



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) 30476 (Completion Date 10/05/2023) and 26627 (Completion Date 08/08/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/05/2023 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-2600-1-b, WAC 388-78A-2600-2-i, WAC 388-78A-2600-2-l, WAC 388-78A-2600-1-a, WAC 388-78A-2240, WAC 388-78A-2080, WAC 388-78A-2080-1, WAC 388-78A-2080-2, WAC 388-78A-2080-3, WAC 388-78A-2080-4, WAC 388-78A-2080-5, WAC 388-78A-2130-1, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator
Tracy Ramirez, Assisted Living Facility Licensors

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

Sincerely,

Gwin Kaercher

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



Residential Care Services Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 26627
Investigator: Melissa Milanez
Investigation Date(s): 07/13/2023 through 08/08/2023
Complainant Contact Date(s): 07/19/2023

Provider Type: Assisted Living Facility
Intake ID: 88678
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

A named resident did not receive their prescribed medications.

Investigation Methods:

Sample: Total residents: 1
Resident sample size: 77
Closed records sample size:

Observations: Environment, cares, residents, staff to resident interactions, medication room, medication carts, staff availability and response to resident's needs.

Interviews: Staff Facility, Residents, and others not associated with the facility.

Record Reviews: Characteristic roster, facility policies, resident pre-admission assessment, state care assessment, physician orders, hospital notes, AMR records, outside provider notes.

Investigation Summary:

Interviews and Record review showed that the named resident was not administered prescribed medications. Facility staff failed to implement the facility's, "Pre-Admission," policy causing the named resident to experience pain and harm. A deficient practice was identified related to the facility not following there, "Pre-Admission" policy. Failed practice identified WAC 388-78A 2080, WAC 388-78A-2240 & WAC 388-78A-2600, Reference Statement of Deficiencies dated 08/01/2023.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2581	Compliance Determination # 26627
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 13	Licensee: Greenlake Management Columbian, LLC	08/08/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 07/13/2023 and 07/13/2023 of:

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

This document references the following complaint number(s): 88678

The following sample was selected for review during the unannounced on-site visit: 77 of 1 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

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

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

08/16/2023

Date

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

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

Gladys Irazoqui
Administrator (or Representative)

09/22/23
Date

WAC 388-78A-2600 Policies and procedures.

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

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

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

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure staff implemented policies and procedures for admissions, assessments, alert charting, medication services, and pain management for 1 of 1 resident (Resident 1) who required assistance with medication management. These failures resulted in Resident 1 not having their prescribed medications for sixteen days and experiencing severe pain that led to hospitalization.

Findings included...

Record review of the facility's policy titled, "Resident's Pre-Admission Appraisal," dated 08/21/2021, showed that the person completing the preadmission assessment must be a qualified assessor per regulations, and the Wellness Director will gather data on each potential resident to determine the need and type of services to be provided. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment within fourteen days of the resident's move-in date. The Wellness Director reviews the Physician's Report completed within the previous 6 months, if available, for any prohibited conditions or communicable illness.) If the Physician's Report is not available for the pre-admission appraisal, it must be received prior to admission to confirm the resident's eligibility for admission. NOTE: A physician's order is obtained prior to admission day, verifying medications and dosing schedule.

Review of the facility's policy titled, "Day of Admission," dated 08/21/2021 showed that the Wellness Director coordinates the following on move-in day to ensure appropriate resident care using the Admission Checklist Form:

- a) All preadmission documentation is complete and in the resident's record.
- b) All assessment entries and assignments are complete.
- c) The Negotiated Service Agreement (NSA) is completed, signed, and kept in the resident's record. If the Negotiated Service Agreement is not completed, the initial resident service plan must be completed upon admission per regulations.
- d) All physician admission orders are received. The chart is appropriately labeled and organized.
- e) Immunization information is obtained.
- f) All new prescriptions are sent to the pharmacy for same day delivery, or if using existing fills, medications are verified.
- g) The medication is labeled and organized.
- h) The MAR (Medication Assistance Record) is set up, including resident photograph in place.

