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

11/14/2024

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

RE: Royal Columbian Senior Living # 2581

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 50216 (Completion Date 11/14/2024) and 46369 (Completion Date 09/17/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/14/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

The Department staff who did the On Site verification:
Melissa Milanez, Community Complaint Investigator

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, 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 #: 46369
Investigator: Melissa Milanez
Investigation Date(s): 08/29/2024 through 09/17/2024
Complainant Contact Date(s): 09/20/2024

Provider Type: Assisted Living Facility

Intake ID: 144301
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Resident not getting care and services resulting in a fall.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 6 Closed records sample size:
Observations:	Identified resident Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Incident investigation Facility policies Staff patterns

Investigation Summary:
Facility did not integrate information from the admission assessment into the Negotiated Care Plan (NSP) to address the care and services necessary to meet the resident's needs. Failed practice identified. WAC 388-78a-2140 (1)(i)(ii).

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 08/29/2024 and 08/29/2024 of:

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

This document references the following complaint number(s): 144301, 144016, 142883, 142806, 142830, 142503

The following sample was selected for review during the unannounced on-site visit: 6 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator
Laurel Knight, 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.

Stephanie Jones

Residential Care Services

09/26/2024

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)

9/27/24.
Date

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(ii) The resident's full assessments;

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 contained the necessary content needed to meet the needs of 1 of 4 residents (Resident 1). This failure resulted in delayed care that contributed to a hospitalization and inpatient rehabilitation services for the resident.

Findings included...

Review of the facility's policy titled, "Resident Assessment and Negotiated Service Agreement," dated 08/10/2021, showed that the ALF must update the assessments and negotiated service agreements (NSA's) as frequently as necessary to ensure they reflect current resident care needs and preferences. The policy showed that whenever an assessment is updated, the NSA should also be updated. The policy stated that the NSA is to include services as applicable for all areas addressed on the resident assessment and is to be individualized based on the resident's needs and preferences.

Review of Resident 1's admission assessment, dated 08/07/2024, showed that the resident was to be checked on four times per shift.

Facility record review showed Resident 1 was admitted to the facility on [redacted]/2024. The record showed the resident was diagnosed with [redacted], and [redacted]

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

Administrator (or Representative) Date

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[redacted]).

Review of Resident 1's NSA, dated [redacted]/2024, showed no documentation of the need for staff to check on the resident four times per shift.

Review of an incident report, dated 08/14/2024, showed that the Medication Technician (MT) entered Resident 1's room to give them their medications at 8:00 AM, and the resident was found on the floor by their bed. Further review showed that Resident 1 was unable to move, emergency response was called, and the resident was taken to a local hospital.

In an interview on 08/29/2024 at 1:11 PM, Resident 1 stated that they had a fall, and was left on the floor for seven hours without assistance. Resident 1 stated they had been laying on their right leg, and was unable to get out of that position all night. The resident stated they were last checked on at 10:00 PM when they received their night medications. Resident 1 further stated that they had yelled for help throughout the night, and no one showed up to assist them until the next morning when the (MT) brought them their morning medications.

In an interview on 09/10/2024 at 2:14 PM, Staff A, Health and Wellness Director, stated that staff were required to check on residents at least twice a shift, and that this did not happen for Resident 1.

In an interview on 09/12/2024 at 10:04 AM, Collateral Contact (CC1), Resident 1's legal representative, stated that Resident 1 had a fall, and had been on the floor for seven hours. CC1 also stated that the resident had lost their voice from yelling out for help. CC1 stated that the resident had reported to them that it had been part of their care plan to receive frequent safety checks every shift.

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) 11/01/24.

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

Administrator (or Representative) Ruth Wright Date 9/27/24

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