to show that they were qualified and competent to complete the delegated tasks for Resident 8.

In an interview on 10/03/2024 at 10:03 AM, Staff K, Health Services Director, acknowledged that the nurse delegation forms were blank and stated that the nurse delegation company had not reviewed the delegation, done assessments, verified credentials or trained the MT's.

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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


Administrator (or Representative)

10/30/24
Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a new background authorization form was submitted to the department every two years for 2 of 2 staff (Staff E and F). This failure placed the residents at risk of being cared for by disqualified staff.

Review of the delegation paperwork for Resident 8 showed that there was no nursing assessment of the delegated tasks needed. There were no records to show that a RND had visited and assessed Resident 8 to evaluate and determine the plan necessary for delegation of tasks. The records did not show which tasks were to be delegated or to whom. The records showed that the staff credential checklists were blank. The records showed staff credentials had not been verified to show that they were qualified and competent to complete the delegated tasks for Resident 8.

In an interview on 10/03/2024 at 10:03 AM, Staff K, Health Services Director, acknowledged that the nurse delegation forms were blank and stated that the nurse delegation company had not reviewed the delegation, done assessments, verified credentials or trained the MTs.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

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(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a new background authorization form was submitted to the department every two years for 2 of 2 staff (Staff E and F). This failure placed the residents at risk of being cared for by disqualified staff.

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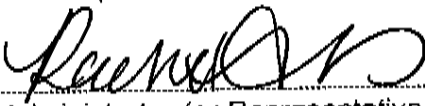
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Findings included...

Review of the personnel file for Staff E, Medication Technician, showed that they were hired on 05/09/2022. Staff E's file showed that their most recent background check was completed on 05/23/2024. Staff E's file showed a previous background check was completed on 05/04/2022, which was two years and 19 days prior.

Review of the personnel file for Staff F, Bath Aide, showed that they were hired on 10/22/2021. Staff F's file showed that their most recent background check was completed on 05/30/2024. Staff F's file showed a previous background check was completed on 04/04/2022, which was two years and 57 days prior.

In an interview on 10/01/2024 at 12:53 PM, Staff I, Business Office Manager (BOM), acknowledged that the background checks were submitted late for Staff E and F.

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) <u>11/15/24</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>10/30/24</u> _____ Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a fingerprint background check was completed within one hundred and twenty-days of hire for 1 of 4 staff (Staff C). This failed practice placed residents at risk of receiving care by an unqualified caregiver.

Findings included...

Findings included...

Review of the personnel file for Staff E, Medication Technician, showed that they were hired on 05/09/2022. Staff E's file showed that their most recent background check was completed on 05/23/2024. Staff E's file showed a previous background check was completed on 05/04/2022, which was two years and 19 days prior.

Review of the personnel file for Staff F, Bath Aide, showed that they were hired on 10/22/2021. Staff F's file showed that their most recent background check was completed on 05/30/2024. Staff F's file showed a previous background check was completed on 04/04/2022, which was two years and 57 days prior.

In an interview on 10/01/2024 at 12:53 PM, Staff I, Business Office Manager (BOM), acknowledged that the background checks were submitted late for Staff E and F.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a fingerprint background check was completed within one hundred and twenty-days of hire for 1 of 4 staff (Staff C). This failed practice placed residents at risk of receiving care by an unqualified caregiver.

Findings included...

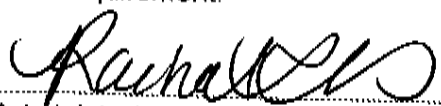
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Review of Staff C's, Medication Technician (MT), personnel file showed that they were hired on 06/24/2024. Staff C's file did not show that they had a fingerprint background check pending and/or completed.

