



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  
4441 W. Airport FWY Ste 160  
Irving, TX 75062

RE: Royal Columbian Senior Living License # 2581

Dear Administrator:

This letter addresses Compliance Determination(s) 27754 (Completion Date 08/11/2023) and 20183 (Completion Date 06/09/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/11/2023 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-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3, WAC 388-78A-2120-4, WAC 388-78A-2210-1-b, WAC 388-78A-2610, WAC 388-78A-2610-1, WAC 388-78A-2610-2, WAC 388-78A-2610-2-a, WAC 388-78A-2610-2-b, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-d, WAC 388-78A-2610-2-e, WAC 388-78A-2610-2-f, WAC 388-78A-3010-5-b, WAC 388-78A-3010-5-c-i, WAC 388-78A-3010-5-c-iv, WAC 388-78A-3010-5-c-v, WAC 388-78A-3010-8-a-i, WAC 388-78A-3010-8-a-ii, WAC 388-78A-3010-8-a, WAC 388-78A-3010-8-d, WAC 388-78A-3010-8-e, WAC 388-78A-3010-8-f

The Department staff who did the on-site verification:

Laurel Knight, Community Complaint Investigator  
Melissa Milanez, Community Complaint Investigator

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

Sincerely,

*Gwin Kaercher*

Gwin Kaercher, Field Manager

Royal Columbian Senior Living # 2581

08/11/2023

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Region 1, Unit G

Residential Care Services



## Residential Care Services Investigation Summary Report

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/22/2023, 02/23/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 71095  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified Resident experiencing vomiting, diarrhea resulting in dehydration.
  2. Identified Resident not receiving the appropriate diet.
  3. Identified Resident not being monitored to ensure medical needs being met.
- 

### Investigation Methods:

|                        |                                                                                                                  |
|------------------------|------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2                                 |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Dining<br>Staff to resident interactions<br>Environment<br>Care and services |
| <b>Interviews:</b>     | Identified resident<br>Residents<br>Nursing staff<br>Dietary staff<br>Kitchen staff                              |
| <b>Record Reviews:</b> | Medical records<br>State reporting log<br>Care Plan<br>Chart notes                                               |

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### Investigation Summary:

1. Identified resident stated they were weak from being ill. Staff interviews confirmed the resident had been having nausea and vomiting and experienced falls. In addition, resident was sent to the hospital with dehydration and a urinary tract infection. There were not facility records noting current assessments, weights, oral intake or change in condition. Deficient practice was identified related to the failure to monitor the resident's condition, please see the statement of deficiency for WAC 388-78A-2120 dated 06/09/2023.

2. Observations showed Identified resident was brought food and it was unwrapped and left at the bedside. The resident was observed to be unable to locate their drink or food. The resident was unable to physically sit up to feed themselves. The facility licensed staff stated that the resident had been ill with nausea and vomiting. Unable to locate records for tracking weights, or oral intake, tracking and monitoring of changes. No deficient practice identified.

3. The resident was sent to the hospital for evaluation about 10 hours after the fall. There were not facility records noting current assessments, weights, oral intake or change in condition. Deficient practice was identified related to the failure to monitor the resident's condition, please see the statement of deficiency for WAC 388-78A-2120 dated 05/12/2023.

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**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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/22/2023, 03/03/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 71250  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified Residents' room was marked with a sign that misidentified their name.
  2. The apartment was dirty, they did not have sheets on the bed and the rooms smelled of urine.
  3. Identified Resident was wearing the other resident's clothing that was too small.
  4. Identified Resident was wearing soiled pajamas, and no staff answered their call for assistance to change.
  5. Identified Resident had scabs and bruising on their arms that they said was from staff hurting them.
  6. Identified Residents had rotten food in the fridge, no cups to drink water. Both residents stated they were hungry, and staff said the residents threw away their food.
  7. The closet door was hanging off the track and looked ready to fall.
  8. Medications were not given as ordered.
- 

### Investigation Methods:

|                        |                                                                                                                                                                                    |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2                                                                                                   |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Dining<br>Resident rooms<br>Staff to resident interactions<br>Resident care equipment                                                          |
| <b>Interviews:</b>     | Identified resident<br>Staff<br>Nursing staff<br>Kitchen staff                                                                                                                     |
| <b>Record Reviews:</b> | Medical records to include negotiated service agreement, medication administration records and chart notes<br>State reporting log<br>Facility policies<br>pharmacy dispensing logs |

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**Investigation Summary:**

1. Identified Residents' room was marked with their names on the door, and one was incorrect.
2. The apartment was visibly soiled and had a strong smell of urine and feces. The beds were covered with a blanket, the room had visible stool on the mattresses. Their representative stated they thought they had to help the Named Residents with cleaning the apartment. Review of the negotiated service agreement stated the facility was responsible for housekeeping assistance. Staff interviews confirmed that all staff were responsible for cleaning biohazards to prevent the spread to other areas of the apartment. Deficient practice identified, please see the statement of deficiency dated 06/09/2023 for failing to ensure infection control practices were in effect, WAC 388-78a-2610.
3. The Named Resident was wearing clothing that belonged to their spouse. The clothing was too small for their frame and the resident said that it was uncomfortable to wear. Observation of the closet showed just the small sized clothing. The resident and their representative stated they had clothing when they moved in but did not know what happened to their clothing. The facility staff stated they did not come with any clothes, and they took donated clothing to them. No deficient practice identified.
4. Named Resident was observed in a nightgown that had stool on it, the resident also had stool on their body. Both residents had body odors. Staff interviews confirmed the residents were resistant to help with showering, changing, or clothing changes at times. Their representative stated they had to help with supplying personal care items and helping with personal care when they visited because staff were not keeping up with the cares.
5. Named Resident had bruising and scabbed areas on their arms. Resident interviews confirmed they had hit their arms on their wheelchair and the walls, and no one was mean to them. Staff interviews confirmed that the residents helped each other instead of calling and waiting for assistance. No deficient practice identified.
6. Named Residents had a refrigerator with new and expired food in it. Rotten food was observed in the garbage. There were no cups for water. Staff interviews concluded that staff were always able to get food for the residents after the kitchen closed and there was no reason, they couldn't have had another meal delivered. Staff stated that the Identified residents sometimes didn't remember they had food brought to them by the facility.
7. The closet door was hanging off the track and was unstable to the touch. Resident interview confirmed they were unable to open and close the closet doors. Facility staff stated they were not aware of the door condition. No deficient practice identified.
8. The Named Resident's representative stated that their medications were not being given as ordered. Interviews with licensed staff at their new facility stated they received part of the resident's medications ordered when they were discharged. The identified resident's medication reconciliation showed medication discrepancies between the number dispensed from the pharmacy when compared to the medication administration records. Facility staff stated they had concerns with medication systems. Deficient practice identified, please see the statement of deficiency for failure to ensure safe medication services, WAC 388-78a-2210 dated 06/09/2023

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**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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/23/2023, 05/03/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 70274  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified Resident was found without any supplied food or water.
  2. The care logs were missing three days of being signed off and no care was done.
  2. The apartment had dirty blankets, sheets and moldy clothing in it.
  3. The CPAP, (respiratory equipment for sleep apnea) was moldy and feces covered, the power chair was dirty and the manual wheelchair had been donated.
  4. The new facility was having trouble getting the medication and orders straightened out when they moved. They were unable to find their glucose meter or the continuous glucose monitoring sensors that were ordered and were not applied after they arrived.
  5. The electrical outlets had no cover and wires hanging out.
- 

### Investigation Methods:

|                        |                                                                                    |
|------------------------|------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2   |
| <b>Observations:</b>   | Residents<br>Resident rooms<br>Resident care equipment                             |
| <b>Interviews:</b>     | Residents<br>Nursing staff<br>Identified staff                                     |
| <b>Record Reviews:</b> | Medical records<br>State reporting log<br>Incident investigation<br>Staff patterns |

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### Investigation Summary:

1. Identified Resident no longer lived at the facility. Interviews with their representative confirmed they had visited the resident and observed that they did not have access to food or water to drink because it was not delivered. Interviews with facility staff showed the resident was on the list to have meals delivered to their apartment. No deficient practice rising to the level of citation was identified.
2. The identified Resident's representative stated that they had moved the resident

due to the resident not having proper care and services. They stated that the resident was not able to get up and they had falls when they tried to get out of bed to find help. They stated that the resident's care log was not signed off for three days. Facility staff stated that the resident had care and the staff forgot to sign the sheet. No deficient practice rising to the level of citation was identified.

