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) 42841 (Completion Date 06/18/2024) and 36887 (Completion Date 04/10/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/18/2024 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, WAC 388-78A-2350-1, WAC 388-78A-2350-7-b, WAC 388-78A-2130-3, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b

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

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, 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 #: 36887
Investigator: Melissa Milanez
Provider Type: Assisted Living Facility
Intake ID: 117794
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 02/20/2024 through 04/10/2024
Complainant Contact Date(s): 03/22/2024

Allegation(s):

1. Identified resident was sent to the hospital with high blood sugars, urinary incontinence, yeast infection, and pressure ulcers.
2. Identified resident did not receive incontinence supplies at the facility.
3. Identified resident was misdiagnosed with [redacted].

Investigation Methods:

Sample:	Total residents: 75 Resident sample size: 3 Closed records sample size: 1
Observations:	Environment, Cares, Residents, Staff availability and response to resident's needs, Staff to resident interactions
Interviews:	Residents, staff, and others not associated with the facility.
Record Reviews:	Characteristic roster, resident records (face sheet, assessment, care plan, progress notes, physician orders), facility policies

Investigation Summary:

1. Interviews and record review showed that the named resident no longer resided at the facility. Record review showed that the facility failed to monitor and follow orders to check blood sugars and address new medical concerns. Deficient practice identified and the facility was cited for WAC 388-78A-2120 (1)(2)(a)(b)(3)(a)(b)(4); WAC 388-78A-2130 (3)(a)(b); and 388-78A-2350(1)(7)(b) reference Statement of Deficiencies dated 04/10/2024.

2. Observations showed that the facility had a house stock of incontinent supplies. Interviews and record review showed that the named resident and other residents received the personal care items from the facility that they required. Record review and interviews showed that the named resident had a new onset of urinary incontinence and had not required incontinent supplies until recently. Interviews showed that the facility was waiting for signed orders from the Primary Care Provider but supplied incontinent supplies throughout this time. No failed practice identified.

4. Interviews and record review showed that the identified resident was evaluated by

their Primary Care Provider (PCP) and diagnosed with [redacted]. The facility followed PCP orders to treat rash with topical ointments. The identified resident was later sent to the hospital and had been misdiagnosed with [redacted] No failed practice identified.

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

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 02/20/2024, 03/12/2024 and 02/20/2024 of:

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

This document references the following complaint number(s): 117794, 118489, 118691, 119198

The following sample was selected for review during the unannounced on-site visit: 3 of 75 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

04/23/2024
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.

Ruth Wright
Administrator (or Representative)

4-24-24
Date

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 interview, and record review, the facility failed to evaluate and take action regarding one resident's changes of condition regarding hyperglycemia (high blood sugars), urinary tract infection, and altered skin integrity for 1 of 3 residents (Resident 1). These failures resulted in a delay in treatment for the resident's ongoing high blood sugar readings, skin condition, and urinary tract infection, which contributed to an eight-day hospitalization, and 25 days of extensive physical therapy.

Findings included...

Record review of a facility policy titled, "Alert Charting," dated 04/10/2021, showed that alert charting would be implemented for residents who had recent change in their expected or customary function or other reason that initiates a need for closer monitoring. The alert charting process included: The Wellness Director or designee will assign alert charting responsibilities and monitor the alert charting daily. There was to be an alert charting entry in the resident record each shift.

Record review of the facility's policy titled, "Diabetes 02-When to Call the Health Care Provider," dated 08/10/2021, showed that staff were to seek medical support when the diabetic resident had a change in condition. Call a physician as soon as possible for residents who: a) Have two or more blood sugar levels higher than 250 if they are also having new health problems or a change in their usual health and no treatment has yet been given.
b) Have one or more blood sugar levels higher than 300 two days in a row, unless this is better than earlier measures of blood sugar levels or the resident's physician has given different orders about how to take care of the resident's high blood sugar.
c) Have not eaten well or had enough to drink for a day and have one or more the following: pain in their stomach, fever, weakness, or other indications of illness.