In an interview on 10/02/2024 at 11:13 AM, Staff I, Business Office Manager (BOM), acknowledged that Staff C worked with residents unsupervised. Staff I stated that they were new to the BOM position and unaware of why the fingerprint background check had not been setup.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
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WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

- (a) Orientation and safety;
- (b) Basic;
- (d) Cardiopulmonary resuscitation and first aid; and
- (e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that staff who worked as long-term care workers obtained the orientation, safety training and the basic long-term care worker training for 2 of 4 staff (Staff B and D), failed to ensure that home care aide applications were sent to the department within 14 days of hire for 3 of 4 staff (Staff B, C and D), failed to ensure staff obtained cardiopulmonary resuscitation and first aid trainings for 2 of 6 staff (Staff C and D), and failed to ensure staff received continuing education for 2 of 5 staff (Staff E and F). These

Review of Staff C's, Medication Technician (MT), personnel file showed that they were hired on 06/24/2024. Staff C's file did not show that they had a fingerprint background check pending and/or completed.

In an interview on 10/02/2024 at 11:13 AM, Staff I, Business Office Manager (BOM), acknowledged that Staff C worked with residents unsupervised. Staff I stated that they were new to the BOM position and unaware of why the fingerprint background check had not been setup.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

- (a) Orientation and safety;
- (b) Basic;
- (d) Cardiopulmonary resuscitation and first aid; and
- (e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that staff who worked as long-term care workers obtained the orientation, safety training and the basic long-term care worker training for 2 of 4 staff (Staff B and D), failed to ensure that home care aide applications were sent to the department within 14 days of hire for 3 of 4 staff (Staff B, C and D), failed to ensure staff obtained cardiopulmonary resuscitation and first aid trainings for 2 of 6 staff (Staff C and D), and failed to ensure staff received continuing education for 2 of 5 staff (Staff E and F). These

failures precluded the department from the ability to track and monitor home care aide applicants and placed residents at risk of receiving care from untrained staff.

Findings included...

In an interview on 09/30/2024 at 9:53 AM, Staff A, Administrator, stated that care staff typically trained with a peer on the floor for four to five days, then would work unsupervised with residents.

<Orientation and Safety Training>

Review of Washington Administrative Code (WAC) 388-112A-0200 and 388-112A-0220 showed that staff were to obtain the orientation and safety trainings before providing care to residents.

Review of the personnel file for Staff B, Resident Care Coordinator, showed that they were hired on 01/24/2024. Staff B's file showed that they completed the orientation and safety trainings on 03/26/2024 (62 days after being hired).

Review of the personnel file for Staff D, Medication Technician (MT), showed that they were hired on 12/29/2023. Staff D's file showed that they completed the orientation training on 03/15/2024 (77 days after being hired) and the safety training on 04/29/2024 (122 days after being hired).

In an interview on 10/01/2024 at 11:40 AM, Staff I, Business Office Manager (BOM), stated that they were responsible for getting staff set up for the orientation and safety trainings in the ALF's online training system, upon hire.

<HCA Application>

Review of Staff B's file showed that the ALF had not sent in a Home Care Aide (HCA) application to the department within 14 days of hire.

Review of Staff C's file showed that the ALF had not sent in an HCA application to the department within 14 days of hire.

Staff D's file showed that the ALF had not sent in an HCA application to the department within 14 days of hire.

In an interview on 10/04/2024 at 9:25 AM, Staff K, Health Services Director, stated that

they were unaware that Staff C needed an HCA because they had a Nursing Assistant Registration.

<Basic Long-term Care Worker Training>

Review of WAC 388-112A-0080 showed that staff were to obtain the 70-hour basic long-term care worker training within 120 days of hire, and that they could not provide direct care unsupervised until they completed the basic training.

Review of the personnel file for Staff B showed that they were hired on 01/24/2024. Staff B's file showed that they had not completed the 70-hour basic training as required within 120 days of hire.

In an interview on 10/04/2024 at 9:38 AM, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that Staff I thought all new care staff were automatically enrolled in the 70-hour basic training course upon hire. Staff G stated they planned to reeducate Staff I on that process.

Review of the personnel file for Staff D, night shift MT, showed that they were hired on 12/29/2023. Staff D's file showed that they had not completed the 70-hour basic training as required within 120 days of hire.