2. The Named Resident's apartment had a mix of clean and dirty clothing, and dirty linens in it. There were no moldy items observed. The facility staff stated they had left everything intact in the room and were waiting to see if the resident wanted more of their items. No deficient practice rising to the level of citation was identified.

3. The resident's respiratory equipment was not moldy or feces covered. Facility interviews confirmed that the respiratory company serviced the equipment and concluded it was operational. Facility staff stated that they were given permission by the resident to donate the manual wheelchair. The powerchair seat cover had visible spots on the removable fabric cover and there was dirt and material on the hard surface covering the internal operating parts of the chair. No deficient practice rising to the level of citation was identified.

4. The resident's representative stated that the new facility stated that the medications sent to them showed errors and that the resident was supposed to have a different insulin. Facility interviews confirmed they were unable to locate the resident's personal blood glucose monitor and the sensors for the continuous glucose monitor. Medication orders and the medication administration records showed matching orders. Interview with the provider at the new facility stated they were not able to reconcile the medications received to the ones documented as given. The medication reconciliation records requested from the new facility were not received for review. No deficient practice rising to the level of citation was identified.

5. The resident room was observed by the department investigator and department fire marshal and there was a junction box for cable with non-electric wires exposed. No deficient practice identified.

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**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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/17/2023, 05/03/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 70748  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified resident was experiencing abuse and neglect at the facility.
  2. Identified resident was not being fed, changed or repositioned frequently enough.
  3. Identified resident's wound worsened from lack of repositioning and wound care.
- 

### Investigation Methods:

|                        |                                                                                                                                            |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2                                                           |
| <b>Observations:</b>   | Residents<br>Resident rooms<br>Staff to resident interactions                                                                              |
| <b>Interviews:</b>     | Residents<br>Nursing staff<br>staff<br>Outside agency staff<br>Social Services worker                                                      |
| <b>Record Reviews:</b> | Medical records to include negotiated service agreement, chart notes<br>State reporting log<br>Incident investigation<br>Facility policies |

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### Investigation Summary:

1. The Identified resident had been moved from the facility. Representative and outside agency staff interviews confirmed the resident was discovered in bed with urine, feces and vomit covering them, and they stated the facility had not been able provide the amount of care needed by the resident's change in condition. The facility staff stated they had been very busy with emergencies on the morning this occurred and had not had a chance to provide care yet when the observation was made. There were not facility records noting current assessments, oral intake or change in condition Deficient practice identified, please see the statement of deficiency for failure to monitor resident condition, WAC 388-78a-2120 dated 06/09/2023.

2. The resident was observed to have briefs that needed to be changed due to urine and stool when they came for wound care visits on more than one date. Facility care logs showed some gaps in log signatures.
  3. The outside agency notes showed the resident wound was worsening due to lack of repositioning and dressing changes. Deficient practice identified, please see the statement of deficiency for failure to monitor resident condition, WAC 388-78a-2120 dated 06/09/2023.
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**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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/24/2023, 02/27/2023, 02/28/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 71500  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified resident had two falls in which they hit their head 10 hours before the facility requested transport to the hospital.
  2. Identified resident was confused and facility staff were not supplying additional information on their status for continued care.
- 

### Investigation Methods:

|                        |                                                                                                           |
|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2                          |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Resident rooms<br>Staff to resident interactions                      |
| <b>Interviews:</b>     | Identified resident<br>Nursing staff<br>Residents                                                         |
| <b>Record Reviews:</b> | Medical records<br>Hospital records<br>State reporting log<br>Incident investigation<br>Facility policies |

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### Investigation Summary:

1. The Identified resident was observed prior to the arrival of the emergency medical services. Interviews with facility staff confirmed the resident had two falls nine hours prior and had noted they hit their head and had a bloody nose. Interviews of outside agency staff confirmed stated they did have information supplied to them on the the resident's condition or why it was requested to send the resident to the hospital for evaluation. There were not facility records noting current assessments or change in condition. Deficient practice identified, please see the statement of deficiency for failure to monitor resident condition, WAC 388-78a-2120 dated 05/12/2023.
2. The Identified resident had blood noted on their face and mouth and call pendant.

They stated they had a fall but were unable to provide details. Interviews with facility staff confirmed a change in the resident's condition that day. Facility staff interviews and policy review showed the facility policy was to send resident's to the hospital in timely manner if they hit their head. Deficient practice identified, please see the statement of deficiency for failure to monitor resident condition, WAC 388-78a-2120 dated 06/09/2023.

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**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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/27/2023, 02/28/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 72003  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified resident was made to walk and that caused them to injure their knee that later caused them to fall.
- 

### Investigation Methods:

|                        |                                                                                                                                              |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2                                                             |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Staff to resident interactions                                                                           |
| <b>Interviews:</b>     | Identified resident<br>Residents<br>Nursing staff                                                                                            |
| <b>Record Reviews:</b> | Medical records including negotiated service agreement and chart notes.<br>State reporting log<br>Incident investigation<br>Hospital records |

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### Investigation Summary:

1. Identified Resident stated an Identified staff member had them try to walk after not walking for months due to weakness and that caused them to fall. Facility staff interviews confirmed the resident fell and was transferred to the hospital and were admitted for a wound and blood infection from open leg wounds. Facility staff stated that their investigation showed the resident was not made to walk. Deficient practice was identified related to the failure to monitor the resident's wound condition, please see the statement of deficiency for WAC 388-78a-2120 dated 06/09/2023.
- 

### 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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/27/2023, 02/28/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 72000  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified Resident experiencing vomiting and diarrhea.
  2. Identified Resident was unable to access their food and drink.
  3. Identified Resident not being monitored to ensure the care and services were meeting their needs.
- 

### Investigation Methods:

|                        |                                                                                                           |
|------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2                          |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Resident rooms<br>Staff to resident interactions                      |
| <b>Interviews:</b>     | Identified resident<br>Nursing staff<br>Residents                                                         |
| <b>Record Reviews:</b> | Medical records<br>Hospital records<br>State reporting log<br>Incident investigation<br>Facility policies |

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### Investigation Summary:

1. Outside agency staff interviews confirmed the Identified resident said they fell and were unable to provide any details due to confusion. Facility staff interviews confirmed that the resident fall was not witnessed but had recent history of falls, urinary tract infection, vomiting and diarrhea illnesses that required hospital visits. There were not facility records noting current assessments, oral intake or change in condition. Deficient practice identified for failing to ensure the resident's condition, please see the statement of deficiency for WAC 388-78a-2120 dated 06/09/2023.
2. Interviews with outside agency staff confirmed the Identified resident had breakfast tray that was not opened, was cold to the touch and out of reach. There were not

facility records noting current assessments, oral intake or change in condition. Deficient practice identified for failing to ensure the resident's condition, please see the statement of deficiency for WAC 388-78a-2120 dated 05/12/2023.

