STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

05/14/2026

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) 77357 (Completion Date 05/14/2026) and 70539 (Completion Date 03/19/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/14/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

The Department staff who did the On Site verification:
Robin Barnes, Assisted Living Facility Licensor

This document was prepared by Residential Care Services for the Locator website.

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

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2581	Compliance Determination # 70539
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 6	Licensee: Greenlake Management Columbian, LLC	03/19/2026

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 follow-up on 12/22/2025 and 01/06/2026 of:
Royal Columbian Senior Living
5615 W Umatilla Ave
Kennewick, WA 99336

This document references the following SOD dated: 03/19/2026

The following sample was selected for review during the unannounced on-site visit: 4 of 97 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2581	Compliance Determination # 70539
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 2 of 6	Licensee: Greenlake Management Columbian, LLC	03/19/2026

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

03/26/2026
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)

3/31/2026
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to ensure residents received medications as ordered for 4 of 4 residents (Resident 1, 2, 3, & 4) and missed blood pressure monitoring for 3 of 4 residents (Resident 1, 2, & 4). This failure resulted in increased stiffness and pain for Resident 3 and late medications for Resident 1, 2, 3 & 4 and placed them at risk of health complications.

Findings included...

Review of the facility's policy titled, "Medication Incidents and Errors," dated 02/15/2024, showed that medication administration or assistance would be provided to residents in a manner that is safe and consistently free of errors. The policy showed that all medication incidents and errors would be investigated thoroughly and reported consistently. The policy further showed that corrective action would be taken with every

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error and that staff members who commit medication errors would receive appropriate re-training and disciplinary action as indicated.

Resident 1

Review of Resident 1's Negotiated Service Agreement (NSA), dated 08/07/2025, showed that the resident had multiple sclerosis (a chronic neurological disorder), high blood pressure and non-insulin dependent diabetes mellitus (condition where the body cells fail to use insulin to regulate blood sugars). Further review showed Resident 1 required staff assistance to administer their medications.

Review of Resident 1's current physician orders dated 12/27/2025 showed:
• Metoprolol (medication for high blood pressure) Administer one tablet by mouth every morning for blood pressure management. The December 2025 Medication Administration Record (MAR) showed instruction to take blood pressure and pulse measurements prior to administration and to hold the metoprolol for a systolic (top number) blood pressure less than 110 or if the pulse less than 60 beats per minute.
• Lisinopril 40 mg tablet by mouth every day for treatment of high blood pressure.
• Hydralazine 50 mg tablet by mouth three times daily for the treatment of high blood pressure.

Review of Resident 1's December 2025 MAR and variance report dated 12/12/2025-12/27/2025 showed that the resident's metoprolol was late 3 times, the lisinopril was late 3 times and the hydralazine was late 4 times in the 16-day period.

Review of Resident 1's personal medication log showed that Resident did not have their blood pressure and pulse measured prior to giving their metoprolol on 12/12/2025, 12/16/2025, 12/17/2025, 12/18/2025 and 12/25/2025.

In an interview on 12/31/2025 at 2:22 PM, Resident 1 stated that the facility continued to struggle with late medications and reordering medications in a timely manner. Resident 1 stated that they continued to track the number of times they went and picked up the medications from the Medication Technician (MT) to ensure they received them in a timely manner. Resident 1 stated that the MT's continued to tell the resident there was not a working blood pressure cuff on the medication cart, so they stated they were going to ask their primary care to write an order for a personal blood pressure cuff to ensure one would always be available. Resident 1 stated that there had been times when their blood pressure medications were held because they had a low blood pressure reading or a low heart rate.

Resident 2

Review of Resident 2's NSA, dated 05/11/2025, showed the resident had diagnoses of [redacted] and [redacted]. The NSA showed the resident required total staff assistance to administer their medication as the resident cannot take medication without assistance.

Review of Resident 2's current physician orders dated 12/23/2025 showed:
• Metformin (medication to treat high blood sugar). Take 1000 milligrams (mg) by mouth for diabetes treatment.
• Gabapentin (medication to treat seizures and nerve pain) 600 mg by mouth three times daily at 8:00AM, 12:00 PM and 5:00 PM.

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• Metoprolol succinate 50mg Extended Release one tablet by mouth two times daily.
• Midodrine 2.5 mg by mouth three times daily for symptomatic orthostatic hypotension (sudden severe blood pressure drop when standing).
• Xarelto (blood thinning medication) 20 mg tablet by mouth every night at 5:00 PM with dinner.

