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

05/02/2025

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) 57105 (Completion Date 05/02/2025) and 52749 (Completion Date 01/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/02/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

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

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

The Department staff who did the On Site verification:
Laurel Knight, Community Complaint Investigator

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

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF 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 #: 52749
Investigator: Laurel Knight
Investigation Date(s): 01/08/2025 through 01/24/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 160753
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Identified resident unexpected death.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 5 Closed records sample size: 1
Observations:	Residents Staff to resident interactions
Interviews:	Identified staff Nursing staff Residents EMS Coroner
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations.

Investigation Summary:
Identified resident's representative stated that the resident was a Do Not Resuscitate and had delivered the documents to the facility. Facility staff interviews confirmed the facility did not have any documents available to them when the resident had a medical emergency. The staff called for Emergency Medical Services and the resident was given emergency assistance. Facility documents showed that the resident chose to have Cardiopulmonary Resuscitation (CPR) on one document and to not have CPR on another document. Failed practice identified. Please see the Statement of Deficiency dated 01/24/2025 for Washington Administrative Code 388-78a-2600 (2)(d).

Conclusion / Action:

☒ 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 #: 52749
Investigator: Laurel Knight
Provider Type: Assisted Living Facility
Intake ID: 162140
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 01/08/2025 through 01/24/2025
Complainant Contact Date(s): 01/22/2025, 01/29/2025

Allegation(s):
Identified resident unexpected death.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 5 Closed records sample size: 1
Observations:	Residents Staff to resident interactions
Interviews:	Identified staff Nursing staff Residents EMS Coroner
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations.

Investigation Summary:
Identified resident's representative stated that the resident was a Do Not Resuscitate and had delivered the documents to the facility. Facility staff interviews confirmed the facility did not have any documents available to them when the resident had a medical emergency. The staff called for Emergency Medical Services and the resident was given emergency assistance. Facility documents showed that the resident chose to have Cardiopulmonary Resuscitation (CPR) on one document and chose to not have CPR on another document. Failed practice identified. Please see the Statement of Deficiency dated 01/24/2025 for Washington Administrative Code 388-78a-2600 (2)(d).

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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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 01/08/2025 of:

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

This document references the following complaint number(s): 161079, 160295, 160753, 162140

The following sample was selected for review during the unannounced on-site visit: 5 of 72 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

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

Statement of Deficiencies	License #: 2581	Compliance Determination #:52749
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 2 of 6	Licensee: Greenlake Management Columbian, LLC	01/24/2025

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.

Laura Williams-Davis
Residential Care Services

02/04/2025
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.

Rachel A
Administrator (or Representative)

2/11/25
Date

WAC 388-78A-2600 Policies and procedures.

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This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their policies for when a resident stops breathing and did not having a current advance directive status on file for 1 of 1 resident (Resident 1). This failure contributed to the resident receiving life saving measures, Cardiopulmonary Resuscitation due to the facility not having the Resident 1's POLST and contradictions in life saving measure guidance in residents' record.

Findings included...

Review of the facility policy titled "Advance Directives" dated 02/15/2024, showed that staff were directed to ascertain whether the resident has an advance directive, living will or Portable Order for Life Sustaining Treatment, (POLST) form upon move in. The copy of the advanced directive, living will or POLST was to be placed in the front of the resident's record and the status entered on the Medication Administration Record (MAR) and Primary Care Provider (PCP) order form.

Review of the facility policy titled "Emergencies-Major Medical Emergency and Documentation" dated 02/15/2024, showed that staff were directed to immediately call EMS for residents showing any sign or symptom of a medical crisis. Staff were directed

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Laura Williams-Davis
Residential Care Services

02/04/2025
Date

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Administrator (or Representative)

Date

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Review of the facility policy titled "Emergencies-Major Medical Emergency and Documentation" dated 02/15/2024, showed that staff were directed to immediately call EMS for residents showing any sign or symptom of a medical crisis. Staff were directed

to not hesitate to summon EMS anytime there was a change in the stability of the resident or a serious threat to their health or wellbeing. Signs and symptoms of distress were included but not limited to: Shortness of breath, chest pain, loss of consciousness or change in level of consciousness. If the Licensed Nurse was not immediately available and staff were unsure of the extent of issue or injury, 911 was to be called.

A review of Resident 1's record included a negotiated service agreement, (NSA,) dated updated 11/06/2024 showed the resident wished to be a full code (have emergency interventions) if a medical emergency occurred.

Review of Resident 1's record showed an undated face sheet indicating the resident was a full code. Another undated demographic page from the resident's paper file in the facility showed that Resident 1 did not want Cardiopulmonary Resuscitation, (CPR) in the event their heart stopped, or they stopped breathing.