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**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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/07/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 69043  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified resident fell and was lying on the floor for multiple hours.
  2. Identified resident had significant wounds and rashes.
- 

### Investigation Methods:

|                        |                                                                                  |
|------------------------|----------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2 |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Dining                                       |
| <b>Interviews:</b>     | Identified resident<br>Residents<br>Nursing staff                                |
| <b>Record Reviews:</b> | Medical records<br>State reporting log<br>Hospital records                       |

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### Investigation Summary:

1. Identified resident interview confirmed the resident fell and laid on the floor for what they felt was a long time. Interviews with facility staff confirmed that the resident had recent nausea, vomiting and falls and when they found the resident they estimated that it had been eight or nine hours. Hospital record review showed they were admitted for treatment of rhabdomyolysis, (kidney damage from serious muscle damage from prolonged time on the floor) and wound care. Deficient practice was identified related to the failure to monitor the resident's condition after the fall and illness, please see the statement of deficiency for failure to monitor the resident's condition, WAC 388-78a-2120 dated 06/09/2023.

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### 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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/02/2023, 02/03/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 68539  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified Resident's medications are not ordered regularly from the pharmacy or given correctly.

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### Investigation Methods:

|                        |                                                                                  |
|------------------------|----------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2 |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Dining                                       |
| <b>Interviews:</b>     | staff<br>Residents<br>Nursing staff<br>Family members                            |
| <b>Record Reviews:</b> | Medical records<br>State reporting log<br>pharmacy dispensing logs               |

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### Investigation Summary:

1. Identified resident interview confirmed they were aware their medications were not being given as ordered and they were worried they were going to die from not getting their insulin correctly. Interviews with licensed staff at their new facility confirmed they received only part of the resident's medications when the resident discharged from the facility. Observation and record review showed discrepancies in the number of medications documented on the record as given as compared to the number of medications left on hand. The pharmacy dispensing logs showed medications as dispensed that did not match the medications documented as given. Facility staff stated they had concerns with medication systems. Deficient practice was identified, please see the statement of deficiency for failing to ensure a safe medication system, WAC 388-78a-2210 dated 06/09/2023.

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**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

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**Provider/Facility:** Royal Columbian Senior Living  
**License/Cert.#:** 2581  
**Compliance Determination #:** 20183  
**Investigator:** Laurel Knight  
**Investigation Date(s):** 02/02/2023 through 06/09/2023  
**Complainant Contact Date(s):** 02/09/2023

**Provider Type:** Assisted Living Facility  
**Intake ID:** 69623  
**Region/Unit #:** RCS Region 1 / Unit G

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### Allegation(s):

1. Identified resident is not receiving the care and services they need at the facility.
  2. Identified resident has a wound that is worsening due to sitting in wet briefs and not having dressing changes as ordered between agency visits.
- 

### Investigation Methods:

|                        |                                                                                                                                                                                        |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 76<br>Resident sample size: 20<br>Closed records sample size: 2                                                                                                       |
| <b>Observations:</b>   | Residents<br>Resident rooms<br>Staff to resident interactions<br>Resident care equipment                                                                                               |
| <b>Interviews:</b>     | Residents<br>Nursing staff<br>staff<br>Therapy staff<br>Social services                                                                                                                |
| <b>Record Reviews:</b> | Medical records including negotiated service agreement, chart notes<br>State reporting log<br>Incident investigation<br>Outside agency records including assessments, notes and orders |

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### Investigation Summary:

1. The Identified resident observation showed they had a food plate at their bedside but were unable to reach or feed themselves. Interviews with outside agency staff confirmed the resident's food was observed untouched at the bedside when they visited. Interviews with the resident representative concluded they felt the facility had not been able to feed and provide the amount of care needed by the resident's change in condition and the resident was moved from the facility to a higher level of care at their request. Unable to locate records for tracking oral intake and monitoring of

changes. Deficient practice was identified, please see the Statement of Deficiency dated 06/09/2023 for failure to monitor the resident's condition, WAC 388-78a-2120.

2. Observation of Identified resident wound care and dressing change was done. Interview of outside agency staff confirmed the wound dimensions were increasing and had found non ordered wound care product in the wound. Record review of outside agency notes showed their wound was worsening due to lack of repositioning and dressing changes. Unable to locate facility records for tracking wound status, dressing changes, oral intake tracking, or monitoring of changes. Deficient practice was identified, please see the Statement of Deficiency dated 06/09/2023 for failure to monitor the resident's condition, WAC 388-78a-2120.

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**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

|                           |                                               |                                  |
|---------------------------|-----------------------------------------------|----------------------------------|
| Statement of Deficiencies | License #: 2581                               | Compliance Determination # 20183 |
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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 02/02/2023, 02/07/2023, 02/09/2023 and 03/03/2023 of:

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

This document references the following complaint number(s): 71095, 71250, 70274, 70748, 71500, 71949, 69362, 72003, 72000, 72540, 70796, 69043, 68603, 68539, 69623, 73411

The following sample was selected for review during the unannounced on-site visit: 20 of 76 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator  
Sarah Clark, Community Complaint Investigator

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

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

*Gwin Kaercher*  
Residential Care Services

06/21/2023  
Date

Statement of Deficiencies

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Plan of Correction

Royal Columbian Senior Living

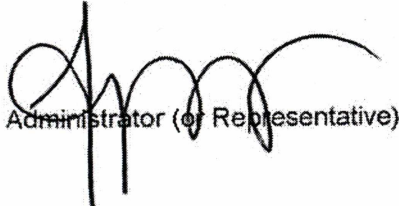
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I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.



Administrator (or Representative)

Date 7.7.23

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

(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

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(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 implemented interventions to prevent further decline in condition for residents who had a change in condition for 4 of 4 residents (Residents 1, 2, 3 & 7). These failures contributed to residents transferring to outside care settings for Residents 2 & 7 and hospital admissions for Residents 1, 3 & 7.

**Findings included...**

Review of the facility policy titled, "Clinical 13-Fall Response," dated 08/10/2021, showed that the Health and Wellness Director or Medication Technician (MT) on duty each shift would summon emergency medical services, (EMS) for any resident that hit their head, had significant trauma, or if there was a question, they may have head trauma. The Health and Wellness Director or MT would monitor the resident for 48 hours after the fall and make a brief narrative charting entry. The Negotiated Service Agreement (NSA) would be updated with a first fall and repeat falls, a fall with injury requiring medical intervention/treatment and any change in condition.

Review of the facility policy titled, "Clinical 04-Wound and Skin care," dated 08/10/2021, showed that the facility would promote good skin integrity and wound healing practices. They would evaluate and manage resident skin care needs with an individualized NSA and promote good skin integrity through appropriate interventions including managing bowel and bladder incontinence, addressing nutrition and hydration needs, appropriate utilization of pressure reducing devices, proper turning and repositioning, and any other physician ordered interventions. When an area of concern is identified the Community nurse or designee is to meet with the resident and complete the Skin Integrity Monitoring Form. One form is completed for each separate area of concern.



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The Community nurse or designee is to follow-up at least weekly until the skin issue is resolved. The Wellness Director will complete appropriate documentation including interventions implemented and response to treatment. If another agency such as home health is involved to assist in the skin care program, the Wellness Director is still required to complete and document skin integrity. The facility will seek emergency medical attention if there are signs and symptoms of the wound becoming infected. Signs and symptoms may include, but are not limited to pain, swelling, redness, warmth to the touch, purulent drainage or odor.