In an interview on 10/01/2024 at 12:28 PM, Staff I stated that they did not know that Staff D needed to complete the 70-hour basic training. Staff I confirmed that Staff D did not have a credential to allow them to provide care to residents.

<CPR and First-aid Training>

Review of WAC 388-112A-0720 showed that staff were required to obtain and maintain cardiopulmonary resuscitation (CPR) and first-aid training certificates within 30 days of hire.

Review of the personnel file for Staff C, MT, showed that they were hired on 06/24/2024. Staff C's file showed that they did not have a CPR and first-aid training certificate.

Review of the personnel file for Staff D showed that they were hired on 12/29/2023 as the night shift MT. Staff D's file showed that their CPR and first-aid certificate had expired on 04/16/2024. Staff D's file showed that they did not renew their CPR certificate until 06/08/2024 (53 days after it had expired).

In an interview on 10/01/2024 at 11:40 AM, Staff I stated that they were responsible for

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tracking CPR and first-aid trainings for all staff.

<Continuing Education Credits (CEs)>

Review of WAC 388-112A-0611 showed that staff were to obtain 12 hours of CE credits from birthday to birthday every year.

Review of the personnel file for Staff E, MT, showed that they were hired on 05/09/2022. Staff E's file showed that they had completed eight hours of CE credits from their birthday in 2023 to their birthday in 2024.

Review of the personnel file for Staff F, Shower Aide, showed that they were hired on 10/22/2021. Staff F's file showed that they had not completed any hours of CE credits from their birthday in 2023 to their birthday in 2024.

In an interview on 10/01/2024 at 12:47 PM, Staff I stated that it was the responsibility of Staff K, Health Services Director, to monitor CE hours for the care staff. Staff I stated that they could not find a full file for Staff F to show they had any completed CE hours.

In an interview on 10/02/2024 at 2:47 PM, Staff H, Director of Sales and Marketing, stated that Staff I should have been monitoring and keeping up on the staff training records for the orientation and safety, HCA, basic training, CPR and first aid, and CE credits.

Plan/Attestation Statement

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Administrator (or Representative)

10/30/24
Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

- (1) An initial skin test within three days of employment; and

tracking CPR and first-aid trainings for all staff.

<Continuing Education Credits (CEs)>

Review of WAC 388-112A-0611 showed that staff were to obtain 12 hours of CE credits from birthday to birthday every year.

Review of the personnel file for Staff E, MT, showed that they were hired on 05/09/2022. Staff E's file showed that they had completed eight hours of CE credits from their birthday in 2023 to their birthday in 2024.

Review of the personnel file for Staff F, Shower Aide, showed that they were hired on 10/22/2021. Staff F's file showed that they had not completed any hours of CE credits from their birthday in 2023 to their birthday in 2024.

In an interview on 10/01/2024 at 12:47 PM, Staff I stated that it was the responsibility of Staff K, Health Services Director, to monitor CE hours for the care staff. Staff I stated that they could not find a full file for Staff F to show they had any completed CE hours.

In an interview on 10/02/2024 at 2:47 PM, Staff H, Director of Sales and Marketing, stated that Staff I should have been monitoring and keeping up on the staff training records for the orientation and safety, HCA, basic training, CPR and first aid, and CE credits.

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Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

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(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an initial test for tuberculosis was completed within three days of hire for 2 of 4 staff (Staff B and C). This failure placed residents at risk of potential exposure to a communicable disease.

Findings included...

Review of facility staff personnel files showed the following:

The file for Staff B, Resident Care Coordinator, showed that they were hired on 01/24/2024. Staff B's file showed that a first step TB skin test was completed on 04/18/2024 (85 days after their hire date).

The file for Staff C, Medication Technician, showed that they were hired on 06/24/2024. Staff C's file showed that they had not had any TB testing completed.

In an interview on 10/02/2024 at 11:39 AM, Staff I stated that they did not know why the TB tests were late and/or not done for Staff B and C.

In an interview on 10/04/2024 at 12:35 PM, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that Staff B and C would have required a two-step TB skin test upon hire.