Review of the facility's policy titled, "Resident Assessment and Negotiated Service Agreement," dated 08/10/2021 showed that the Wellness Director creates the Negotiated Service Agreement at the time of admission. If the Negotiated Service Agreement is not completed, the initial resident service plan must be completed upon admission per regulations contained in this policy. The assisted living facility must complete a full assessment [conducted by a qualified assessor] addressing the following, within fourteen days of the resident's move-in date.

Review of the facility's policy titled, "Alert Charting," dated 08/10/2021 showed that alert charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring.

- 1. Alert charting procedures will be initiated if a resident:
 - a) Is new to the Community.
 - b) Exhibits a change in condition.
 - c) Is returning from the hospital, ER, or urgent care.
 - d) Has fallen.
- 2. The alert charting process includes:
 - a) The resident's name and concern will be placed in a discreet location readily visible to care staff or alert charting reminder is turned on in the service planning program.
 - b) Each resident placed on alert charting will be monitored for at least 48 hours following the initiation of alert charting. The Wellness Director or designee will assign alert charting responsibilities and monitor the alert charting on a daily basis. There is to be an alert charting entry in the resident record each shift.

Review of the facility's policy titled, "Medication Services," dated 08/10/2021 showed that the Community provides medication ordering and medication assistance services. The Executive Director will ensure that medication related services required or requested by each resident are provided.

The facility failed to provide medications as referenced above WAC 388-78-2210 (1) An assisted living facility providing medication service, either directly or indirectly, must: (2)

The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250: (a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and (b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

Review of the facility's policy titled, "Pain Management," dated 08/10/2021 showed that the facility "promotes the comfort of all residents by active pain management."

1. The Community shall incorporate the following actions as part of the pain management program:
 - a) If the resident has pain management problems, document ongoing pain evaluation and treatment in resident's record on an ongoing basis as needed.
 - b) The Wellness Director is accountable for ensuring that all residents are properly assessed for pain and receive adequate, appropriate treatment.
 - c) Practitioner orders are implemented in a timely manner to ensure pain relief. Information about changes in condition or orders is discussed at change of shift.
2. Residents who have pain management problems should be regularly and systematically evaluated for pain:
 - a) Upon a resident's admission.
 - b) Whenever a resident has an acute illness or injury or experiences a decline in function or a change in mood or cognition.
 - c) Daily, for residents with a known painful condition.

Review of Department of Social Services (DSHS) client information portal showed Resident 1 admitted to the facility on [REDACTED]/2023. The DSHS Assessment dated 05/10/2023 showed diagnoses which included [REDACTED], and [REDACTED]. The assessment showed Resident 1 required assistance with medication ordering and administration, blood sugar monitoring and assistance with dressing and bathing. The assessment showed Resident 1's prescribed medication which included medications to treat diabetes, heart condition and pain.

During an observation and interview on [REDACTED]/2023 at 2:47 PM Resident 1 was seated in the dining room. Resident 1 stated that they moved into the facility on [REDACTED]/2023 and had not received any of their prescribed medications. Resident 1 further stated that the facility told them numerous times that they (facility) were unable to obtain any medications due to not having Resident 1's records on hand. Resident 1 stated they had notified the staff that they were in "a lot" of pain and would ask for medications but was told each time "We are working on it." In addition, they were told by facility staff that they (facility) were not allowed to give Resident 1 medications because there were no written physician orders. Resident 1 stated they had no choice but to go to the Dollar Store and buy Tylenol (pain relief medication) because they could not take the pain much longer. They stated that they had been "blacking out" for the last two weeks and had two falls due to not having medications for pain, diabetic medication or blood pressure medication. Resident 1 stated they requested to go to the ER on 07/06/2023 for severe back pain and leg pain. They stated as of this date of the interview (16 days after admission to the facility), they still had not received any of their medications.