#### Resident 7

Facility record review showed the resident was admitted to the facility on [REDACTED]/2022. They had diagnoses including [REDACTED]. The resident required assistance of two staff for positioning, transfers, and ADL's. Resident 7 used a power chair for mobility.

Review of Resident 7's Chart Notes showed a note by Staff B, Licensed Nurse on 12/20/2022 at 5:08 PM that Resident 7 had hit their knee on the doorframe causing an abrasion to their left knee. There were no other notes that showed the resident's wound was being assessed or monitored by the facility nurse.

Resident 7's shower/skin sheets from 11/24/2022 through 02/16/2023 showed the licensed nurse did not complete the skin portion despite the resident having an abrasion to their left knee. No additional shower/skin sheets were provided as of 03/20/2023.

On [REDACTED]/2023, Staff H, MT made a note at 10:30 AM that showed Resident 7 had a fall while transferring with Staff P, Caregiver. The resident became nauseated, vomited, and requested to go to the hospital because their leg was hurting.

Record review showed Resident 7 was admitted to the hospital for treatment of [REDACTED] on [REDACTED]/2023, [REDACTED] and [REDACTED].

Review of the hospital's wound assessment dated [REDACTED]/2023 showed multiple wounds on admission to the hospital including multiple wounds in various stages to the left and right lower legs, left knee abdominal folds and Resident 7's bottom. During the hospital admission, Resident 7 had a change in condition and rapidly needed to have critical care services and was transferred to the intensive care unit where the resident was intubated, (breathing tube inserted for breathing) and immediate life saving measures were initiated. Resident 7 was in the hospital for 18 days and then discharged to a rehabilitation facility.

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On 02/28/2023 at 2:15 PM Staff A, Executive Director stated Resident 7 had a home health nurse in charge of doing their wound care. Staff A said a home health nurse had checked on that day [02/28/2023] to see where the resident was, and the facility let them know they were transferred out.

On 02/28/2023, reviewed Resident 7s record, there were no documented skins assessments or wounds care from a home health agency.

On 03/02/2023 at 11:04 AM, Resident 7 stated they had injured his knee on the doorframe of their room because the corner was tight while seated in their powerchair. They stated they had developed an infection of the wounds. Resident 7 stated Staff B was aware of their wounds, but they did not have any dressings, care or visits provided at the facility by the facility nurse or home health nurse.

On 03/02/2023 at 11:17 AM Collateral Contact 8 (CC8), Home Health Clinical Director stated that their agency had a referral sent on 02/22/2023 from Resident 7's primary care for wound care of a non-infected skin tear and multiple skin wounds. The CC8 stated they had Resident 7 on the schedule to start wound care 03/03/2023.

On 03/20/2023 at 11:31 AM, Staff D, Resident Care Coordinator stated Resident 7 liked to have showers on the weekend and the shower sheets from the weekend should have wound descriptions. Staff D stated that Resident 7 had wounds on their legs and home health had been ordered by the primary care provider's office at their last appointment. The wound care referral was sent by the office to the home health agency and a visit had been scheduled but the resident went to the hospital first.

#### Resident 1

Review of Resident 1's record showed the resident was admitted to the ALF on [REDACTED]/2020. Their NSA dated 04/21/2022 showed the resident needed occasional assistance with dressing, transfers, toileting, standby monitoring for safety and staff should ask the resident if they needed help. Resident 1 required assistance with meals, medications, and housekeeping.

Review of the Alert Charting log, which tracks resident incidents or changes in condition did not have an entry for Resident 1's fall dated 01/29/2023. The log had columns that included prompts for name, reason for the alert charting, the observations and information to report, the frequency of the alert and the length of the alert and a column to indicate when the alert charting was discontinued. No documentation of an incident report, investigation, interventions or other monitoring measures were found in Resident 1's medical record.

Review of a chart note dated 02/01/2023 at 7:41 PM by Staff I, MT showed the resident was confused and was not using their walker. They were escorted back to their apartment



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where they vomited and stated they felt better. The note stated the resident's representative asked for a urine sample to be collected to evaluate for a urinary tract infection, (UTI) and vital signs were taken, (Blood Pressure 178/86, pulse 104) and the nurse was called to assess the resident. There were no abnormalities noted.

In review of Resident 1's facility record, there were no other documented records between 02/01/2023 7:41 PM and when the resident was admitted to the hospital after a second fall on [REDACTED]/2023 to show Resident 1 had been evaluated, monitored or any new implementations identified.

Hospital record review dated [REDACTED]/2023 showed the resident was admitted to the hospital on [REDACTED]/2023 with [REDACTED] to a ground level fall with prolonged down time on the floor. Resident 1 also was diagnosed on admission with [REDACTED] and [REDACTED]

Resident 1 was observed on 02/07/2023 at 12:45 PM at a rehabilitation center. The resident was pale, had multiple bruises in varying colors on their face, arms, and legs. Resident 1 stated they recently had two falls at the assisted living facility. They stated the first fall happened in the shower on 01/29/2023 and resulted in an injury to their elbow. They later vomited but they were not sure why. The resident stated they did not get checked on frequently after their fall and that they fell again and went to the hospital on Saturday ([REDACTED]/2023.) Resident 1 was not sure how long they were lying on the floor but stated they thought it was quite a while.

On 02/07/2023, Staff D stated Resident 1 was not acting like themselves after their fall on 01/29/2023 and they had observed the resident have some confusion and vomiting.

On 02/08/2023 at 10:25 AM, Staff H stated they were working on the morning of [REDACTED]/2023 and observed that Resident 1 was not in their usual spot in the lobby at 8:00 AM. They sent Staff K, a caregiver to check on the resident. Resident 1 was found lying at the foot of the bed without their call pendant. Staff H stated they thought the resident fell while changing their clothes and laid there most of the night. Staff H stated the resident normally went to bed around 9:00 or 10:00 PM.

On 02/08/2023 at 10:35 AM, Staff B stated they was aware that Resident 1 fell in the shower on 01/29/2023 and had a skin tear from the fall. Staff B stated they had not updated the resident's medical record as needed for Resident 1 because they were too busy to get the monitoring updates done. There was no documentation by Staff B, in Resident 1's record to show there was monitoring, evaluated or identify any interventions when a change of condition occurred.

As of 02/08/2023, Resident 1s facility record showed there were no updates to the NSA

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after 04/21/2022 regarding falls, monitoring, preventative interventions, or a change in resident condition as indicated in the ALF's fall policy.

## Resident 3

Facility record review showed Resident 3 was admitted to the facility on [REDACTED]/2022 and the residents NSA dated 02/01/2023 showed that Resident 3 required assistance with meal set up due to vision impairment, medications, showers, housekeeping, and laundry.

Review of an incident report dated 02/22/2023 at 4:50 AM showed the resident was found on the floor of their bedroom on top of a basket. The resident had a laceration to their lip and a bloody nose per Staff O, Caregiver. Staff B made an additional note on the incident report to show the resident was found on the floor again at 9:00 AM and there were no injuries. No additional monitoring, assessment or interventions were noted.

Resident 3 was observed in their room on 02/22/2023 at 1:17 PM. Their mouth and lips were dry and cracked, with dried blood on them from a laceration. Resident 3 was confused at times, and it was hard for them to talk because of their dry mouth. There was a large blood clot in the back of Resident 3's throat making it hard for them to swallow. Their left knee was bruised and turning dark and there was a scabbed abrasion on the right shin.