This is a recurring deficiency previously cited on 02/21/2023.

Plan/Attestation Statement

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This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an initial test for tuberculosis was completed within three days of hire for 2 of 4 staff (Staff B and C). This failure placed residents at risk of potential exposure to a communicable disease.

Findings included...

Review of facility staff personnel files showed the following:

The file for Staff B, Resident Care Coordinator, showed that they were hired on 01/24/2024. Staff B's file showed that a first step TB skin test was completed on 04/18/2024 (85 days after their hire date).

The file for Staff C, Medication Technician, showed that they were hired on 06/24/2024. Staff C's file showed that they had not had any TB testing completed.

In an interview on 10/02/2024 at 11:39 AM, Staff I stated that they did not know why the TB tests were late and/or not done for Staff B and C.

In an interview on 10/04/2024 at 12:35 PM, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that Staff B and C would have required a two-step TB skin test upon hire.

This is a recurring deficiency previously cited on 02/21/2023.

Plan/Attestation Statement

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Administrator (or Representative)	Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;
 - (c) A psychiatric advanced registered nurse practitioner; or
 - (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that specialty training for mental health was completed by staff who provided care to residents diagnosed with [REDACTED] for 1 of 4 staff (Staff D). This failure placed residents at risk of care from untrained staff.

Findings included...

Review of the facility's undated characteristic roster showed that six residents that lived in the facility had [REDACTED] diagnosis.

Review of Resident 1's Department of Social and Health Services (DSHS) assessment, dated 09/20/2024, showed that the resident had a diagnosis of [REDACTED] and [REDACTED]. The assessment showed that Resident 1 received services from a mental health counselor.

_____ Administrator (or Representative)	_____ Date
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WAC 388-112A-0400 What is specialty training and who is required to take it?

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- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;
 - (c) A psychiatric advanced registered nurse practitioner; or
 - (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that specialty training for mental health was completed by staff who provided care to residents diagnosed with [REDACTED] for 1 of 4 staff (Staff D). This failure placed residents at risk of care from untrained staff.

Findings included...

Review of the facility's undated characteristic roster showed that six residents that lived in the facility had [REDACTED] diagnosis.

Review of Resident 1's Department of Social and Health Services (DSHS) assessment, dated 09/20/2024, showed that the resident had a diagnosis of [REDACTED] and [REDACTED]. The assessment showed that Resident 1 received services from a mental health counselor.

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Review of Resident 4's full facility assessment, dated 08/20/2024, showed that the resident had a diagnosis of [REDACTED].

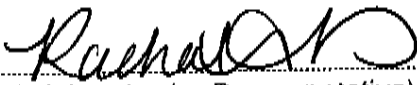
Review of Resident 5's DSHS assessment, dated 03/22/2024, showed that the resident had a diagnosis of [REDACTED] and [REDACTED].

Review of Staff D's, Medication Technician, personnel file showed that they were hired on 12/29/2023. Staff D's file did not show that they had a specialty training for mental health completed, which was 279 days from their date of hire.

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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Administrator (or Representative)

10/30/24
Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that specialty training for dementia was completed by staff who provided care to residents diagnosed with [REDACTED] for 1 of 4 staff (Staff D). This failure placed residents at risk of care from untrained staff.

Findings included...

Review of Resident 4's full facility assessment, dated 08/20/2024, showed that the resident had a diagnosis of [REDACTED].

Review of Resident 5's DSHS assessment, dated 03/22/2024, showed that the resident had a diagnosis of [REDACTED] and [REDACTED].

Review of Staff D's, Medication Technician, personnel file showed that they were hired on 12/29/2023. Staff D's file did not show that they had a specialty training for mental health completed, which was 279 days from their date of hire.

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Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that specialty training for dementia was completed by staff who provided care to residents diagnosed with [REDACTED] for 1 of 4 staff (Staff D). This failure placed residents at risk of care from untrained staff.

Findings included...

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Review of the facility's undated characteristic roster showed that 10 residents lived in the facility that had either dementia, Alzheimer's and/or cognitive impairment marked.