Administrator (or Representative) Date

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c) Have not eaten well or had enough to drink for a day and have one or more the following: pain in their stomach, fever, weakness, or other indications of illness.

Skin Condition and Physician's Orders

Record review of Resident 1's records, undated, showed that Resident 1 was admitted to the facility on [redacted] 2022 with diagnoses that included [redacted] and [redacted]

Review of Resident 1's Health Alert Form (communication from care staff to show change of condition) submitted to Staff B, Licensed Practical Nurse (LPN) dated 12/20/2023 showed Resident 1 seemed different than usual, overall needed more help than usual, needed help with toileting, had a change in behaviors, had a change in personal hygiene and the resident was excessively urinating (symptoms of high blood sugars) and was not able to transfer to the commode on time.

Review of Resident 1's "Health Alert Form" submitted to Staff B, Licensed Practical Nurse (LPN) dated 12/27/2023 (one week after the first notification) showed Resident 1 continued to need additional assistance with cares, their apartment was not cleaned, they were staying in their apartment more than usual, and had a change in physical ability or balance.

Review of Resident 1's "Health Alert Forms" dated on 12/20/2023 and 12/27/2023 showed that they had not been reviewed by the Health & Wellness Director/Supervisor/Designee or had failed to acknowledge if any actions needed to be taken for Resident 1. Additionally, there had been three boxes that had not been checked to acknowledge that the form had been reviewed, if alert charting/monitoring was required, or if there was a need for a re-assessment and any possible Negotiated Service Agreement changes.

Review of Resident 1's progress note dated 12/21/2023 showed that Staff A, Resident Care Coordinator (RCC), documented that the shower aid reported that the resident had red areas on their back leg and on their buttocks, resident was to be placed on alert charting to monitor until healed.

Review of Resident 1's Shower sheets dated; 12/21/2023, 01/11/2024, and 01/15/2024 showed that the resident had reddened areas and rashes to the groin and buttocks. The record showed no evaluation or action taken regarding the skin condition identified in the Shower sheets.

Review of Resident 1's progress note dated 12/27/2023 showed that Staff B documented that a "Stop and Watch Form" (change in condition/health alert form) written by an unidentified Medication Technician (MT) noted that "the resident had become weak and seemed different than usual, sometimes cannot take [themselves] to the restroom, which was new. The resident's balance was also altered, will inform doctor and family. Resident will be on alert charting."

Review of Collateral Contact 2 (CC2), visit note dated 12/27/2023 showed that the resident was seen for concerns with excessive urination and had requested for the facility to obtain a Urinalysis (a test of your urine used to detect and manage a wide range of disorders, such as a urinary tract infection, and diabetes), and an order was written to check the resident's Hemoglobin A1C (a simple blood test that measures average blood sugar levels over the past three months, and the primary test to assist a health care team to manage diabetes).

Review of Resident 1's medical records dated 01/08/2024 showed that CC2, ordered for Resident 1 to have a condom catheter (a bladder containment strategy for men who have problems with urinary incontinence) placed.

Review of Resident 1's record from 12/21/2023 – 01/31/2024 showed that the skin condition was never evaluated, and no interventions were identified to treat the condition. Additionally, records showed that a condom catheter was never placed on the resident.

On 03/06/2024 at 4:01 PM, Collateral Contact 1 (CC1), stated they went to visit Resident 1 on 12/30/2023, and what they saw was "disturbing." CC1 stated that Resident 1 had a difficult time expressing their needs, appeared to be in pain, and pointed towards their groin area. CC1 stated they observed a rash that was red and inflamed on Resident 1's groin area. CC1 stated that they then immediately called for Staff A, RCC, and asked them if they had been aware of a rash that Resident 1's rash. CC1 stated that Staff A then stated to them that they were made aware of the rash by a picture that had been sent to them by another staff member and that they had not observed the rash and were not aware of any treatment that had been ordered. CC1 stated, Staff A advised them to go buy Desitin ointment/cream (used for diaper rash) for Resident 1.