During an interview on 02/22/2023 at 2:24 PM, Staff B was in Resident 3's room and stated they were told the resident fell about 4:00 AM on 02/22/2023. Staff B stated they fell again and found the resident on floor around 9:00 AM (five hours later). When observing the resident, Staff B stated they were not aware of where the blood in the Resident 1's mouth was coming from. Staff B stated they were too busy with heavy care residents to get the necessary monitoring updates done for Resident 3 after having found the resident on the floor around 9:00 AM that morning.

On 02/24/2022 at 12:00 PM, Collateral Contact 3 (CC3), Emergency Medical Services Paramedic stated they observed Resident 3 at the facility on 02/22/2023. They stated Resident 3 had a dry mouth, scrapes and bruising on their face and a bit of a swollen nose. The resident looked injured and couldn't tell CC3 what happened. They stated Staff B would only say that the state told her the Resident had to be evaluated at the hospital. They stated they discovered the resident had fallen about 10 hours previously, hit their head and then fell again a few hours later. The resident was scratching at their brief like they may have a UTI. CC3 stated the Staff B "did not tell us the resident had recent symptoms of nausea and vomiting".

On 02/24/2023 at 1:03 PM Staff N, Caregiver stated they were working when Resident 3 fell the second time on 02/22/2023. They stated Resident 3 and their roommate Resident 4 had been ill with vomiting and diarrhea. Staff B had asked for help getting Resident 3 up off the floor. Staff N stated they thought the nurse was going to do an assessment and monitoring of the resident's condition, but they followed the caregiver out of the room. No



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assessment, monitoring or interventions were completed or identified at that time.

On 02/27/2023 at 10:04 AM Collateral Contact 4 (CC4), Emergency Medical Services Supervisor stated Resident 3 was found lying on the floor after another fall on 02/27/2023. The bed had dried blood spots in multiple places under the bath blanket on the mattress and on the call light pendant. The resident had dried blood on their left nostril and face. An unidentified facility caregiver said it was old and their left hand was bleeding. The area the resident was lying in had dried feces or vomit splatter on the carpet and wall that was a brown color. CC4 was concerned about the resident because they had an altered mental status and were not able to communicate what happened. CC4 stated there were concerns about the facility's ability to recognize the resident's care needs as their condition changed and recommended Resident 3 not return to current ALF.

## Resident 2

Facility record review showed Resident 2 was admitted to the facility on [REDACTED]/2018.

The NSA dated 01/26/2023 showed the resident was started on hospice care and required total assistance from staff. It showed the resident was unable to use their call light for help independently and caregivers were to check on Resident 2 every two hours and when calling out for help. Caregivers were to reposition every two hours around the clock and use two people for transfers.

The residents chart note showed on 01/16/2023 at 3:34 PM, Staff D noted the resident had developed a wound and home health was ordered noted on 01/16/2023, and another note on 01/19/2023 at 3:36 PM Staff D noted the resident started on hospice and was using a hospital bed. Chart notes did not show any notes or wound assessments and no documentation of monitoring the resident by the facility nurse.

Hospice record review dated 01/20/2023 showed that on admission at 1:00 PM Resident 2 was assessed as maximum assistance needed for feeding and total dependence on staff for activities of daily living (essential and routine tasks). Hospice notes showed the resident had lost 12 pounds in four months and weighed [REDACTED] pounds on admission.

A chart note made by CC2 on 02/01/2023 at 2:30 PM showed that Resident 2 was found soaked in urine that saturated through their brief and the sheets beneath them. The note showed an increased area of redness in the perineal area. Note review showed CC2 contacted Staff B about the importance of keeping the resident clean, dry, and repositioned frequently to prevent the wound worsening.

Chart notes made by CC2 on 02/08/2023 at 2:00 PM showed the resident was found in bed left in the high position, they had a soiled brief and another full plate of cold food

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sitting at the bedside covered with foil.

Hospice order review provided by the ALF and the agency show an order for wound care on 01/24/2023 at 2:38 PM to apply a collagen sheet to wound daily for 30 days and cover wound with silicone cover dressing every day for 30 days. "Cleanse wound with cleanser of choice. Pat dry. Apply collagen sheet to wound bed. Folding, tearing, stacking, and filling tunneling and depth of wound bed. Cover with bordered dressing. Change daily. Caregiver to change on the days nurse is unavailable per nurse instruction."

On 02/08/2023 at 6:30 PM Staff L, Caregiver stated that Resident 2 needed total assistance with eating. Staff L stated that sometimes they felt the resident was not getting all their meals because they were very hungry when Staff L came on shift. Staff L stated they did not get training they needed to know what to do when they found things like residents not getting care they needed. Staff L stated that Resident 1's wounds were taken care of by hospice and if they were soiled to let the MT know.

On 02/09/2023 at 3:40 PM, CC2 stated they had talked with Staff B about the wound condition not healing or improving. They stated they were told by Staff B they had asked facility staff to reposition the resident every two hours, but that Staff B was not sure if it is being done. The CC2 stated that based on their observations the resident was not getting adequate repositioning, changing or nutrition to help the wound heal. CC2 stated that the staff were not delegated to change the dressing and so they were not getting changed on the days the agency was not coming to the building. "I specifically left the dressing packages on the table today to see if they would change the dressing. None of the dressings from the box have been used except for the ones I have done. Today is not my usual day to come and the dressing here is left from yesterday". The CC2 stated they were concerned the facility did not notice or meet the changing care concerns of their shared patient.

Resident 2 was observed at the facility on 02/09/2023 at 4:00 PM. The resident was lying in bed and appeared thin and pale. Wound observations done during a dressing change on the resident's coccyx (bottom) by Collateral Contact 2 (CC2), an outside agency nurse. The wound was a Stage III pressure ulcer, (deeper wound with full skin thickness) that measured 4 x 5 centimeters (cm) with tunneling into the area around the wound another 3-4 cm. Resident specific wound care supplies brought by the outside agency were observed in the Resident's room.

On 02/09/2023 at 7:06 PM Staff A was asked what care and services Resident 2 received from the facility. They stated Resident 2 is on hospice and that Staff B has been working with staff to make sure they are repositioned frequently. Staff A stated that Resident 1 has a wound that is managed by hospice, and the facility did not have any orders that tell them what to do for dressings.

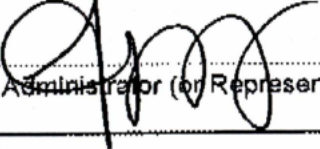
On 02/16/2023 at 2:30 PM Resident 2's Collateral Contact 9, Resident Representative, stated they had spoken with the facility nurse about their concerns that the facility was not recognizing the changing care needs of Resident 2. They stated an outside agency for



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hospice services moved Resident 2 to a hospice facility unplanned on [REDACTED] 2023 after the outside agency staff found the resident lying in bed covered in feces and vomit.

This is a recurring deficiency previously cited on 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) <u>07.07.23</u> . |                         |
| In addition, I will implement a system to monitor and ensure continued compliance with this requirement.                                                                                                                                                                 |                         |
| <br>Administrator (or Representative)                                                                                                                                                   | <u>07.07.23</u><br>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.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that their medication system provided a safe delivery of resident medications for six of six Residents (Residents 6, 8, 9, 10, 11 and 12). This failure resulted in residents missing medication and errors in medication administration.

**Findings included...**

Record review of the facility's medication policy titled, "Med 2 – Medication Services" dated 08/10/21, showed that the Executive director would ensure that medication related services required or requested by each resident was provided. All medication handled, stored, or assisted with would be documented on the Medication Assistance Record, (MAR) and in accordance with state regulations.