Review of Resident 9's DSHS assessment, dated 03/24/2024, showed that the resident had a diagnosis of [REDACTED].

Review of Staff D's, Medication Technician, personnel file showed that they were hired on 12/29/2023. Staff D's file did not show that they had a specialty training for dementia completed, which was 279 days from their date of hire.

In an interview on 10/02/2024 at 11:13 AM, Staff I, Business Office Manager (BOM), stated that they were new to the BOM position and unaware of why Staff C had no specialty training for dementia completed.

In an interview on 10/04/2024 at 9:23 AM Staff K, Health and Services Director, stated that Staff D required the specialty training for dementia.

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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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



Administrator (or Representative)

10/30/24
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:

(p) To coordinate services and share resident information with outside resources, consistent with WAC 388-78A-2350 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility failed to

Review of the facility's undated characteristic roster showed that 10 residents lived in the facility that had either dementia, Alzheimer's and/or cognitive impairment marked.

Review of Resident 9's DSHS assessment, dated 03/24/2024, showed that the resident had a diagnosis of [REDACTED].

Review of Staff D's, Medication Technician, personnel file showed that they were hired on 12/29/2023. Staff D's file did not show that they had a specialty training for dementia completed, which was 279 days from their date of hire.

In an interview on 10/02/2024 at 11:13 AM, Staff I, Business Office Manager (BOM), stated that they were new to the BOM position and unaware of why Staff C had no specialty training for dementia completed.

In an interview on 10/04/2024 at 9:23 AM Staff K, Health and Services Director, stated that Staff D required the specialty training for dementia.

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Administrator (or Representative)

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:

(p) To coordinate services and share resident information with outside resources, consistent with WAC 388-78A-2350 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility failed to

ensure their policy for coordinating care was followed for 2 of 3 residents (Resident 4 and 7). This failure caused Resident 4 and 7 to have unmet care needs and services.

Findings included...

Record review of the facility's policy titled, "Coordination of Care with Off-Site Health Care Providers," revised on 02/15/2024, showed that when a resident visited their primary care doctor or another outside care provider the facility would ensure that those orders were received and implemented appropriately.

Resident 4

In an interview on 10/01/2024 at 10:52 AM, Resident 4 was observed sitting in an electric scooter. Resident 4 stated that facility staff were not assisting them with walking twice a day as the doctor had ordered. Resident 4 stated that they posted the calendar on their door so that staff could initial and document if they walked the resident.

Review of Resident 4's doctor's order, dated 06/18/2024, showed instructions to, "Assist resident with walking and stretching twice daily," and "Follow behind with wheelchair for safety."

Review of Resident 4's June 2024, July 2024, August 2024, and September 2024 Medication Administration Records and Treatment Administration Records (MARs and TARs) showed they did not include the doctor's order for walking with the resident twice a day.

Observation on 10/01/2024 at 10:52 AM showed that on the outside of Resident 4's apartment door was a monthly calendar with handwritten times and initials on some of the dates.

Review of the calendar for the months of June 2024 to September 2024 showed the following dates when Resident 4 was not walked:

- June 2024 staff did not assist Resident 4 with walking 21 out of 24 times as ordered.
- July 2024 staff did not assist Resident 4 with walking 58 out of 62 times as ordered.
- August 2024 staff did not assist Resident 4 with walking 58 out of 62 times as ordered.
- September 2024 staff did not assist Resident 4 with walking 44 out of 60 times as ordered.

Review of Resident 4's NSA, dated 08/19/2024, showed that the resident had diagnoses of [REDACTED]

[REDACTED] and [REDACTED]

[REDACTED] The NSA also showed that the resident was independent with ambulation and staff were to coordinate physical therapy

appointments. The NSA did not show that staff were to assist Resident 4 with walking twice a day.

In an interview on 10/01/2024 at 3:00 PM Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that if Resident 4's order to be walked twice a day was not on the NSA then it was not being done.