In an interview on 03/12/2024 at 3:54 PM, Staff A, RCC, stated that they were aware of a rash on Resident 1's groin and buttocks area that had developed around 12/20/2023 that was "really bad". Staff A also stated that they had observed CC1 crying, and stated, "I don't blame her, the rash was bad." Staff A stated they received an order for a condom catheter on 01/08/2024 to be placed on the resident due to a new onset of frequent urinary incontinence (loss of bladder control). They stated that they had not sent out the order for the catheter and that the resident never received it. Additionally, Staff A, stated that they had received orders for a blood draw on 12/27/2023 from the Primary Care Provider (PCP) for Resident 1. Staff A stated the facility did not have a system in place to be able to implement the orders for requested lab work for Resident 1.

Diabetes - Blood Sugar and Medication Management

Review of Resident 1's Physician's Orders, dated 01/04/2024, noted that CC2, ordered for Resident 1 to have their blood sugars checked three times a day for one week.

Resident 1's medical records showed no documentation from facility staff on blood sugar checks for the ordered time frame of 01/04/2024 – 01/11/2024.

Review of Resident 1's Physician's Orders, dated 01/17/2024, noted that CC2, ordered for the resident to start Lantus 10 units (a fast-acting insulin used to control high blood sugars), and for blood sugars to be checked daily before administration of insulin.

Review of Resident 1's records showed no documentation of blood sugar checks for the ordered time frame of 01/17/2024 – 01/23/2024.

Review of a progress note dated 01/19/2024 (two days after the 01/17/2024 order was received) showed that the resident was to be monitored for side effects of starting Lantus 10 units. Review of progress notes dated 1/20/2024-1/31/2024 showed no documentation or monitoring for Resident 1.

Review of Resident 1's Physician's Orders dated 01/22/2024 showed that CC2, prescribed for resident to start Humalog 5 units (a fast-acting insulin used to control high blood sugars) with meals, staff to check blood sugars two hours after meals and at bedtime.

Review of Resident 1's record from 01/22/2024 to 01/23/2024 showed no documentation of blood sugar checks until 01/24/2024.

Review of Resident 1's (MAR) dated 01/24/2024 at 11:37 AM, showed that the ordered insulin was not administered due to medication not available.

Review of Resident 1's progress note dated 01/25/2024 (three days after the order was received) showed that the resident was started on Humalog 5 units three times a day.

Review of Resident 1's Medication Administration Record (MAR) from 01/24/2024 to 01/31/2024 (21 days after initial PCP orders to check blood sugars) showed the following abnormal blood sugar (BS) readings (normal BS's for in people with Diabetes are 70 to 130 milligrams /deciliter (mg/dL) before meals, and less than 180 mg/dL after meals): three blood sugars above 300, seven blood sugars above 400, ten blood sugars above 500, and two blood sugars resulting in 600. Normal blood sugar for in people with Diabetes are 70 to 130 mg/dL) before meals, and less than 180 mg/dL after meals.

Review of Resident 1's progress notes from 01/24/2024-01/31/2024 did not show the facility evaluated or took any action regarding the noted high blood sugars.

Review of Resident 1's progress notes dated [redacted]2024 showed that Resident 1 was found unresponsive and was sent to the hospital.

Review of Resident 1's hospital records dated [redacted]2024 showed that the resident was admitted to the hospital for acute change in mental status, Metabolic Encephalopathy (brain disorder causing confusion from metabolic disturbances) related to hyperglycemia and infection, acute symptomatic UTI, Methicillin-resistant staphylococcus aureus (MRSA- a cause of staph infection), Hyperglycemia (high blood sugars), and Tinea Corporis (a rash caused by a fungal infection).

Review of Resident 1's hospital discharge summary dated [redacted]2024 showed that the resident was discharged from the hospital to a long-term care facility and would require extensive continued wound care and Intravenous (IV) antibiotics for 2 more weeks.

