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

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

RE: Royal Columbian Senior Living License # 2581

Dear Administrator:

This letter addresses Compliance Determination(s) 33729 (Completion Date 12/12/2023) and 28708 (Completion Date 10/20/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/12/2023 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-2450-2-b, WAC 388-78A-2450-2-c, WAC 388-78A-2450-3-a, WAC 388-78A-2450-2-e, WAC 388-78A-2450-3-d-i-A

The Department staff who did the on-site verification:
Melissa Milanez, Community Complaint Investigator

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

Sincerely,

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 #: 28708
Investigator: Gwin Kaercher
Investigation Date(s): 08/29/2023 through 10/20/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 95503
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1) A named resident's pain was not acknowledged during cares.
2) A named resident was not given their pain medication.
3) A named resident's call light was not answered.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, cares, residents, resident rooms, staff to resident interactions, resident to resident interactions, facility common areas, staff availability and response to resident's needs, call light response time, medication pass.
Interviews:	Staff Facility, Residents, and others not associated with the facility.
Record Reviews:	Characteristic roster, facility policies, resident record (face sheet, assessments, care plan, progress notes, physician orders), Facility incident report and investigation, Hospice medical records, call light logs, staff records, staff phone lists.

Investigation Summary:

1,2) Observations, interviews, and record review showed the facility failed to protect a named resident from a named staff member who had been suspected of abuse and neglect. Interviews and record review also showed that facility staff failed to ensure staff persons had proper training, credentials and other qualifications necessary to provide the care and services. The facility had deficient practice and a citation written for WACs 388-78A-2450 Reference Statement of Deficiencies 10/20/2023.
3) Observations showed that staff were available and responsive to resident’s needs. Call lights were being answered timely. Staff to resident interactions were observed to be appropriate and respectful. Resident interviews showed that they felt safe, and staff were responsive to their needs. Record review showed that the named resident's call light was answered within 5 minutes. No failed practice found.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 28708
Investigator: Gwin Kaercher
Investigation Date(s): 08/29/2023 through 10/20/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 95717
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1) A named resident was in pain during cares.
2) A named resident was denied pain medications.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, cares, residents, resident rooms, staff to resident interactions, resident to resident interactions, facility common areas, staff availability and response to resident's needs, call light response time, medication pass.
Interviews:	Staff Facility, Residents, and others not associated with the facility.
Record Reviews:	Characteristic roster, facility policies, resident record (face sheet, assessments, care plan, progress notes, physician orders), Facility incident report and investigation, Hospice medical records, call light logs, staff records, staff phone lists.

Investigation Summary:

1,2) Observations, interviews, and record review showed the facility failed to protect a named resident from a named staff member who had been suspected of abuse and neglect. Interviews and record review also showed that facility staff failed to ensure staff persons had proper training, credentials and other qualifications necessary to provide the care and services. The facility had deficient practice and a citation written, WAC 388-78A-2450. Reference Statement of Deficiencies dated 10/20/2023.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 28708
Investigator: Gwin Kaercher
Investigation Date(s): 08/29/2023 through 10/20/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 95800
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A named staff member caused pain during cares and refused to administer pain medications.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, cares, residents, resident rooms, staff to resident interactions, resident to resident interactions, facility common areas, staff availability and response to resident's needs, call light response time, medication pass.
Interviews:	Staff Facility, Residents, and others not associated with the facility.
Record Reviews:	Characteristic roster, facility policies, resident record (face sheet, assessments, care plan, progress notes, physician orders), Facility incident report and investigation, Hospice medical records, call light logs, staff records, staff phone lists.

Investigation Summary:
1) Observations, interviews, and record review showed the facility failed to protect a named resident from a named staff member who had been suspected of abuse and neglect. Interviews and record review also showed that facility staff failed to ensure staff persons had proper training, credentials and other qualifications necessary to provide the care and services. The facility had deficient practice and a citation written, WAC 388-78A-2450. Reference Statement of Deficiencies dated 10/20/2023.