Review of an incident report dated [redacted]/2024 initiated by Staff C, Medication Technician (MT) showed that Resident 1 had pushed their call light and told Staff D, Caregiver that they were not feeling well. Staff C documented that they finished providing care and services to another resident and went to check on Resident 1.

Review of Resident 1's facility call light record on [redacted]/2024, showed the resident pushed their pendant for help at 11:18 PM and the pendant was cleared at 11:29 PM

Review of the EMS call logs on [redacted]/2024, showed that 911 was contacted at 11:37 PM and the dispatcher directed CPR be started. CPR was in progress at 11:38 PM until EMS took over at 11:44 PM.

Review of written witness statements made by Staff D included with the incident report dated [redacted]/2024, showed that Resident 1 put on their call light and told staff that they didn't feel well. Staff D called Staff C, (Medication Technician) and told them that Resident 1 didn't feel or look good. Staff D stated it took two phone calls to Staff C and help from Staff E, Caregiver to get Staff C to come and look at Resident 1.

In an interview on 01/21/2025 at 12:25 PM, Staff D stated that they answered Resident 1's light (pendant) where they were sitting on their walker in the dining room, and they looked pale. Staff D stated that Resident 1 said they didn't feel well and were nauseated, had pain down their arm and was out of breath. Staff D stated that she called Staff C at 11:28 PM and said Resident 1 was pale, nauseated and out of breath and Staff C said that they were finishing a medication pass. Staff D stated that she called Staff C again at 11:30 PM and stated that Resident 1 was slumped over on their walker and was losing consciousness and was told by Staff C that they were still giving meds. Staff D stated that they could no longer reach their phone because they were holding up the resident, so they yelled for help from Staff E. Staff E ran to the medication room to tell Staff C that Resident 1 was dying and to see if Staff C knew

whether they were a DNR or not. Staff D stated that the MT was the staff who would know right away if they were a DNR or not.

Review of written witness statements made by Staff E regarding the incident report dated [redacted]/2024, showed that they heard Staff D calling for help and when they arrived to help Staff D, Resident 1 was blue-purple and unconscious. Staff E ran to the medication room to get Staff C and ask if Resident 1 was a Do Not Resuscitate (DNR) or a full code.

In an interview on 01/21/2025 at 12:43 PM, Staff E confirmed the components of their witness statement. Staff E had been concerned that the resident was dying. Staff E stated that Staff C was no in any hurry to leave the med room, and that Resident 2 told Staff C to go help the resident that was dying. Staff E left the room to run back to dining room and that two residents were telling them to start CPR. Staff E stated that Staff C made their way to the dining room and then called 911 who directed them to start CPR.

In an interview on 01/21/2025 at 1:10 PM Resident 3 stated that they had been present during the entire incident and it was horrendous. Resident 3 stated that it took 12 minutes for the staff to do any interventions for Resident 1. Resident 3 stated that they had to tell Staff C to call 911and that Staff C was arguing with staff, residents and the dispatcher instead of doing good CPR. Resident 3 stated they were certified in CPR and that Staff C kept telling them to leave when they tried to provide helpful information.

In an interview on 01/23/2025 at 10:47 AM, Resident 2 stated that when they came off the elevator, they saw Resident 1 sitting on their walker and they looked terrible and was breathing hard. They stated that they directed the staff to go down the hall a little further to help. Resident 2 stated they were with Staff C when Staff E came running up saying that they needed Staff C to hurry to help the Resident 1. Resident 2 said that they told Staff C to go, and they would get their medication later, but Staff C didn't leave the med room and wanted to still get the medication for them.

In an interview on 01/23/2025 at 3:49 PM, Staff C stated they looked for Resident 1's code status but there wasn't anything written and there was not a POLST form in the resident record. Staff C stated the facility needed a better system to quickly identify the code status of residents in an emergency. Staff C stated that they ran down the hall and started CPR and there was no saving Resident 1 because it was a heart attack. Staff C stated that Resident 1 died despite her best efforts to save them.

In an interview 01/22/2025 at 8:43 AM, Collateral Contact 1 (CC1), Resident's 1 representative stated that they were upset that the resident had CPR. They stated that they had delivered Resident 1's POLST form to the facility when admitted. CC1 stated that later they had tried to follow up with the facility to ensure that they had the documentation on file and were told they could not find the form but would continue to look.

In an interview on 01/24/2025 at 9:15 Staff A, Administrator stated that they were unaware that Resident 1's record had two different designations of Full Code and DNR.

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) 3/10/25.

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

Administrator (or Representative) — Date 2/11/25

In an interview on 01/24/2025 at 9:15 Staff A, Administrator stated that they were unaware that Resident 1's record had two different designations of Full Code and DNR.

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)_____ .

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

_____ _____

Administrator (or Representative) Date