In an interview on 03/21/2024 at 8:51 AM, CC2 stated that lab work was ordered for Resident 1 on 12/27/2024, but that the facility had not coordinated for labs to be drawn. Additionally, they ordered blood sugar checks, and a urinalysis (a test of your urine used to detect and manage a wide range of disorders, such as a urinary tract infection, and diabetes) to be done by the facility and was unsure if they were ever completed. CC2 also stated that they had to find their own phlebotomist (a person who collects blood from patients and prepare the blood for testing) to draw Resident 1's labs at the facility on 01/14/2024 (18 days after first initial labs were ordered). On 01/16/2024, they received Resident 1's A1C results of 18.4 % (the goal for most adults with diabetes is an A1C that is less than 7%). CC2 stated they ordered insulin to be started but was never contacted on any high blood sugar readings after that. CC2 stated that on one occasion they entered the facility and asked an unidentified medication technician how Resident 1's blood sugars were, and was told that they were high, and that they would print out the results, but never received results. CC2 further stated that they should have been notified about Resident 1's high blood sugar readings as that required emergency treatment.

On 03/22/2024 at 1:54 PM, CC1, stated that they were told by Staff A that the facility would take Resident 1 to get their lab (blood) work done. CC1 confirmed the lab work was never done by the facility. In addition to the labs ordered in December, CC1 stated there were also labs ordered in October that the facility did not obtain. CC1 also stated that they had not been notified of high blood sugar readings and did not become aware of this until Resident 1's admission to the hospital.

In an interview on 03/26/2024 at 12:52 PM, Staff A, RCC, stated that they were not sure why the Urinalysis test ordered on 12/27/2024 had not been collected and that labs had not been drawn due to not having a system in place. Staff A also stated that it is the facility's policy to notify the primary care provider and send the resident to the hospital if blood sugars are over 500. Staff A also stated that they were unsure if the provider was ever notified of the high blood sugar readings and did not know why the resident had not been sent to the hospital if that was their policy to do so.

This is a recurring deficiency previously cited on 10/31/2023, 06/09/2023 and 04/04/2022 for subsections (3)(a)(b)(4).

Statement of Deficiencies	License #: 2581	Compliance Determination # 36887
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 7 of 12	Licensee: Greenlake Management Columbian, LLC	04/10/2024

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 5-24-24

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

Ruth Wright
Administrator (or Representative)

4-24-24
Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to coordinate outside healthcare services regarding changes in the residents physical functioning for 1 of 3 residents (Resident 1). This failure resulted in a delay in obtaining an ordered laboratory test (procedure in which a sample of blood, urine, other bodily fluid, or tissue is examined to get information about a person's health) and contributed to the resident's delay in receiving medical treatment.

Findings included...

Review of the Assisted Living Facility (ALF) policy, dated, 08/10/2021, titled, "Coordination of Health Care Services" shows that the facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

Record review of the facility's policy titled, "Diabetes 02-When to Call the Health Care Provider," dated 08/10/2021, showed that staff were to seek medical support when the diabetic resident had a change in condition. Call a physician as soon as possible for residents who: a) Have two or more blood sugar levels higher than 250 if they are also having new health problems or a change in their usual health and no treatment has yet been given.
b) Have one or more blood sugar levels higher than 300 two days in a row, unless this is better than earlier measures of blood sugar levels or the resident's physician has given different orders about how to take care of the resident's high blood sugar.

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b) Have one or more blood sugar levels higher than 300 two days in a row, unless this is better than earlier measures of blood sugar levels or the resident’s physician has given different orders about how to take care of the resident’s high blood sugar.

c) Have not eaten well or had enough to drink for a day and have one or more the following: pain in their stomach, fever, weakness, or other indications of illness.

Review of the Assisted Living Residence and Care Agreement dated, 01/04/2022, showed that transportation will be available to residents, or otherwise assure the provision of scheduled transportation to the nearest appropriate health facilities for medical and dental appointments, within 10-mile radius. Transportation is available from 9:00 AM- 4:00 PM on designated days. Other transportation outside normal business hours may be arranged by the resident with the Community's Activities Director for an additional charge, or with an outside agency.