During an interview on [REDACTED]/2023 at 3:30 PM, Staff B, Medication Technician (MT), stated that Resident 1 had moved into the facility on [REDACTED]/2023 and had no medication orders. Staff B stated that as of 07/12/2023 there were no physician orders or medications for Resident 1.

During an interview on [REDACTED]/2023 at 3:34 PM, Staff C, Residential Care Manager (RCM), stated they asked Staff A, Administrator for Resident 1's paperwork on the day of admission, but was told by Staff A that Resident 1 was "independent" and there were no orders. Staff C stated that the ALF had not administered any medications to Resident 1 and they (Staff C) were concerned because Resident 1 was complaining of pain and had been asking for their medications. Staff C stated that Resident 1 requested to go to the hospital on 07/06/2023 because they were in severe pain. Staff C stated that on 07/11/2023 they had called Staff E, Advanced Registered Nurse Practitioner (ARNP) to ask about Resident 1's medications and was told that the orders were sent to the pharmacy on that day (07/11/2023). Further, Staff E informed Staff C that Resident 1 should not be independent with self-administering medications. Staff C stated that as of today, [REDACTED]/2023 (sixteen days after admission), Resident 1 had no medications at the facility.

During an interview on [REDACTED]/2023 at 3:47 PM, Staff A, Administrator stated that Resident 1 moved into the facility on [REDACTED]/2023 and required care and services including assistance with medications. Staff A stated that they had completed a pre-admission assessment for Resident 1, but it was somewhere in a "pile of papers" in the Business Office. Staff A stated that Resident 1 had no medications at the facility as of [REDACTED]/2023 and the facility was waiting for signed orders. Furthermore, Staff A acknowledged that there were no assessments, NSA, monitoring of the resident's diabetic condition or other conditions, no vital signs, no progress notes and alert charting had been done for Resident 1.

During an interview on [REDACTED]/2023 at 3:57 PM, Staff F, Clinical Compliance Director, stated, "this is a dangerous situation." Staff F confirmed that the facility's policy was that there should have been a referral, then an assessment and confirmed doctor's orders prior to the resident moving into the facility but acknowledged that this had not occurred in this situation.

During an interview on [REDACTED]/2023 at 4:07 PM, Staff D, Health and Wellness Director (HWD), stated that they had not received any admission paperwork for Resident 1, and was told there was nothing available since the resident was considered to be "Independent." They further stated that they had not completed an assessment on Resident 1 upon admission or after returning from the hospital. Staff D stated that they had not administered any medications to the resident while in the facility and that Resident 1 had not been on the roster until 07/12/2023. Upon interviewing Staff D, Staff A handed Resident 1's state care assessment to Staff D. Staff D stated that this had been the first time they seen the assessment and stated, "I was not told anything about [Resident 1], and I do not know why."

Interview on [REDACTED]/2023 at 5:03 PM, with Staff E, Advanced Registered Nurse Practitioner

(ARNP), stated they came to the facility to assess Resident 1 on [REDACTED]/2023 per Staff A's request (ten days after admission) but were unable to prescribe medications due to the resident not having records at the facility. They further stated that the resident should have had written admission orders from their provider prior to moving into the facility. Staff E stated that on [REDACTED]/2023 (13 days after Resident 1's admission) that the facility provided records for Resident 1, and they were then able to write medication orders on 07/11/2023. Furthermore, Staff E did not know why the resident had not received their medications as of [REDACTED]/2023.

During a telephone interview on 07/17/2023 at 11:52 AM, with Collateral Contact 1 (CC1) Pharmacy Representative, confirmed that on 07/11/2023 the pharmacy had received orders from the ALF for Resident 1. However, the pharmacy was unable to send Resident 1's medications to the facility due to missing information. They stated that on 07/11/2023 at 1:05 PM, they faxed the facility to request Resident 1's allergies and diagnoses but had not received a response from the facility.