Resident 6

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On 02/02/2023 at 1:45 PM, Staff Q, Front desk staff, provided the characteristic roster which showed Resident 6 moved into the facility on [REDACTED]/2022 and facility staff assisted Resident 6 with their medication.

Review of Resident 6's Negotiated Service Plan (NSA) dated 08/12/2022 showed that the resident was a type 1 diabetic and required insulin and blood sugar monitoring. The NSA showed that the facility was responsible for ordering, stocking, and the assistance with medications. The section 'Self Medication/Administration' had two options checked: Needs assistance with one or more medications and Required administration for one or more medications and blood sugar checks updated by Staff B, Facility licensed nurse on 12/15/2022. Resident 6's record showed that the resident was transferred to the hospital on [REDACTED]/2023 for diabetic related issues.

On 02/22/2023 at 9:08 AM, Collateral Contact (CC6) stated that Resident 6 was going to be admitted to their facility after discharging from the hospital and that when they went to pick up Resident 6's medication, at the ALF and there were only seven of the 15 medications, including insulins, available and one pack only had two pills in it. CC6 stated that when she asked Staff D, Resident Care Coordinator (RCC)/Medication Technician (MT), about the resident's medications and Staff D stated they were required to dispose of insulin 28 days after being opened. Additionally, there were no replacement medications for the resident because they had missed their primary care provider appointment.

On 02/02/2023 at 10:35 AM, Resident 6 stated that they did not always get their medications as ordered, especially their insulins, and only had their blood sugar checks done once a day a lot of the time instead of the four times a day as ordered. They stated they did not refuse their medications.

Resident 6 was observed in their hospital bed on 02/03/2023 at 12:20 PM. They were pale and appeared unkept. Resident 6 stated that they were admitted to the hospital for their [REDACTED] and that they also were needing to start dialysis to treat their newly diagnosed [REDACTED]

Review of the medication inventory sent to the new facility, the pharmacy dispensing log dated 02/03/2023, and Resident 6's December 2022 and January 2023 MARs showed the following errors that showed the facility did not have a safe system in place for assisting Resident 6 with their medications:

- Humalog 100 units per ml/3ml syringes. Review of the December 2022 MAR (12/14/2022 through 12/31/2022) showed the following:

Order dated 12/14/2022 Humalog sliding scale: inject subcutaneously per sliding scale 3 times daily before meals:  
If 120-149 = 2 units



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150-199 = 3 units  
 200-249 = 6 units  
 250-299 = 9 units  
 300-349 = 12 units  
 Greater than 349 = 15 units and CALL MD

\*The resident's blood sugar ranged from 39-500 milligrams (mg)/deciliter (dL).  
 \*There were 11 of 52 sliding scale insulin doses that were not given (shown by blank boxes on MAR).

Additionally, Resident 6's medical record showed no documentation where the facility contacted the MD each time the resident's blood sugar was greater than 349 mg/dL.

Review of the January 2023 MAR (01/01/2023 through 01/16/2023) showed the following:

Order dated 12/14/2022 Humalog sliding scale: inject subcutaneously per sliding scale 3 times daily before meals:  
 If 120-149 = 2 units  
 150-199 = 3 units  
 200-249 = 6 units  
 250-299 = 9 units  
 300-349 = 12 units  
 Greater than 349 = 15 units and CALL MD

\*The resident's blood sugar ranged from 39-500 milligrams (mg)/deciliter (dL).  
 \*There were 11 of 52 sliding scale insulin doses that were not given (shown by blank boxes on MAR).

Additionally, Resident 6's medical record showed no documentation where the facility contacted the MD each time the resident's blood sugar was greater than 349 mg/dL.

- Levemir FlexTouch pen, 100 units per ml/3 ml syringe. Order read to inject 10 units subcutaneously, (under the skin) each morning. 1500 units were dispensed on 12/07/2022. Review of the pharmacy logs and MARs showed eight doses that were documented as given at 8:00 PM without an order.
- Eliquis, (critical medication to thin blood) 5 mg tablets ordered twice daily. Review of the pharmacy logs and the MARs showed a 57-tablet difference.
- Buspirone, (medication for anxiety) 5 mg tablets twice daily. Review of the pharmacy logs and the MARs showed a difference of 28 tablets documented as given in comparison to the number left on hand at the discharge date.
- Duloxetine, (medication for depression) 30 mg cap daily. Review of the pharmacy logs and the MARs showed a difference of 22 capsules between the number of capsules dispensed and those documented as given.
- Ferrous sulfate, (iron supplement) 325(65) mg tabs twice daily. Review of the pharmacy logs and the MARs showed a 90-tablet difference between the number of tablets dispensed

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in comparison to the number left on hand.

- Gabapentin (medication for nerve pain) 400 mg capsules twice daily. Review of the pharmacy logs and the MARs showed a 34-capsule difference between the number of capsules dispensed and the number of capsules documented as given.
- Mirtazapine, (medication for major depressive disorder) 15 mg tab daily. Review of the pharmacy logs and the MARs showed a difference of 72 tablets between the number dispensed, the documented number and the number left on hand at discharge.
- Ropinirole (medication for restless legs) 4 mg tablets daily. Review of the pharmacy logs and the MARs showed a difference of 40 tablets between the number dispensed and the number of tablets documented as given.
- Sodium Bicarbonate 650 mg tabs twice daily. Review of the pharmacy logs and the MARs showed a 12-tablet difference between dispensed medication and the number of medications left.

## Resident 8

Review of Resident 8's facility record showed that the resident was admitted to the facility on [REDACTED]/2019 for medication management, dressing, meal prep and support with activities of daily living. Their NSA dated 04/24/2022 showed that Resident 8 needed frequent checks due to wandering and exit seeking. The facility was to assist with medications.

Review of the pharmacy dispensing logs dated 02/10/2023, facility MARs for November, December and January compared to the medications sent to the new secure facility showed the following errors:

- Aripiprazole, (medication for depression) 5 mg tablets daily. Review of the pharmacy logs and the MARs showed difference of 66 tablets between the dispensed medications, documented as given and the number of tablets left.
- Citalopram, (medication for depression/anxiety) 20 mg tablets daily. Review of the pharmacy logs and the MARs showed a difference of 39 tablets between the dispensed medications, documented as given and the number of tablets left.
- Furosemide, (medication to reduce swelling) 40 mg tablets daily. Review of the pharmacy logs and the MARs showed a difference of five tablets between the dispensed medications, documented as given and the number of tablets left.
- Levothyroxine, (medication for underactive thyroid) 75 mcg tablets daily. Review of the pharmacy logs and the MARs showed a difference of six tablets between the dispensed medications, tablets documented as given and the number of tablets left.
- Memantine (medication for treating Alzheimer's) 10 mg tablets twice daily. Review of the pharmacy logs and the MARs a 19-tablet difference between the dispensed medications, tablets documented as given and the number of tablets left.
- Trazadone, (antidepressant) 50 mg tablets daily. Review of the pharmacy logs and the MARs showed a difference of 10 tablets between the dispensed medications, tablets documented as given and the number of tablets left.
- Vitamin B12 (vitamin supplement) 1000mcg tabs daily. Review of the pharmacy logs and the MARs showed a 27-tablet difference.

## Resident 9



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Licensee: Greenlake Management Columbian, LLC

Compliance Determination # 20163  
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Review of Resident 9's record showed that she was admitted to the facility on [REDACTED]/2022. The NSA dated 01/26/2023 completed by Staff B showed that the resident required assistance with administration for one or more medications due to her severe memory impairment. The NSA showed that the resident was often resistant to care and would try to hit staff when they were trying to provide care.