Review of Resident 1's Health Alert Form (communication from care staff to show change of condition) submitted to Staff B, Licensed Practical Nurse (LPN) dated 12/20/2023 showed Resident 1 seemed different than usual, overall needed more help than usual, needed help with toileting, had a change in behaviors, had a change in personal hygiene and the resident was excessively urinating (symptoms of high blood sugars) and was not able to transfer to the commode on time.

Review of Resident 1's "Health Alert Form" submitted to Staff B, Licensed Practical Nurse (LPN) dated 12/27/2023 (one week after the first notification) showed Resident 1 continued to need additional assistance with cares, their apartment was not cleaned, they were staying in their apartment more than usual, and had a change in physical ability or balance.

Review of Resident 1's "Health Alert Forms" dated on 12/20/2023 and 12/27/2023 showed that they had not been reviewed by the Health & Wellness Director/Supervisor/Designee or had failed to acknowledge if any actions needed to be taken for Resident 1. Additionally, there had been three boxes that had not been checked to acknowledge that the form had been reviewed, if alert charting/monitoring was required, or if there was a need for a re-assessment and any possible Negotiated Service Agreement changes.

Record review of Resident 1's physician orders, dated, 12/27/2023 showed that there was an order written for blood to be drawn and sent to laboratory for testing.

In an interview on 03/12/2024 at 3:54 PM, Staff A, Residential Care Coordinator (RCC), stated that Resident 1 had physician orders for blood to be drawn. They stated that the orders were never done due to the facility not having a system in place.

In an interview on 03/21/2024 at 8:51 AM, Collateral Contact 2 (CC2), stated that they had ordered blood work to be drawn for Resident 1 on 12/27/2024. CC2 stated that the facility was unable to get anyone to draw the blood at the facility and the facility did not take the resident out to the laboratory for the draw.

In an interview on 03/22/2024 at 1:54 PM, Collateral Contact 1 (CC1), stated that they had been made aware of the orders for blood work back in October and at the end of December 2023 for Resident 1. They stated that they were told by Staff A, that the facility would be responsible for taking the resident out to the laboratory for the collection. CC1 stated that it never happened.

In an interview on 03/26/2024 at 12:52 PM, Staff A, RCC, stated that the facility offers two days out of the week to take residents to appointments or they can schedule transportation with two outside agencies, but they were not sure why Resident 1 was never taken to get their blood drawn.

Record review of Resident 1's progress note dated [redacted]2024, showed that the resident was found unresponsive and was sent out to the hospital.

Record review of Resident 1's emergency department (ER) note dated [redacted]2024 showed that the resident arrived in the ER with altered level of consciousness and elevated blood sugars.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date) 5-24-24.

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

Ruth Wright
Administrator (or Representative)

4-24-24.
Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical. mental, or emotional functioning: and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) was updated to reflect a resident's change of

In an interview on 03/22/2024 at 1:54 PM, Collateral Contact 1 (CC1), stated that they had been made aware of the orders for blood work back in October and at the end of December 2023 for Resident 1. They stated that they were told by Staff A, that the facility would be responsible for taking the resident out to the laboratory for the collection. CC1 stated that it never happened.

In an interview on 03/26/2024 at 12:52 PM, Staff A, RCC, stated that the facility offers two days out of the week to take residents to appointments or they can schedule transportation with two outside agencies, but they were not sure why Resident 1 was never taken to get their blood drawn.

Record review of Resident 1's progress note dated [redacted]2024, showed that the resident was found unresponsive and was sent out to the hospital.

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(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) was updated to reflect a resident's change of

condition and care needs for 1 of 3 residents (Residents 1) with declining physical and cognitive conditions. These failures resulted in staff not having instructions; on how to monitor for signs and symptoms of hyperglycemia (high blood sugar), what to do if the blood sugars were high or low, how to address the resident's skin condition, and how to provide assistance to the resident with their declining physical and cognitive condition change.

Findings included...