Conclusion / Action:

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

☐ N/A

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

Statement of Deficiencies	License #: 2581	Compliance Determination # 28708
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 7	Licensee: Greenlake Management Columbian, LLC	10/16/2023

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 08/29/2023 and 08/29/2023 of:

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

This document references the following complaint number(s): 94281, 95503, 95717, 95800

The following sample was selected for review during the unannounced on-site visit: 4 of 77 current residents and 1 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

10/24/2023
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.

Administrator (or Representative) 10/30/2023 Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

(3) The assisted living facility must:

(a) Protect all residents by ensuring any staff person suspected or accused of abuse, neglect, financial exploitation, or abandonment does not have access to any resident until the assisted living facility investigates and takes action to ensure resident safety;

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to protect residents from abuse and neglect by failing to ensure that 1 of 2 staff (Staff B) had training, credentials, experience, and other qualifications necessary to provide care and services for vulnerable adults. This failure resulted in residents receiving care and medication administration from an unqualified staff and contributed to 1 of 1 resident (Resident 1) receiving delayed medication administration and pain during positioning.

Findings included...

Record review of the facility's policy titled, "Staffing, Cardiopulmonary Resuscitation (CPR), First Aid, and Emergency Training" dated 08/10/2021, showed that staff shall have orientation and training or certification pertinent to duties, including but not limited to: training required by chapter 388.112, Home care aide certification as required by regulations, cardiopulmonary resuscitation, first aid and HIV/Aids training.

Review of the Department's Assisted Living Facilities Guidebook, dated February 2018, showed facilities must protect the health and safety of every resident, including those that are incapable of perception or who are unable to express themselves. The Department's Assisted Living Facilities Guidebook also showed that "Willful" means that the individual intended the action or inaction itself that he/she knew or should have known could cause one or more negative outcomes to assisted living facility resident(s), including harm, anguish, pain, or injury. Willful inaction includes, but is not limited to, an assisted living facility staff member's refusal to provide the necessary care and required services, or, intentional deprivation of a resident, or both.

Record review of the facility's policy titled "Elder Abuse, Neglect, and Exploitation" dated 08/10/2021, showed resident abuse neglect, and exploitation are prohibited. The assisted living facility must: Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life, determine the circumstances of the event, when necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated, and immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect during the course of the investigation.

Record Review on 08/29/2023 of the Department of Health (DOH) credential search website showed that Staff B, Medication Technician (MT), did not have active or pending credentials. Additionally, DOH credential website showed Staff B had a Medical Assistant Registration (MA) credential that was expired on 10/12/2020.

Resident 1's record review of the progress notes showed:

- Dated 08/17/2023, showed that the Resident 1 returned from the hospital with a diagnosis of [redacted] and [redacted]
- Dated 08/18/2023, showed that the Resident 1 obtained a fall and was found on the floor in the living room and had complained of left hip pain.
- Dated 08/28/2023, showed that Resident 1 had a decline in status and family had concerns that pain medications where not being administered by the staff upon request.

Resident 1's record review of the Hospice chart notes showed:

- Dated 08/22/2023, showed Resident 1 was admitted Hospice on 08/22/2023 with a diagnosis of [redacted] Hospice records also showed that Resident 1 had an active problem listed as: pain to the left hip that is relieved by oral pain medication and that the pain was worsened by movement to the left hip.

- Dated 08/23/2023, showed Resident 1 had "Terrible pain in the pelvis, and daughter is having issues with moving him to change him."

- Dated 08/26/2023, showed a pain observation assessment completed by the licensed nurse indicated Resident 1 had pain to the left hip, pain was relieved by oral pain medications, and pain is worsened by movement to the left side.

Review of Resident 1's Medication Administration Record (MAR), dated 08/02/2023, showed that Resident 1 had an order for Hydromorphone every three hours as needed for pain.

Review of the Negotiated Service Agreement (NSA) showed an assessment date of [redacted]/2023 (ten days after the residents passing). The NSA also showed that Resident 1 was admitted to Hospice with a diagnosis of [redacted] and would require pain management for comfort care. Additionally, the NSA showed that Resident 1 was unaware of medications they were taking or dosages due to having memory issues. The MT was to offer pain medications and Resident 1 would need constant reminders of the pain medications available to them. The NSA also showed Resident 1 had pain that was "very strong" and had an order for Fentanyl patches (used to treat severe pain) every three days and Hydromorphone (used to treat moderate to severe pain) every three hours for pain.

