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

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

RE: Royal Columbian Senior Living License # 2581

Dear Administrator:

This letter addresses Compliance Determination(s) 24818 (Completion Date 06/02/2023) and 20832 (Completion Date 04/25/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/02/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4

The Department staff who did the on-site verification:
Felicia Cantu, Community Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 20832
Investigator: Felicia Cantu
Provider Type: Assisted Living Facility
Intake ID: 73243
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 03/08/2023 through 04/25/2023
Complainant Contact Date(s): 03/08/2023, 04/25/2023

Allegation(s):

1) A Named resident was exposed to fentanyl inhalation in the facility, that caused hallucinations, falls, and hospitalization.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Identified resident Facility staff Others not associated with the facility
Record Reviews:	Characteristic records Hospital records Resident records(face sheet, care plans, assessments, chart notes, doctor orders) Incident records

Investigation Summary:

Record review and interviews showed that the named resident was concerned they were having accidents and incidents due to second hand fentanyl smoke inhalation. The named resident had two falls and an incident of hallucinations and confusion that required hospitalization. The facility failed to investigate unwitnessed falls with injury and incident of hallucinations. Failed practice found. 388-78A-2371

Conclusion / Action:

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

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Statement of Deficiencies	License # 2581	Compliance Determination # 20832
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 4	Licensee: Greenlake Management Columbian, LLC	04/25/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 03/08/2023 and 03/08/2023 of:

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

This document references the following complaint number(s): 73243

The following sample was selected for review during the unannounced on-site visit: 4 of 81 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, Community Complaint Investigator

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

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

Gwin Kaarcher — 05/04/2023
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)

5/19/23
Date

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

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

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

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

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

(2) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to investigate, document investigative actions to determine the circumstances of accidents/incidents, and develop preventative measures, to protect the residents' health and wellbeing for 1 of 3 residents (Resident 1). This failure contributed to repeated falls, incidents, and hospitalization of Resident 1, and placed other residents in the ALF at risk for harm.

Findings included...

Record review of the facility's policy titled, "Internal Incident Report and State Incident Report" dated 08/10/2021, showed that the ALF must investigate and document investigative actions and findings for any accident, injury; or incident jeopardizing or affecting a resident health or life. When necessary, document appropriate measures to prevent future incidents.

Resident 1

Record review showed Resident 1 admitted to the ALF on [redacted]/2021. Review of an assessment dated 03/14/2023 showed that the resident was able to make needs known and did not have memory impairment issues.

On 03/08/2023 at 2:00 PM Resident 1 stated that they had been in and out the hospital for months, had experienced frequent falls, and had a drug reaction. Resident 1 stated that the hospital found fentanyl (a medication used for pain that has risk for addiction and can

cause trouble with breathing and death) in their lab work. "I have never used that medication and have never had that prescribed."

On 03/08/2023 at 2:00 PM Resident 1 also stated that they found out through other residents in the ALF that Resident 2 overdosed on fentanyl in Resident 3's room (next door to Resident 1) in January 2023. Resident 1 expressed concern that they were likely exposed to fentanyl via inhalation months prior and may have caused their hallucinations and falls. "I think that I had fallen due to the exposure, I had smelled weird stuff through my door often, and had told staff about the smell months prior, I think I could have fallen due to being under the influence." Resident 1 stated that the facility staff was aware there was ongoing inhalation drug use occurring by certain residents since October 2022. Resident 1 also stated that management did nothing timely to prevent further drug use in the building. "People would tell them, but they would not do anything about it." Resident 1 stated that they did not feel safe in the facility. I feel like they [ALF] did not protect the residents and my hospitalization could have been prevented.

On 03/08/2023 at 2:55 PM it was observed that Resident 1 and Resident 3 were next door neighbors. Apartments were five feet apart from Resident 1's door to Resident 3's door.

On 03/08/2023 at 4:55 PM Resident 1's Representative and Durable Power of Attorney (DPOA), CC1 stated that Resident 1 had a sequence of events in December 2022:

- On 12/22/2022 Resident 1 had an unwitnessed accident and was taken to the hospital due to knee pain. It was determined that Resident 1 had a ruptured knee.
- On 12/24/2022 Resident 1 had an unwitnessed fall and hit their head and was more confused.
- On [redacted] 2022 the facility staff called to notify CC1 that Resident 1 was not responding to care staff. CC1 went to the facility to check on Resident 1 and found them lying halfway out of the bed and was confused. Facility staff called for an ambulance. Resident 1 was admitted to the hospital for disorientation and hallucinations.

Record review of Resident 1's hospital History and Physical record showed:

- On 12/22/2022, Resident 1 had a same day Emergency Room (ER) visit which showed the resident was seen for unwitnessed fall that resulted in knee injury.
- On 12/24/2022, Resident 1 had an unwitnessed fall with increased confusion.
- On [redacted] 2022 Resident 1 was admitted to the hospital for confusion, hallucinations, and increased falls. Residents 1's confusion started three days prior according to the record. Lab work was positive for fentanyl with no history of fentanyl use. A diagnosis of [redacted] was identified. Resident 1 was discharged from hospital to another facility for rehabilitation on [redacted] 2023.

On 03/08/2023 at 4:55 PM Resident 1's Representative and Durable Power of Attorney (DPOA), CC1 stated that she told Staff A, Administrator in late December 2022 about Resident 1's positive fentanyl test in the hospital and was concerned that Resident 1 was exposed by secondhand inhalation. CC1 stated they had not received follow-up from Staff A or the facility.

On 03/08/2023 at 1:16 PM Staff A stated that she was aware that Resident 2 and Resident 3 had been smoking "paraphernalia" next door to Resident 1's room, and that it had been going on since November 2022. Resident 2 overdosed in Resident 3's room on illegal drugs and was sent to the hospital. Staff A heard rumors about fentanyl use in the building. Staff A stated that she did not recall being told by Resident 1's daughter that Resident 1 tested positive for fentanyl.

On 03/08/2023 at 1:16 PM Staff A stated that on 12/22/2022 and 12/24/2022 Resident 1 had unwitnessed falls. Staff A stated that she thought the unwitnessed falls were investigated and further stated that the allegation of Resident 1's fentanyl exposure was not investigated.

On 04/25/2023 at 12:37 PM, CC1 expressed that she felt if Resident 1's falls had been investigated the hospitalization on [redacted]/2022 could have been prevented. There was no follow-up on the incidents, no interventions done to protect Resident 1. "They could have offered to move rooms." CC1 stated "No one knew how and why the incidents occurred."

The record did not show that the above incidents were investigated. It was verified with Staff A that no investigations had been done regarding the above incidents in an email on 03/29/2023 at 6:35 PM.

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) 5/19/23

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

Administrator (or Representative) — Date: 5/19/23