During a telephone interview on 07/18/2023 at 4:02 PM, Staff F stated that it was Staff D's HWD, responsibility to assess the resident upon admission and after a hospital visit. Staff F stated that the facility had terminated Staff D's employment. Staff F confirmed that there were no progress notes, assessments, temporary service plans, and no information regarding Resident 1 in the ALF's communication log.

During a telephone interview on 07/19/2023 at 11:36 AM, with Collateral Contact 2 (CC2) Emergency Response Technician stated that they (emergency transport) were called out to the facility to assess and evaluate a resident who had been in pain. CC2 stated that upon arriving to the facility they noted Resident 1 laying on a couch by the front door. Resident 1 began to tell them their medical history, stated they were in pain and had numbness and tingling in their lower extremities. CC2 stated that Resident 1 reported to them they had not had their medications for over a week and a half.

Review of pharmacy records dated 07/11/2023 at 4:05 PM showed confirmation that the facility had received a request for Resident 1's drug allergies, diagnoses, and a signed medication list.

Review of a pharmacy internal communication form dated 07/13/2023 showed that, "the facility dropped the ball, patient did not have doctor's orders when [Resident 1] came in."

Review of the emergency response Patient Care Report dated 07/06/2023, showed that emergency response was dispatched to the facility for a resident with a chief complaint of lower back pain with numbness to the extremities and care staff reported that they had no medications to give Resident 1. Record also showed, "Patient also reports [they] blacked out for minutes at a time due to the pain in [their] back, sugar levels and high blood pressure." Patient continues to state they fell on the tile in their room recently and that is possibly why their back hurts more today. Patient continues to state that they usually take Gabapentin (pain medication) for pain, and a blood thinner, but couldn't remember what it's called. Patient's history is Hypertension (high blood pressure), Diabetes and Chronic back pain." Record review also showed that Resident 1's blood glucose level was 293 (normal

blood sugar levels are 70 to 130).

Review of the emergency department provider notes dated 07/06/2023 showed that Resident 1 was evaluated at the hospital for "Medication nonadherence due to being out of medications for several weeks" and chronic lower back pain. In addition, the hospital discharge summary showed that the resident was diagnosed with [REDACTED] and was administered intramuscular (injection given into the muscle) [REDACTED] (a nonsteroidal anti-inflammatory drug for pain relief), [REDACTED] and [REDACTED] and was prescribed Metformin (used to treat high blood sugars) 1,000 mg one tablet by mouth 2 times a day, Rivaroxaban (used to treat and prevent blood clots) 10 mg tablet take 1 tablet by mouth daily, Atorvastatin (used to treat high cholesterol and reduce the risk of stroke and heart attack) 10 mg take 2 tablets by mouth daily, and Cyclobenzaprine (used to treat pain and stiffness caused by muscle spasms) 10 mg take 1 tablet by mouth 3 times daily as needed for muscle spasms for up to 14 days.

See WAC 388-78A-2240 Non availability of Medications.

This is a recurring deficiency previously cited on 01/05/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 9/22/23.

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

Gladys Irazoqui

09/22/23

Administrator (or Representative)

Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure medication was available for 1 of 1 resident (Resident 1) who required assistance with obtaining and administration of prescribed medications. This failure resulted in the resident not receiving prescribed medications for 16 days. Additionally, not receiving any medications for 16 days contributed to ongoing and severe pain and placed Resident 1 at risk of exacerbation of medical conditions.

Findings included...

Record review of the facility's policy titled, "Medication Services" dated 08/10/2021, showed that the Executive Director would ensure that medication related services required or requested by each resident was provided.

Record review of the facility's policy titled, "Med Room Workflow" dated 08/10/2021, showed that Nurses/Medication Technician (Med-techs) will follow a consistent workflow to ensure medication orders and MARs are up to date and refills are received in a timely manner. When a new order is received for a new medication: all orders are to be reviewed by the Wellness Director or designee, placed on the MAR, and will be signed off with the name, date, and signature.