Resident 7

<Therapy Services>

In an interview on 10/02/2024 at 9:07 AM, Resident 7 stated that their provider had ordered physical therapy services that had never been started.

Review of Resident 7's provider's notes, dated 04/08/2024, showed that the resident was to be referred for physical therapy services.

Review of Resident 7's provider's order, dated 04/22/2024, showed, "home health physical therapy eval and treat low back pain."

Review of Resident 7's provider's notes, dated 08/12/2024, showed, "still no [physical therapy] for neuropathy."

Review of Resident 7's therapy notes titled, "Discharge – Transfer Summary Report," showed that the resident started physical therapy services on 07/27/2023 and that the services ended on 09/12/2023. The document did not show that services were started again after the order was written on 04/22/2024.

In an interview on 10/04/2024 at 9:26 AM, Staff K, Health Services Director, stated that the home health notes provided were the most recent therapy service notes. Staff K acknowledged that notes were dated prior to the referral date of 04/22/2024. Staff K was not able to provide more recent documentation.

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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, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/15/24.

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Administrator (or Representative)

10/30/24
Date

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that pets living on the ALF premises had regular examinations and immunizations for 4 of 4 pets (Pet 1, 2, 3 and 4). This failure put residents at risk for contact with pets who may have transmissible diseases.

Findings included...

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

In an interview on 10/02/2024 at 10:56 AM, Staff L, Concierge, stated that there were no pet records in the ALF for Pet 3 [Cat] and Pet 4 [Cat].

Review of the veterinary records for Pet 1 [Dog] showed that they were due 10/31/2023 for a wellness exam and kennel cough vaccination.

Review of the veterinary records for Pet 2 [Dog] showed that they were due 03/15/2023 for a rabies vaccination.

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Administrator (or Representative)

Date

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that pets living on the ALF premises had regular examinations and immunizations for 4 of 4 pets (Pet 1, 2, 3 and 4). This failure put residents at risk for contact with pets who may have transmissible diseases.

Findings included...

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

In an interview on 10/02/2024 at 10:56 AM, Staff L, Concierge, stated that there were no pet records in the ALF for Pet 3 [Cat] and Pet 4 [Cat].

Review of the veterinary records for Pet 1 [Dog] showed that they were due 10/31/2023 for a wellness exam and kennel cough vaccination.

Review of the veterinary records for Pet 2 [Dog] showed that they were due 03/15/2023 for a rabies vaccination.

10.23.2024 15:52:03

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In an interview on 10/02/2024 at 3:29 PM, Staff H, Director of Sales and Marketing, stated that the facility did not have a system in place to track veterinary records for the pets that lived at the ALF. Staff G stated that residents had brought in pets after they moved in and did not inform the ALF staff.

This is a recurring deficiency previously cited on 02/21/2023.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>10/30/24</u> Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to inform each resident upon admission and at least every twenty-four months in writing of the

In an interview on 10/02/2024 at 3:29 PM, Staff H, Director of Sales and Marketing, stated that the facility did not have a system in place to track veterinary records for the pets that lived at the ALF. Staff G stated that residents had brought in pets after they moved in and did not inform the ALF staff.

This is a recurring deficiency previously cited on 02/21/2023.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to inform each resident upon admission and at least every twenty-four months in writing of the

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service items, charges, activities available in the facility, and the rules of the facility's operation for 2 of 2 residents (Resident 1 and 2). This failure precluded the residents from making informed decisions regarding living choices at the ALF.

Findings included...

In an interview on 10/02/2024 at 10:47 AM, Staff A, Administrator, stated that it was Staff I, Business Office Manager's responsibility to review the ALF's full admission agreement, to inform residents of the available service items, charges, activities, and the rules of the facility's operation, upon a resident's move in and every twenty-four months as required.

Review of the demographics sheet in Resident 1's record showed that they admitted to the facility on [REDACTED]/2022. Resident 1's record showed that it did not include an admission rental agreement. Review of Resident 1's record showed that they had not been informed of the ALF's available service items, charges, activities, and the rules of the facility's operation.