During an interview on 08/29/2023 at 11:28 AM, Staff A, Administrator, stated that Staff B was hired on 06/14/2023 but had no records for Staff B. Staff A also stated that they thought Staff B had their Medical Assistant Certification and was not aware that they were unable to work at an Assisted Living Facility with that license. Staff A was unable to provide, CPR and First Aid Card, Safety and Orientation Certification, Delegation certifications, HIV/Aids training, and had no verified work references for Staff B. In addition, Staff A, stated that they had received several phone calls on the evening of 08/25/2023 and the morning of 08/26/2023 from Collateral Contact (CC1) regarding concerns about delays in receiving prescribed pain medication for Resident 1.

During an interview on 08/29/2023 at 12:37 PM, Collateral Contact (CC1), Representative and Durable Power of Attorney (DPOA), was observed crying and stated that they did not feel safe leaving Resident 1 alone in their room knowing that Staff B was in the facility, and they did not want their [resident] to be hurt again. CC1 stated that on 08/25/2023, Staff B had turned the [resident] onto their left side after being told three times that Resident 1 could not be placed on that side due to complaints of pain related to a fall that had occurred on 08/18/2023. CC1 stated that during this time the [resident], was observed moaning, facial grimacing, hitting their head with their hand, and was positioned in a fetal position. After the incident took place, CC1 stated they had requested a pain pill for Resident 1, but the request had been denied at that moment by Staff B. CC1 stated that Staff B would not administer the pain medication because Resident 1 had not asked for it. CC1 stated they then had to call the Hospice nurse and Staff F, Licensed Practical Nurse (LPN) to request pain medication for their [resident] because Staff B would not administer it. CC1 stated this prolonged the administration of pain relief medications for Resident 1.

During an interview on 08/29/2023 at 1:48 PM, Staff C, Caregiver, stated that they entered

Resident 1's room with Staff B the evening of 08/25/2023 to clean and change their brief. Staff B stated CC1 was present in the apartment at that time. Staff C stated Staff B turned Resident 1 onto their left side. Staff C stated that Resident 1 "groaned" during this time. Staff C stated they were aware of the pain that Resident 1 had to the left side due to a recent fall that had taken place. Staff C stated that CC1 had told Staff B that Resident 1 could not be on that side, but that Staff B continued to hold them up onto that side. Staff C stated that Staff B told CC1 to "Let them do their job." After, the third request that had been made by CC1, Staff C asked Staff B to turn the resident onto the right side instead to provide care. During this transition, Staff C stated that Resident 1 began to "groan" again.

During an interview on 08/29/2023 at 4:32 PM, Staff A, stated that Staff B was told not to enter Resident 1's room after the incident that had taken place on 08/19/2023 where an altercation had occurred due to Staff B not administering pain medicine when requested. Staff A also stated that they think that Staff B entered Resident 1's room on both occasions to purposely upset CC1. In addition, Staff A stated, "I can see [Staff B] doing this."

During an interview on 08/30/2023 at 12:05 PM, Staff F, stated that they were concerned about Staff B working at the facility due to complaints brought forward from another Administrator at one of their sister buildings, where Staff B had recently been fired from. Staff F stated that they were told by the Administrator that they could not believe that the Assisted Living Facility (ALF) had re-hired them to work there, and that they needed to be "very careful" and keep an eye on Staff B because they were "Toxic." Additionally, Staff F stated that they would hear Staff B talk rudely to other staff over the walkies, and that some residents had stated Staff B was "Not that nice." Staff F also stated that they had been trying to gather information and write ups for Staff B so that they could "Hurry and get her out of the facility." Staff F also stated that they were aware of the situations that had occurred on the evening of 08/25/2023 and the morning of 08/26/2023 where Staff B had prolonged the administration of pain relief medications. Staff F stated that they also requested for Staff B to administer the prescribed pain medication per the doctors' orders but had too received push back from Staff B. Staff F stated that they continued to have concerns regarding Staff B and had been trying to build a case on them. Staff F stated they had enough evidence to terminate Staff B and was planning to do so on Monday 08/28/2023 but had been made aware that Staff B had quit on 08/26/2023. Staff F then stated that they showed up to work on 08/28/2023 and was surprised to see Staff B working on the medication cart. Staff F also stated that they felt Staff B re-entered Resident 1's room on both occasions to purposely upset CC1.