Review of Department of Social Services (DSHS) client information portal showed Resident 1 admitted to the facility on [REDACTED]/2023. The DSHS Assessment dated 05/10/2023 showed diagnoses which included [REDACTED], and [REDACTED]. The assessment showed Resident 1 required assistance with medication ordering and administration, blood sugar monitoring and assistance with dressing and bathing. The assessment contained Resident 1's prescribed medication which included medications to treat diabetes, heart condition and pain.

During an interview on [REDACTED]/2023 at 2:47 PM, Resident 1 stated they admitted to the facility on [REDACTED]/2023. The resident stated that since their admission they had not received any of their prescribed medications. Further, the pain was so bad that on 07/06/2023 they requested to go to the hospital for back and leg pain. At the hospital they were given an injection to help relieve the pain and they returned to the ALF on the same day. As of [REDACTED]/2023 (sixteen days after admission to the facility) they still had not received any of their prescribed medications from the ALF.

Review of Resident 1's hospital after visit summary, dated 07/06/2023 showed the resident was sent to the hospital for back pain and was prescribed Cyclobenzaprine (a muscle relaxant used to treat pain), Atorvastatin (used to treat high cholesterol), Metformin (used to treat Diabetes), and Rivaroxaban (used to treat and prevent blood clots). In addition, the hospital's After Visit Summary, dated 07/06/2023, showed the pharmacy of notified of the prescribed medications.

During an interview on [REDACTED]/2023 at 3:34 PM, Staff C, Residential Care Manger, stated that as of [REDACTED]/2023, Resident 1 had no medications at the facility.

On [REDACTED]/2023 at 3:47 PM, Staff A, Administrator acknowledged that Resident 1 required assistance with medication administration and blood sugar monitoring. Staff A stated that

the facility had did not have physician orders for the resident, therefore they were unable to obtain the resident's medications.

On 07/17/2023 at 11:52 AM, Collateral Contact 1 (CC1) Pharmacist stated that they were unable to dispense medications to the facility for Resident 1 since they had not received the requested diagnosis list and current allergies from the facility.

During an interview on 07/26/2023 at 3:31 PM, Staff A, Administrator, stated that they were unaware of medications that had been ordered and prescribed to Resident 1 on the 07/06/2023 hospital visit. Staff A stated that the procedure for a resident returning from the emergency room was not followed. the facility's nurse should have conducted an assessment, and the medication technicians should have handled new orders and sent them to the pharmacy. However, they acknowledged that this did not happen.

During a telephone interview on 08/01/2023 at 1:47 PM, CC3, Pharmacy Technician, confirmed they received physician orders on 07/06/2023 from the emergency room doctor for Resident 1 but were unable to send the medications due to Resident 1 not being active in their system. They stated that they were not made aware of this resident needing medication services until 07/11/2023.

During a telephone interview on 08/01/2023 at 2:15 PM, Staff C, stated they were unaware of any medications that had been prescribed for Resident 1 during their ER visit. They confirmed that the proper procedure should have been for the facility staff to review the hospital discharge summary for orders. If the discharge summary was unavailable, they should have contacted the emergency room to request it and verify any newly prescribed orders. Furthermore, they stated that all new orders should have been verified by the facility and requested to be sent immediately or the following day but acknowledged that this did not occur.

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) 9/22/23.

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

Gladys Irazoqui

Administrator (or Representative)

9/22/23

Date

WAC 388-78A-2080 Qualified assessor. The assisted living facility must ensure the person responsible for completing a preadmission assessment of a prospective resident:

- (1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or
- (2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or
- (3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or
- (4) Is a physician with a valid state license to practice medicine; or
- (5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current assisted living facility residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, assisted living facility, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to use a qualified assessor for the pre-admission assessment for one of 1 of 1 resident (Resident 1). This failure resulted in delays in medication and blood sugar monitoring and placed the resident at risk of unmet and unassessed needs.

Findings included....

