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) 34468 (Completion Date 12/20/2023) and 29259 (Completion Date 10/31/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/20/2023 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, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2120-1, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-2, WAC 388-78A-2120, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-1

The Department staff who did the on-site verification:
Tracy Ramirez, Assisted Living Facility Licensor

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 #: 29259
Investigator: Melissa Milanez
Investigation Date(s): 09/08/2023 through 10/31/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 100025
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1. The named resident had a fall incident due to staff not answering their call light.
2. The named resident had severe pain from the fall and refused to go to the hospital that day. The named resident had continued pain and went to the hospital on the third day and was diagnosed with [redacted] and the facility had not reported it to the Complaint Resolution Unit (CRU).
3. The named resident had continued severe pain, had a health decline with not eating much, and was in bed most of the time was returned to the facility on hospice services, and passed away.

Investigation Methods:

Sample:	Total residents: 75 Resident sample size: 2 Closed records sample size: 0
Observations:	The facility's common areas, resident to resident and staff to resident interactions were observed.
Interviews:	Sampled resident, facility staff, and others not associated with the facility.
Record Reviews:	Resident characteristic roster, resident records (face sheet, assessments, care plans, progress notes, temporary service plans (TSPs), Medication Administration Record (MARs), hospital notes, and hospice notes), incident/investigations, call light report and fall policy.

Investigation Summary:

1. Record review of the call light report showed the named resident had no call light activated at the time of the fall incident. No failed practice identified.
2. Record review and interviews with facility staff showed that the facility did not report and thoroughly investigate the named resident's fall incident and injuries. Determined failed practice WAC 388-78A-2630 Reporting and WAC 388-78A-2371 Investigations. Statement of Deficiency (SOD) 10/31/2023.
3. Record review and interviews showed that the named resident had a significant decline after the fall incident and sepsis secondary to the UTI. Determined failed

practice WAC 388-78A-2120 Monitoring. Statement of Deficiency (SOD) 10/31/2023.

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 # 29259
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 9	Licensee: Greenlake Management Columbian, LLC	10/31/2023

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 09/08/2023 and 10/04/2023 of:

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

This document references the following complaint number(s): 97289, 100025

The following sample was selected for review during the unannounced on-site visit: 2 of 75 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator
Tracy Ramirez, Assisted Living Facility Licensor

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

11/13/2023 — 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.

Statement of Deficiencies	License #: 2581	Compliance Determination # 29259
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 2 of 9	Licensee: Greenlake Management Columbian, LLC	10/31/2023

Administrator (or Representative)

11/16/2023
Date

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

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

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

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

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

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(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 interview and record review, the Assisted Living Facility (ALF) failed to evaluate pain and take appropriate action when physicians ordered a urine sample and pain medication for 1 of 2 residents (Resident 1) who had a change of condition and a fall with injury. These failures resulted in Resident 1 experiencing ongoing high levels of pain for consecutive days and delayed urine sample testing which contributed to Resident 1 being placed on hospice after being hospitalized.

Findings included...

Record review of the facility's policy, "Urinary Tract Infection," dated on 08/10/2021, showed that the ALF was to refer the residents for appropriate assessment and treatment when suspecting a UTI. The policy showed that the staff needed to notify their appropriate supervisor and document the symptoms of a UTI. The policy included interventions for staff to follow for a suspected UTI.

Record review of the facility's policy, "Change in Resident Status" dated on 08/10/2021, showed that the ALF had the responsibility to provide care to each resident and summon medical attention when the resident had a change in status. The policy showed that the ALF was to report changes in a resident with decreased mobility, weakness, and complaints

of pain and or discomfort to their supervisors. The policy included that the ALF was to notify residents' Responsible Party, Physician immediately, and document the residents' changes within their medical record.

Response to Physician's Order

Review of Resident 1's Negotiated Service Agreement (NSA), dated 03/14/2023, showed that the resident had a history of urinary retention (difficulty urinating and completely emptying the bladder which can lead to infections). The record showed the resident self-propelled in a wheelchair and was alert and oriented.