Review of the demographics sheet in Resident 2's record showed that they admitted to the facility on [REDACTED]/2022. Resident 2's record showed the most current rental agreement was signed 06/30/2022. The record did not show that Resident 2 had been informed every twenty-four months of the ALF's available service items, charges, activities, and the rules of the facility's operation.

In an interview on 10/02/2024 at 2:48 PM, Staff H, Director of Sales and Marketing, stated that there was no admission rental agreement signed for Resident 1. Staff H stated that there was not a rental agreement signed every twenty-four months for Resident 2.

Plan/Attestation Statement

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Rachael D. Gies
Administrator (or Representative)

10/30/24
Date

service items, charges, activities available in the facility, and the rules of the facility's operation for 2 of 2 residents (Resident 1 and 2). This failure precluded the residents from making informed decisions regarding living choices at the ALF.

Findings included...

In an interview on 10/02/2024 at 10:47 AM, Staff A, Administrator, stated that it was Staff I, Business Office Manager's responsibility to review the ALF's full admission agreement, to inform residents of the available service items, charges, activities, and the rules of the facility's operation, upon a resident's move in and every twenty-four months as required.

Review of the demographics sheet in Resident 1's record showed that they admitted to the facility on [REDACTED]/2022. Resident 1's record showed that it did not include an admission rental agreement. Review of Resident 1's record showed that they had not been informed of the ALF's available service items, charges, activities, and the rules of the facility's operation.

Review of the demographics sheet in Resident 2's record showed that they admitted to the facility on [REDACTED]/2022. Resident 2's record showed the most current rental agreement was signed 06/30/2022. The record did not show that Resident 2 had been informed every twenty-four months of the ALF's available service items, charges, activities, and the rules of the facility's operation.

In an interview on 10/02/2024 at 2:48 PM, Staff H, Director of Sales and Marketing, stated that there was no admission rental agreement signed for Resident 1. Staff H stated that there was not a rental agreement signed every twenty-four months for Resident 2.

Plan/Attestation Statement

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Administrator (or Representative)

Date

WAC 388-78A-2850 Required reviews of building plans.

(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(i) Physical structure;

(3) The assisted living facility must submit plans to construction review services as directed by construction review services and consistent with WAC 388-78A-2361 for approval prior to beginning any construction.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to submit construction plans for review and approval, to construction review services for 1 of 5 exit doors (southwest exit door). This failure resulted in a facility modification that had not been reviewed or approved.

Findings included...

In an interview on 09/30/2024 at 10:45 AM, Staff A, Administrator, stated that the facility had installed a new exit door on the south side of the facility, where residents went in and out to smoke.

In an interview on 09/30/2024 at 11:34 AM, Staff H, Director of Sales and Marketing, and Staff J, Maintenance Director, stated that the first floor south exit door, by the nurse's station, had a new automatic door with a four-inch by four-inch push button opener on the wall to the right.

Observation on 09/30/2024 at 11:34 AM, showed that the facility had installed a new automatic swing door and a floor to ceiling length window to left of the door. Observation showed there were exposed two-inch by four-inch wood studs and sheetrock across the top of the door frame from corner to corner.

In an interview on 09/30/2024 at 11:34 AM, Staff J, stated that the door had been installed about a month ago. Staff J stated that they had not finished the trim or sheetrock next to the door. Staff J stated that the ALF had not contacted CRS for the removal and addition of the new door.

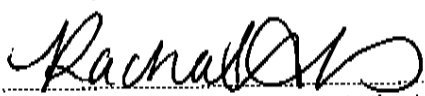
In an interview on 09/30/2024 at 11:58 AM, Staff H stated that the exit door was a sliding glass door before being replaced. Staff H stated that the work completed would have needed a review by CRS.

10.23.2024 15:52:03

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In an interview on 09/30/2024 at 12:00 PM, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that the ALF had not contacted CRS for the removal and addition of the new door.