During an interview on 09/13/2023 at 2:14 PM, Staff H, Receptionist, stated that it was their responsibility to check three references on new hires, but did not remember completing them for Staff B.

During an interview on 09/20/2023 at 5:05 PM, CC1, stated that Staff B entered Resident 1's room the morning of 08/26/2023 2023 they observed Resident 1 curled up in a fetal position, attempting to rip off their urostomy bag (special bag used to collect urine attached to the abdomen), they were fidgety, agitated and appeared to be in pain. CC1 stated that they called Hospice to assess Resident 1. CC1 stated that before leaving the facility, the Hospice nurse had requested from Staff B to give Resident 1 a pain pill due to

the resident being in pain. CC1 stated that Staff B went up to the room after the hospice nurse left, and asked Resident 1, "Do you want a pain pill, are you sure you want a pain pill." CC1 stated that Resident 1 shook their head yes, then Staff B asked the resident again twice before administering the pain pill, "Are you sure you want a pain pill, are you sure?" CC1 stated that Staff B told them that Resident 1 nodded their head no. CC1 stated that they did not see or hear Resident 1 say no. CC1 stated that at this point Resident 1 was non-verbal and was actively dying. Staff B told CC1 that they would not give Resident 1 a pain pill because they did not verbally request it. CC1 walked out into the hallway with Staff B and requested four more times for Resident 1 to get a pain pill, but the request was denied. CC1 stated that they "Blew up," and had an argument with Staff B in the hallway. CC1 also stated they were made aware of Staff B being terminated the afternoon of 08/29/2023 and felt a sense of comfort knowing that they would not be around to hurt their loved one any longer.

During an interview on 09/21/2023 at 11:29 AM, Staff A, confirmed that Staff B was allowed to continue to work during the ALF's investigation. Staff A confirmed that Staff B worked 8/26/2023 from 6:00 AM-10:00 PM (day after the alleged abuse incident) and worked 08/29/2023 from 6:00 AM-2:00 PM. In addition, Staff A confirmed that there had been an altercation between Staff B and CC1 the morning of 08/26/2023 due to Staff B not wanting to administer as needed pain medications.

During an interview on 09/21/2023 at 12:13 PM, (CC2), Hospice Nurse, stated that they told Staff B to administer pain medication to Resident 1 on several occasions. CC2 stated that Staff B told them that they would only administer medication on Staff B's terms and that the resident needed to ask for them. CC2 explained to Staff B that the resident was not able to do that but showed visible signs of pain and needed pain medicine. CC2 also stated that Staff B was argumentative towards Hospice staff on each interaction. CC2 confirmed that they spoke with Staff B on the evening of 08/25/2023 and requested Staff B to administer pain medication, they stated Staff B told them, "I will see if they need it." CC2 also stated that they requested Resident 1 to be given pain medication on the morning of 08/26/2023 because they had just completed an assessment and noted the resident was showing signs of pain. CC2 stated that they are unsure if Resident 1 ever received their pain medication, because they were told by facility staff that there had been no documentation of Resident 1 ever receiving pain medication on 08/25 and 08/26/2023. CC2 confirmed that Resident 1 was unable to verbally ask for pain medication, based on the Hospice nurse's pain assessment that had just been completed the morning of 08/26/2023.

Review of the facility's staff separation form dated 08/29/2023 showed that Staff B was terminated for performance/neglect of duty, and allegation of abuse and neglect of an elderly.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2581	Compliance Determination # 28708
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 7 of 7	Licensee: Greenlake Management Columbian, LLC	10/16/2023

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 11/25/2023

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

[signature]
Administrator (or Representative)

10/30/2023
Date