In an interview on 10/05/2023 at 1:11 PM with Collateral Contact 1 (CC1), Resident 1's Primary Care Physician's Nurse, stated that the facility had called them on 08/17/2023 during business hours concerned that Resident 1 had a Urinary Tract Infection (UTI), and that Resident 1 had been crying upon urination. CC1 stated that in response the provider's office gave orders for the ALF to obtain a urine sample to be sent to the local laboratory for testing.

Review of Resident 1's record dated 08/17/2023 through [redacted]/2023 did not show that the facility acted on the physician's orders to obtain urine sample for the resident's symptoms of a UTI. The record showed no evaluation or monitoring of the symptoms of the UTI or documentation of the facility obtaining the urine sampled as ordered by the physician. The record showed no action was taken in response to the physician's order.

An [redacted]/2023 hospital record showed that Resident 1 was admitted from the ALF to the hospital on [redacted]/2023. The record showed Resident 1 was chronically ill-appearing, moaned with any movement and touch, had incoherent speech, decreased level of consciousness, and altered mental status. The record showed that Resident 1 had been admitted to the local hospital for fluids and intravenous (IV) antibiotics (used when infections are severe and need aggressive treatment) for a UTI and sepsis (the body's extreme response to an infection and is life-threatening), continued rib pain from fracture, and would be placed on hospice services.

On 10/04/2023 at 11:50 AM Staff C, Medication Technician (MT), stated that Resident 1's urine was dark in color and that there was not much urine output from Resident 1. Staff C stated that at that time they had notified their supervisors but did not recall the exact date.

In an interview on 10/11/2023 at 3:25 PM with Collateral Contact 2 (CC2), Resident's Representative stated that the facility did not notify them that there were concerns that Resident 1 had a UTI.

In an interview on 10/12/2023 at 10:45 AM with Collateral Contact 3 (CC3), Hospice Nurse, stated that Resident 1's admitting diagnosis to hospice services was [redacted] which was a rare diagnosis to use however, if the sepsis was severe showing it was terminal than

they (hospice) could admit for it. CC3 stated that Resident 1 had been placed as imminent (approaching death) status.

During an interview on 10/12/2023 at 2:13 PM with Collateral Contact 4 (CC4), Laboratory Representative, stated that for the month of August 2023 they had received only one urine sample for Resident 1 that had been sent from the local hospital on [redacted]/2023. CC4 stated that there was no record of receiving urine sample from the ALF facility.

Response To Pain Following a Fall

On 10/04/2023 at 11:50 AM, Staff C, MT, stated that Resident 1 had a fall on 08/17/2023 and declined significantly, had a lot of pain, that was not being managed. Staff C stated that it would take four staff to move Resident 1 due to the pain. Staff C said, "The resident would yell and scream out." In addition, Staff C stated that they had notified their supervisors.

Review of Resident 1's progress notes dated 08/18/2023 showed that staff had concerns of a broken hip, had found redness to the right rib area, bruising to the right forearm and knee. The progress notes also included that Resident 1 had been crying.

Review of Resident 1's record from 08/17/2023 through [redacted]/2023 showed no notification to the resident's primary physician regarding Resident 1's fall with severe pain. The record showed no attempts to obtain orders for pain control.

Review of Resident 1's August 2023 Medication Record Administration (MAR) showed that from 08/17/2023 through [redacted]/2023 there was no medication for pain provided to the resident.

A progress note dated [redacted]/2023 at 1:02 PM showed Resident 1 had been transported by ambulance to the local hospital due to extreme body pain.

Review of Resident 1's hospital notes dated [redacted]/2023, showed that the resident was seen due to three days of right-sided pain after the unwitnessed fall incident that occurred on 8/17/2023. The hospital notes included imaging results that showed Resident 1 had multiple right rib fractures.