Resident 9 was observed at the facility on 02/22/2023 at 1:00 PM. The resident was dressed but not groomed. They had an odor of stool and urine in their room and on their body.

On 02/22/2023 at 12:47, Collateral Contact 7 (CC7) stated that the facility had not been providing the agreed upon cares and services including medications for Residents 9 and 10.

Review of the pharmacy dispensing logs dated 03/03/2023, facility MARs for February compared to the medications sent to the new secure facility showed the following errors:

- Amlodipine, (medication for high blood pressure) 5 mg tablets. 2 tabs daily. Review of the pharmacy logs and the MARs showed a difference of 88 tablets between the dispensed medications and the tablets documented as given.
- Quetiapine, (medication for anxiety/agitation) 25 mg tablets daily. Review of the February MAR shows no medications were given.

## Resident 10

Review of Resident 10's records showed that they were admitted to the facility [REDACTED]/2022. The NSA dated 01/26/2023 by Staff B showed that the resident needed assistance with medication administration, medication management and refills.

Resident 10 was observed in the facility on 02/22/2023 at 1:00 PM. The resident was observed wearing clothing that was too small and pink in color, he stated that he did not have any clothing and was wearing Resident 9's clothing. The resident apartment had a strong odor of urine and feces.

Review of the pharmacy dispensing logs dated 03/03/2023, facility MARs for February compared to the medications sent to the new secure facility showed the following inconsistencies:

- Amiodarone, (medication for treating heart rhythm issues) 200 mg tablet daily. Review of the pharmacy logs and the MARs showed a difference of 17 tablets between the dispensed number of tablets and the number of tablets left on hand.
- Atorvastatin, (medication to treat high cholesterol) 40 mg tablets. Review of the pharmacy logs and the MARs showed a difference of eight tablets between the dispensed

## State of Washington

16.21.2023 13:41:43

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number of tablets and the number of tablets left on hand.

- Benzonatate, (cough medication) 200 mg capsules three times a day. Review of the pharmacy logs and the MARs showed a difference of 108 capsules between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.
- Calcium Carbonate, (antacid) 648 mg tablets, 2 tabs daily. Review of the pharmacy logs and the MARs showed a difference of 4 capsules between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.
- Eliquis, (blood thinner) 2.5 mg tablets twice daily. Review of the pharmacy logs and the MARs showed a difference of 4 capsules between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.
- Omeprazole, (medication for acid reflux) 20 mg capsules twice daily. Review of the pharmacy logs and the MARs showed a difference of 36 capsules between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand for February. There were no capsules dispensed in January.
- Ropinirole, (medication for restless legs) 0.25 mg tablets daily. Review of the pharmacy logs and the MARs showed a difference of 13 capsules between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.
- Trazadone, (antidepressant) 50 mg tablets daily. Review of the pharmacy logs and the MARs showed a difference of 7 capsules between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.
- Valacyclovir, (medication to treat herpes) 1 GM tablets daily. Review of the pharmacy logs and the MARs showed a difference of 5 capsules between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.

## Resident 11

On 02/02/2023 at 1:45 PM review of the characteristic roster provided by Staff Q showed that Resident 11 was admitted to the facility [REDACTED] 2022. showed that the resident needed assistance with medications.

On 02/22/2023 at 12:05 CC6, Registered Nurse stated that they were given medication cards that did not match the number of medications that should be on hand during the reconciliation process to admit them to their new facility.

On 04/19/2023 CC7, pharmacist stated that Resident 10 had orders to decrease their blood pressure medication from 10 mg to 5 mg. The facility MAR had not changed the order on 02/01/2023 and continued to give the higher dose.

Review of the pharmacy dispensing logs dated 03/16/2023, facility MARs for February compared to the medications sent to the new secure facility showed the following discrepancies:

- Lisinopril, (blood pressure medication) 5 mg tablet daily. The resident's MAR showed the



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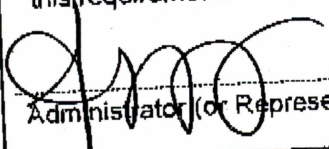
resident order as 10 mg daily. They received the wrong dose of the medication 18 times in February.

- Levetiracetam, (antiseizure medication) 1000 mg tablets twice daily. Review of the pharmacy logs and the MARs showed a difference of 13 tablets between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.
- Carvedilol, (blood pressure medication) 6.25 mg tablets twice daily. Review of the pharmacy logs and the MARs showed a difference of 37 tablets between the number of dispensed medications, the documented number of capsules given, and the number of capsules left on hand.
- Pantoprazole sodium 40 mg tabs, 22 on hand dated 07/11/22, MAR review showed that the medication was not currently ordered and not destroyed by the facility.

On 02/22/2023 at 3:03 PM Staff B, facility licensed nurse stated that she was aware of medication issues but stated that she did not have the facility support that she needed to make the changes that were necessary.

On 02/28/2023 at 2:45 PM Staff A stated their medication policy included making an inventory sheet of medications released to other facilities or medications destroyed and there should have been inventory sheets for the residents discharged with their medication to other facilities.

This is a recurring deficiency previously cited on 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) <u>07.07.23</u> . |                         |
| In addition, I will implement a system to monitor and ensure continued compliance with this requirement.                                                                                                                                                                 |                         |
| <br>Administrator (or Representative)                                                                                                                                                 | <u>07.07.23</u><br>Date |

**WAC 388-78A-2610 Infection control.**

- (1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.
- (2) The assisted living facility must:
  - (a) Develop and implement a system to identify and manage infections;

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- (b) Restrict a staff person's contact with residents when the staff person has a known communicable disease in the infectious stage that is likely to be spread in the assisted living facility setting or by casual contact;
- (c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;
- (d) Provide all resident care and services according to current acceptable standards for infection control;
- (e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;
- (f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review the Assisted Living Facility, (ALF) failed to implement infection control practices to limit the spread of communicable diseases and report to the Local Health Jurisdiction (LHJ) when residents reported symptoms of nausea, vomiting and diarrhea for 10 of 10 residents (3, 4, 5, 9, 10, 11, 12, 19, 20 & 24). The lack of immediate action placed residents living in the facility at risk of exposure to the communicable disease and Residents (3, 4, 20, 23 & 24) needed to seek outside medical care for dehydration.

**Findings included...**

Review of the facility's policy titled, "Infection Control 20-Gastrointestinal Illness/Norovirus," dated 12/15/2021, showed the Centers for Disease Control (CDC) defined an outbreak of norovirus as an occurrence of two or more similar illnesses resulting from a common exposure that is either suspected or laboratory confirmed to be norovirus. Guidance from the CDC and/or public health would be followed at all times. The facility Wellness Director would inform the Executive Director (ED) of any known or suspected communicable diseases occurring in residents or staff and implement their infection control policies. The facility would obtain a stool culture for verification of norovirus for the first three suspected cases, cancel group activities, communal dining, and alert visitors of the outbreak. The ALF was to limit staff person's contact with residents when the staff have a known communicable disease that is likely spread by casual contact for 48 hours after they are symptom free. The facility must institute appropriate infection control practices to limit the spread of infections such as frequent cleaning of high touch surfaces and post "Infectious Outbreak" signs for a week after the last reported case. Report communicable diseases to the ED, Dining Services Manager, the department, and the local county health department for guidance.

According to the Center for Disease Control (CDC), "Guidelines for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings," dated 02/15/2017 noted:  
- Avoid exposure to vomitus or diarrhea. Place patients on Contact Precautions [standard set of guidelines to prevent transmission of infectious agents, including epidemiologically



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important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment] in a single occupancy room if they have symptoms consistent with norovirus gastroenteritis.