Record review of the facility's policy titled, "Resident's Pre-Admission Appraisal," dated 08/21/2021, showed that the person completing the preadmission assessment must be a qualified assessor per regulations. The Wellness Director (Licensed Nurse) will gather data on each potential resident to determine the need and type of services to be provided. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment within fourteen days of the resident's move-in date. If applicable, the Wellness Director also evaluates the resident and utilizes the Assessment for Medication Self-Management to determine if the resident can safely manage their medications.

Record review of Resident 1's undated pre-admission assessment showed it was completed by Staff A, Administrator, who did not meet the criteria of a qualified assessor. The assessment was incomplete (pages left blank and unchecked boxes).

During an Interview on 07/26/2023 at 4:08 PM, with Staff A stated they were aware they did not meet the criteria of a qualified assessor and confirmed that the pre-admission

assessment on Resident 1 was incomplete and not accurate. Staff A acknowledged that had Resident 1's preadmission assessment been conducted by a qualified assessor, would have reduced the risk and Resident 1 may have received their medications as prescribed and other care and services timely.

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) 9/22/23

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

Gladys Irazoqui

9/22/23

Administrator (or Representative)

Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and implement a Negotiated Service Agreement (NSA) for 1 of 1 (Resident 1) who admitted to the facility. This failure resulted in Resident 1 not having any input to their NSA and left staff without direction regarding the resident's needs.

Findings included...

Record review of the facility's policy titled, "Resident Assessment and Negotiated Service Agreement," dated 08/10/2021, showed that The Wellness Director creates the Negotiated Service Agreement at the time of admission. The family, resident, and any other significant individuals are included in the development of the Negotiated Service Agreement. If the Negotiated Service Agreement is not completed, the initial resident service plan must be completed upon admission per regulations contained in this policy. A copy of the

Negotiated Service Agreement is kept in the resident's record. A copy of each resident's Negotiated Service Agreement should also be kept in a Negotiated Service Agreement binder that is readily available to care staff. The assisted living facility must:

- a) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:
 - i) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority.
 - ii) Identifies the resident's immediate needs; and
 - iii) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

Review of Department of Social Services (DSHS) client information portal showed Resident 1 admitted to the facility on [REDACTED]/2023. The DSHS Assessment dated 05/10/2023 showed diagnoses which included [REDACTED], and [REDACTED]. The assessment showed Resident 1 required assistance with medication ordering and administration, blood sugar monitoring and assistance with dressing and bathing.

Review of the Resident 1's record from [REDACTED]/2023 through [REDACTED]/2023 showed no hardcopy or electronic record with resident specific information, NSA, directive to staff and care givers or record that the resident's care and service needs were negotiated with the resident. There was no record or directive to staff regarding the resident residing in the ALF.

During an interview on [REDACTED]/2023 at 3:34 PM, Staff C, Residential Care Manger (RCM), stated they asked Staff A, Administrator for Resident 1's paperwork on the day of admission, but was told by Staff A that Resident 1 was "independent" and there were no orders.

During an interview on [REDACTED]/2023 at 3:47 PM, Staff A, Administrator stated that Resident 1 moved into the ALF on [REDACTED]/2023 and required care and services including assistance with medications. Staff A acknowledged that there were no assessments, NSA, monitoring of the resident's diabetic condition or other conditions, no vital signs, no progress notes and no alert charting had been done for Resident 1.

During an interview on [REDACTED]/2023 at 4:07 PM, Staff D, Health and Wellness Director, stated that they had not received any admission paperwork for Resident 1, and was told there was nothing available since the resident was considered to be "independent." During the interview at 4:10 PM, Staff A handed Staff D Resident 1's DSHS assessment. Staff D stated that this had been the first time they seen the assessment and stated, "I was not told anything about [Resident 1], and I do not know why."

This is a recurring deficiency previously cited on 04/04/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 9/22/23.

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

Gladys Irazoqui

9/22/23

Administrator (or Representative)

Date