Review of Resident 1's progress notes dated 08/21/2023, showed that Resident 1 was in a lot of pain and the pain level was a 10 on the pain scale (10 being the worst pain level). Progress notes dated 8/23/2023, showed that Resident 1 had continued pain and complained of a pain level of eight-plus.

Review of Resident 1's progress notes dated 08/23/2023 showed that the resident was unable to open their eyes that day and was stating they were in pain. The progress notes also included that when staff would assist with cares, "Resident was yelling from the top of their (Resident 1) lungs to stop moving them (Resident 1) and it hurts."

Review of Resident 1's progress notes dated 08/24/2023, stated that, "Resident is still having extreme pain 8 on the pain scale." Progress notes on 08/25/2023, showed that Resident 1 showed the resident reported they had severe pain.

Review of Resident 1's progress notes dated 08/27/2023, showed that Resident 1 complained of discomfort and every time that staff would reposition them the resident would scream.

Review of Resident 1's progress notes dated [redacted]/2023 through 08/27/2023 showed that the resident had continued pain and would yell and scream out in pain. The progress notes showed that Resident 1 would report their pain would reach an eight on a pain scale of zero to 10 (10 being the worst pain level). The record did not show evaluation or appropriate action taken to address the resident's high levels and consecutive days of pain.

The August 2023 Medication Administration Record (MAR) showed:

On 08/23/2023, Resident 1 had an order for Tramadol (pain medication) to take every eight hours as needed for pain. The order had been provided to Resident 1 once on 08/23/2023, twice on 08/24/2024, and once on 08/27/2023. Tramadol not received on 08/25/2023 and 08/26/2023.

On 08/24/2023, Resident 1 had Oxycodone/APAP to take three times daily as needed for breakthrough pain. The order had been provided three times daily to Resident 1 on 08/25/2023 through 08/27/2023.

An [redacted]/2023 hospital record showed that Resident 1 was admitted from the ALF to the hospital on [redacted]/2023. The record showed Resident 1 was chronically ill-appearing, moaned with any movement and touch, had incoherent speech, decreased level of consciousness, and altered mental status. The record showed that Resident 1 had been admitted to the local hospital for fluids and intravenous (IV) antibiotics (used when infections are severe and need aggressive treatment) for a UTI and Sepsis (the body's extreme response to an infection and is life-threatening), continued rib pain from fracture, and would be placed on hospice services.

On 10/04/2023 at 11:50 AM with Staff B, Caregiver, stated that sometimes it would take five staff to assist with physical cares due to Resident 1's pain after the fall which continued until the resident was sent to the hospital. "It was torture for [Resident 1] to move because of lots of pain."

On 10/04/2023 at 11:05 AM with Staff D and Staff E, Resident Care Coordinators, stated that after the fall Resident 1 could not move and when staff would physically assist the resident they would yell in pain. Prior to the fall Resident 1 was able to independently take themselves to and from the dining room for meals without difficulty. Staff D acknowledged that Resident 1 only had Tylenol (over the counter pain medication) kept at their bedside to use as needed after the fall on 08/17/2023 and that no other pain relief interventions or medication were added until Resident 1's hospital admission on [redacted]/2023.

On 10/04/2023 at 4:15 PM, Staff G, MT, stated that Resident 1 had Tylenol prior to the fall incident [08/17/2023] kept at their bedside and did not feel it covered pain management for fractured ribs.

Interview on 10/04/2023 at 10:55 AM with Staff F, Licensed Practical Nurse, Health Service Director, stated that they were new to the ALF and had not been made aware of Resident 1's fall incident [08/17/2023] and/or the pain until [redacted]/2023 when staff had reported to them the resident's decline. Staff F stated that is when they sent the resident out to be evaluated at the local hospital and the resident was admitted.