In an interview on 10/02/2024 at 11:52 AM, with Collateral Contact 5 (CC5), construction review services, stated that the project for the new automatic exit door with partial glass wall and installation would have needed to have gone through CRS for approval. CC5 stated that the ALF had not contacted or placed an application to CRS for review.

Plan/Attestation Statement	
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 _____ Administrator (or Representative)	<u>10/30/24</u> _____ Date

WAC 388-78A-3090 Maintenance and housekeeping.

- (1) The assisted living facility must:
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that the ALF's exterior was structurally sound and in good repair for 2 of 4 (North and South) sides of the facility building. This failure placed the ALF at risk of continued disrepair and potential for worsening of the damaged areas.

Findings included...

Observations on 09/30/2024 at 11:00 AM and 10/03/2024 at 11:34 AM showed the following damages to the roof line of the facility:

In an interview on 09/30/2024 at 12:00 PM, Staff G, Licensed Practical Nurse/Director of Operations and Clinical, stated that the ALF had not contacted CRS for the removal and addition of the new door.

In an interview on 10/02/2024 at 11:52 AM, with Collateral Contact 5 (CC5), construction review services, stated that the project for the new automatic exit door with partial glass wall and installation would have needed to have gone through CRS for approval. CC5 stated that the ALF had not contacted or placed an application to CRS for review.

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Date

WAC 388-78A-3090 Maintenance and housekeeping.

- (1) The assisted living facility must:
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that the ALF's exterior was structurally sound and in good repair for 2 of 4 (North and South) sides of the facility building. This failure placed the ALF at risk of continued disrepair and potential for worsening of the damaged areas.

Findings included...

Observations on 09/30/2024 at 11:00 AM and 10/03/2024 at 11:34 AM showed the following damages to the roof line of the facility:

-Facing the facility, on the east side, to the right of the two main entrances there was a two-foot by three-foot hole in the soffit (underside of a buildings overhang), in the shape of an 'M'. To the right of that area was a one-and-a-half-foot horizontal line on the wood trim and the soffit showed the wood to be splintered and gouged.

-On the southwest back side of the facility, outside of the main dining room and by the outdoor patio area, the ALF's roof's corner showed the soffit and fascia (long, straight board that runs along the lower edge of the roof) to be damaged. A large portion of the corner soffit/fascia and roof was missing. In addition, there was a hole in the fascia and jagged edges of the wood trim to the opposite corner roof line on the southwest side.

-Along the southwest back side of the ALF there was jagged and splintered wood trim to five areas of the roof line.

-On the southwest side of the facility, past the resident smoking area, the length of the back roof line had splintered wood, peeling paint, and the soffit was not connected to the fascia.

-In a continued portion of the southwest corner there was a six-foot in length splintered, jagged wood trim, with the soffit and fascia separated.

-On the south side of the facility there were multiple areas of peeling paint.

-On the south side of the facility there were nine resident windows that had rubber seals that were warped.

-The rain gutters above the third floor on the south and north side of the facility were observed to be full of debris, leaves, and pine needles that were visibly seen from below.

-On the northwest side of the facility, the walkway had a one-inch lift across a sidewalk, making it an uneven surface for walking.

-There were cobwebs and wasp nests throughout the exterior of the building.

In an interview on 09/30/2024 at 11:34 AM, Staff H, Sales and Marketing Manager, and Staff J, Maintenance Director, stated that they had gotten an estimate for the damages under the roof for the whole building and that their policy was to get a total of three estimates. Staff J stated that they did not know why the ALF had not repaired the buildings damage previously.

10.23.2024 15:52:03

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In an interview on 09/30/2024 at 11:35 AM, Staff J stated that the building should have been pressure washed in the spring and fall. Staff J acknowledged that the sidewalk had a one-inch uneven surface for walking.

This is a recurring deficiency previously cited on 02/21/2023.

Plan/Attestation Statement

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Administrator (or Representative)

10/30/24
Date

In an interview on 09/30/2024 at 11:35 AM, Staff J stated that the building should have been pressure washed in the spring and fall. Staff J acknowledged that the sidewalk had a one-inch uneven surface for walking.

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