- During outbreaks, place patients with norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients.
- Actively promote adherence to hand hygiene among healthcare personnel, patients, and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis.

CDC.gov noted Norovirus is a very contagious virus that causes vomiting and diarrhea. The CDC defined "Contact Precautions" as used for patients with known or suspected infections that present an increased risk for contact transmission. Precautions are as follows:

- Ensure appropriate patient placements. In long-term and other residential setting, make room placement decision balancing risk to other patients.
- Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens.
- Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport location.
- Prioritize cleaning and disinfection of the rooms of patients on contact precautions ensuring rooms are frequently cleaned and disinfected focusing on frequently-touched surfaces and equipment in the immediate vicinity of the patient.

Per facilities undated incident report log review, there was a list of 27 residents from 01/18/2023 to 02/20/2023 that were noted to be ill with gastroenteritis symptoms in which 11 were noted to be sent to the hospital.

During observations of the facility by the Department on 02/02/2023 at 12:30 PM, 02/07/2023 at 3:00 PM, 02/09/2023 at 4:10 PM, 02/17/2023 at 1:30 PM, 02/22/2023 at 12:30 PM, and 02/24/2023 at 1:03 PM showed residents moving about in the facility with no contact precautions. There were no observed PPE located by residents' rooms that were experiencing symptoms of diarrhea and vomiting. There were no "Infectious Outbreak" signs posted at the facility during an active Noro Virus Outbreak. During the facility tour of the first, second and third floor on 02/17/2023 at 1:30 PM showed no evidence of resident isolation or standard precautions implemented residents with diarrhea and vomiting.

On 02/22/2023 at 4:55 PM, an undated note was observed taped to the nurse's station desk that showed a list of 29 resident name and room numbers "that have diarrhea and vomiting and are to stay in their rooms." Residents (3, 4, 5, 9, 10, 11, 12, 19, 20 & 24) were on that list. There were no "Infectious Outbreak" signs posted on their doors or PPE supplies inside or outside of their doors to alert staff or visitors they needed to use contact precautions to enter the resident's rooms. There were no gowns observed being donned (placed on) or doffed (placed on) near the resident's rooms.



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On 02/22/2023 at 12:55 PM, it was observed Residents 9 & 10's (who were experiencing diarrhea and vomiting) apartment showed pieces of feces on the toilet, wall, and floor of the bathroom. Residents 9 & 10 did not have linens on their beds. Residents 9 & 10 were on the list of residents that were not able to leave their room due to Noro Virus. There were no "infectious Outbreak" signs or indicators that Resident 9 & 10 were on any contact precautions. There were no PPE stationed near the resident's rooms and no signs of any increased cleaning and sanitizing in their room per the ALF's policy and CDC guidance.

On 02/22/2023 at 4:50 PM, Staff C, Housekeeping and Laundry Director had not acknowledged any increased cleaning and sanitizing schedule for resident's rooms and stated they were not aware of why Residents 3, 4, 9, & 10 did not have linens on their beds.

During an interview on 02/23/2023 at 11:18 AM, CC1 stated the LHJ had not been notified by the facility of the outbreak of possible norovirus, (a very contagious virus that causes nausea, vomiting and diarrhea) in the facility as expected. CC1 stated they would reach out to the facility.

During an interview on 02/24/2023 at 2:30 PM, Staff A, Administrator stated that the LHJ had reached out to the facility to check on them and they had sent a list of residents that had been ill to the LHJ. Staff A stated there were not any staff that were experiencing symptoms.

During an interview on 02/28/2023 at 11:37 AM CC1 stated the LHJ had done an onsite visit to the ALF on 02/24/2023 and had concerns with the cleanliness in the facility. CC1 stated confirmed residents in the ALF became ill with signs and symptoms of Noro Virus on 02/01/2023 and the ALF did not initiate isolation procedures and until 02/15/2023. CC1 stated that staff interviews had shown that a few staff also had symptoms including nausea, vomiting and diarrhea and had been in the building working. The first 2 residents to test positive for norovirus were (Residents 23 & 24) on 2/18/2023. CC1 stated the residents being allowed to resume activities and dining together before the recommended guidelines was a factor in the LHJ requesting the facility re-implement isolation procedures on 02/27/2023 after more residents tested positive for the norovirus.

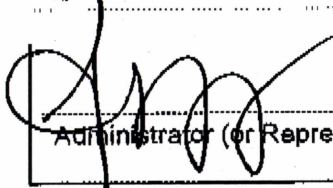
On 02/28/2023 at 2:15 PM, Staff A confirmed they had previously been sending out residents to the hospital for dehydration who were experiencing diarrhea and/or vomiting.

**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) 01-01-23.

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

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Administrator (or Representative)  
07.07.23  
Date

**WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:**

(5) Sleeping rooms size:

(b) Two person rooms shall not have less than seventy square feet of usable floor space per individual;

(c) When a resident sleeping room is located within a private apartment:

(i) The private apartment includes a resident sleeping room, a resident living room, and a private bathroom;

(iv) Both residents mutually agree to share the resident sleeping room; and

(v) If all other requirements of this section are met, then the two residents may share a sleeping room with less than one hundred forty square feet; and

(8) Miscellaneous: Each sleeping room must have:

(e) One or more outside windows with:

(i) Window sills at or above grade, with grade extending horizontally ten or more feet from the building; and

(ii) Adjustable curtains, shades, blinds, or equivalent for visual privacy.

(d) An individual towel and washcloth rack or equivalent, except when there is a private bathroom attached to the resident sleeping or living room, the individual towel and washcloth rack may be located in the attached private bathroom;

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

(f) Separate storage facilities for each resident in or immediately adjacent to that residents sleeping room to adequately store a reasonable quantity of clothing and personal possessions; and

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review the Assisted Living facility, (ALF) failed to ensure that each resident had room accommodations that met necessary space and amenities requirements for 4 of 8 sampled residents, Residents 3, 4, 5, 6, 9, 10, 11 and 12, who shared an apartment licensed for one resident bed. 4 of 4 sampled residents that were unrelated to each other, Residents 3, 4, 5 and 6 were living in rooms that were licensed for only one occupant. The apartment living room did not have the necessary elements to be recognized as a sleeping room for Residents 4 and 6. This failure resulted in these residents and four other residents sleeping in rooms that were not approved to be a licensed sleeping room. This left the residents at risk for not having privacy and dignity.



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Findings included...

Residents were observed on 02/07/2023 at 3:52 PM with their beds in the living room area of the apartment. Observation showed there were not any ways to make the area private such as a door or screen. The residents who were sleeping in the living room did not have an outside window with adjustable coverings for privacy. The residents did not have an area to hang their towel and washcloth or store their personal items such as clothing. There were no secure locking drawer/cabinet to store items for resident use.

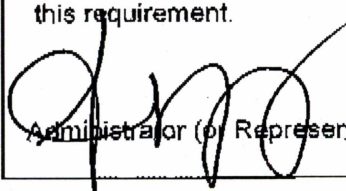
Staff A, Administrator stated on 02/03/2023 at 09:35 AM stated that there were two residents in living rooms that had the square footage to have two residents in them.

Record review of the facility Resident Characteristic Roster from 02/02/2023 and the room list dated 01/24/2023 showed nine apartments licensed for one person were occupied by two residents. Six apartments had residents living in the living room.

**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) 07.07.23.

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

  
Administrator (or Representative)

Date 07.07.23