Interview on 10/05/2023 at 1:11 PM with CC1 Resident 1's Primary Care Physician's Nurse, stated that the facility had not notified them of the fall incident that occurred on 08/17/2023 until 08/22/2023. CC1 included that when notified on 08/22/2023 the facility told them that Resident 1 had rib fractures due to the fall and had been seen on [redacted]/2023 at the local hospital. CC1 stated that they had sent pain medication orders to the facility for pain related to the rib fractures on [redacted]/2023 (two days after the hospital visit). In addition, CC1 stated that Resident 1's Representative had notified them of when resident passed away on [redacted]/2023, and no notification of the resident's passing was made by the ALF.

This is a recurring deficiency previously cited on 06/09/2023 and 04/04/2022 subsections (3)(a)(b)(4)(1)

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) 12/15/2023.

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

Statement of Deficiencies	License #: 2581	Compliance Determination # 29259
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 7 of 9	Licensee: Greenlake Management Columbian, LLC	10/31/2023

Administrator (or Representative) Date 11/16/2023

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

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

(2) Determine the circumstances of the event;

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to investigate, document investigative actions, and implement interventions to reduce the risk of recurrence of resident falls with injuries for 2 of 2 residents (Residents 1 and 2). These failures placed residents at risk of further injury and unidentified care needs.

Findings included...

Review of the facility's, "Internal Incident Report and State Incident Report," dated 08/10/2021, showed that the facility was to investigate, document investigative actions, and findings for any alleged and or suspected abuse, neglect, accident, or incident affecting a resident's health or life. The policy showed that the facility needed to determine the circumstances of the event and protect the residents.

Resident 1

Review of Resident 1's progress notes, dated 08/17/2023, showed that the resident had a fall incident on 8/17/2023, was crying and reported pain to their right rib area.

Review of Resident 1's progress notes, dated [redacted]/2023 at 1:02 PM, showed that the resident had been transported via ambulance to the hospital due to extreme body pain.

Review of Resident 1's hospital record, dated [redacted]/2023, showed that the resident was seen due to experiencing three days of right-sided pain after an unwitnessed fall incident. The hospital record included imaging results that showed Resident 1 had multiple right rib fractures.

Review of Resident 1's facility records dated 08/17/2023 through [redacted]/2023, did not show documentation of an investigation or investigative actions to determine the circumstances of the fall or interventions to reduce the risk of recurrence.

Resident 2

Review of Resident 2's Negotiated Service Agreement (NSA). dated on 03/24/2023, showed that the resident was a moderate to high fall risk. The NSA also instructed that staff should monitor Resident 2 when walking with walker.

Review of Resident 2's progress notes showed the following:

-On 09/29/2023 at 4:32 AM, the resident had a fall incident. The progress note did not show injuries had occurred. The progress note documented that the resident had been confused all night.

-On 09/29/2023 at 11:09 AM, Resident 2 was sent out to the local hospital due to their fall incident around 6:00 AM.

Review of Resident 2's hospital record, dated 9/29/2023, showed that the resident had injuries including a facial contusion (bruising) and a facial laceration (cut).

Observation on 10/04/2023 at 12:07 PM in Resident 2's apartment showed that the resident had facial bruising from under the left eye down the left side their face. The resident stated the bruising was from a fall they had on 09/29/2023.

Review of Resident 2's facility records dated 09/29/2023 through 10/04/2023 did not show documentation of an investigation or investigative actions to determine the circumstances of the fall or interventions to reduce the risk of recurrence.

On 10/04/2023 at 1:45 PM Staff F, Licensed Practical Nurse/ Health Service Director, stated that they were aware of Resident 2's fall incident. Staff F stated that they had not investigated the fall due to being new to the facility, had been busy learning the facility and their role. In addition, Staff F stated that the investigation was not documented or completed per the ALF's policy.

This is a recurring deficiency previously cited on 04/25/2023 subsections (1)(2).

Plan/Attestation Statement

Statement of Deficiencies	License #: 2581	Compliance Determination # 29259
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 9 of 9	Licensee: Greenlake Management Columbian, LLC	10/31/2023

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) 12/15/2023

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

Administrator (or Representative)

11/16/2023
Date