Record review of a facility policy titled, "Resident Assessment and Negotiated Service Agreement," dated 08/10/2021, showed that assessments and Negotiated Service Agreements will be updated as frequently as necessary to ensure they reflect current resident care needs and preferences. Individualized Negotiated Service Agreements are used to plan for and meet resident needs using an interdisciplinary approach. Formal review should take place whenever there is a significant change in resident status.

Review of Resident 1's face sheet showed the ALF admitted the resident on [redacted] 2022 with multiple medical diagnoses including [redacted] and [redacted]

Review of Resident 1's progress note dated 12/21/2023 showed that Staff A, Resident Care Coordinator (RCC), documented that a shower aid reported that the resident had red areas on their back leg and on their buttocks.

Review of Resident 1's shower sheets dated 12/21/2023, 01/11/2024, and 01/15/2024, showed that the resident had newly identified reddened areas and rashes to the groin and buttocks.

Review of Resident 1's Health Alert Form (communication from care staff to show change of condition) submitted to Staff B, Licensed Practical Nurse (LPN) dated 12/20/2023 showed Resident 1 seemed different than usual, overall needed more help than usual, needed help with toileting, had a change in behaviors, had a change in personal hygiene and the resident was excessively urinating (symptoms of high blood sugars) and was not able to transfer to the commode on time.

Review of Resident 1's "Health Alert Form" submitted to Staff B, Licensed Practical Nurse (LPN) dated 12/27/2023 (one week after the first notification) showed Resident 1 continued to need additional assistance with cares, their apartment was not cleaned, they were staying in their apartment more than usual, and had a change in physical ability or balance.

Record review of a progress note written by Staff B (LPN), dated 12/27/2023, showed that

a "Stop and Watch Form" (communication from care staff to show change of condition) was turned in by an identified Medication Technician and showed that the resident had become weak, seemed different than usual, their balance was altered, and sometimes cannot take [themself] to the restroom, which was new.

Record review of a progress note written by Staff B (LPN), dated 12/28/2023, showed that staff reported a change in condition and felt it was necessary to assist Resident 1 with finances by removing their debit card as they had observed them handing it to other residents along with the pin number. Progress notes also showed that they would hold on to the card until the resident was no longer having confusion episodes.

In an interview on 02/20/2024 at 11:19 AM, Staff C, Administrator, stated that the Staff B was no longer employed by the facility as of 02/12/2024 and that they would be unable to answer questions regarding the cares and services for Resident 1. Staff C stated they were new to the facility and was not familiar with the resident.

In an interview on 02/20/2024 at 11:29 AM, Staff A, RCC, stated that Resident 1 was Diabetic and had been on Metformin prior to their change in condition. They stated that Resident 1 had been urinating "really bad," and staff were needing to help them to the bathroom, with dressing, and showering. Staff A stated that in January Resident 1 was getting their blood sugars checked and had started taking insulin for their Diabetes because their A1C (simple blood test that measures average blood sugar levels) was "too high."

Review of Resident 1's Negotiated Service Agreement (NSA) last updated on 09/21/2023, showed it was not updated to reflect the changes in Resident 1's care needs. The NSA failed to give instructions to staff on how to monitor for signs and symptoms of hyperglycemia and did not show instructions on when to notify the provider and how to address high blood sugar results. The NSA did not include Resident 1's skin condition, who was monitoring it, and any interventions related to skin condition. The NSA was not updated to reflect that Resident 1 required additional help with Activities of Daily Living (ADL's) due to change in cognition and weakness.

This is a recurring deficiency previously cited on 03/08/2023.

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) 5-24-24.

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

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In an interview on 02/20/2024 at 11:29 AM, Staff A, RCC, stated that Resident 1 was Diabetic and had been on Metformin prior to their change in condition. They stated that Resident 1 had been urinating “really bad,” and staff were needing to help them to the bathroom, with dressing, and showering. Staff A stated that in January Resident 1 was getting their blood sugars checked and had started taking insulin for their Diabetes because their A1C (simple blood test that measures average blood sugar levels) was “too high.”

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

Ruth Wright
Administrator (or Representative)

5/3/24.
Date

Administrator (or Representative) Date