Review of Resident 2's December 2025 MAR, dated 12/12/2025-12/23/2025, showed Resident 2's gabapentin was late 18 out of 36 scheduled times, metformin was late 10 out of 23 times, metoprolol was late 13 out of 23 times, midodrine was late 18 times out of 35 times and Xarelto 5 out of 11 times.

Further review showed the gabapentin was ordered three times daily for optimum effectiveness. On 12/17/2025 Resident 2 received their dose of gabapentin at 9:50 AM and had received their last dose in the 5:00-6:00 PM window 12/16/2025 causing a longer time before getting their medication for pain. On 12/18/2025 Resident 2 received the gabapentin ordered at 8:00 AM at 10:41 AM and then their next dose ordered at 12:00 PM.

Review of Resident 2's facility blood pressure log showed that Resident 2 was to have their pressure checked twice daily. Resident 2 did not have their blood pressure and pulse measured prior to giving their blood pressure medications (Metoprolol) 8 times out of 24 ordered times on 12/13/2025, 12/16/2025, 12/17/2025,12/18/2025,12/19/2025 x 2 and 12/21/2025 x 2.

In an interview on 12/23/2025 at 12:20 PM, Resident 2 stated that when they were given their pain medications too close together it did not work properly and when the pain medication was late it caused them to have more pain. Resident 2 stated they had a lot of times their medications were brought later than ordered especially for diabetes and blood thinning.

Resident 3

Review of Resident 3's NSA, dated 09/25/2025, showed the resident had type 2 diabetes, heart disease, kidney failure requiring dialysis (life sustaining mechanical filtration of blood) and stiff person syndrome (SPS) (a rare progressive neurological syndrome) and lung issues. Further review showed Resident 1 required total staff assistance to administer their medications as the resident could not take their medications as ordered.

Review of Resident 3's current physician orders, dated 12/23/2025, showed:
• Insulin (hormone produced by the pancreas that regulates blood sugar) lispro (fast acting insulin)100 units per milliliter (ml) pen. Give 100 unit/ml subcutaneously three times daily with meals per sliding scale (dose dependent on blood sugar) and 2 units three times daily with meals in addition to the sliding scale dose for the treatment of diabetes.
• Lantus (long-acting man-made insulin)100 units/ml every night at 9:00 PM for the treatment of diabetes.

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• Levothyroxine (hormone to treat underactive thyroid) 25 micrograms (mcg) by mouth every morning before breakfast at 7:00 AM for the treatment of underactive thyroid. • Antacid chew 1000 mg by mouth three times daily at 8:00 AM, 12:00 PM, and 5:00 PM for treatment of SPS syndrome.
• Clotrimazole1% topical cream, apply to affected area two times daily for treatment of a skin infection.
•Carvedilol 12.5 mg tablet by mouth twice daily with breakfast and lunch for the treatment of high blood pressure.

Review of Resident 3's December MAR, dated 12/12/2025-12/23/2025, showed Resident 3's antacid chews were late 4 times out of 35 times, clotrimazole was late 5 times and missed 2 times with an exception note that showed it was not given due to non-availability. Resident 3 had late insulin lispro 7 times out of 36, Lantus was late 3 times out of 12 times, Levothyroxine was late 6 times out of 12 and Carvedilol was late 7 times out of 24 times.

In an interview on 12/23/2025 at 12:31 PM, Resident 3 stated "I told Staff A, Executive Director (ED) that I was being billed for the medications and then not getting them." Resident 3 stated that they missed their creams for body sores and the antacids for SPS because staff didn't understand the disease the doctor ordered the medications to treat. Resident 3 stated that they become stiff and have added pain without the antacid calcium chews.

Resident 4

Review of Resident 4's NSA, dated 04/03/2025, showed the resident had high blood pressure, esophageal reflux (heartburn) and lung issues. Further review showed Resident 4 required extensive staff assistance to administer their medications as the resident could not take their medications as ordered.

Review of Resident 4's current physician orders, dated 12/23/2025, showed:
• Alendronate 70 mg weekly by mouth, must be given 30 minutes prior to food or other medications for decreased bone density.
• Amlodipine 10 mg tablet by mouth daily for the treatment of high blood pressure.
• Buspirone 10 mg tablet by mouth three times daily at 8:00 AM, 12:00 PM and 5:00 PM for anxiety.
• Gabapentin 100 mg by mouth three times daily for the treatment of nerve pain.
• Methocarbamol 750 mg tab by mouth three times daily for muscle pain and spasms.
• Metoprolol succinate 200mg Extended Release one tablet by mouth daily for the treatment of high blood pressure.
• Losartan 25 mg by mouth daily at bedtime for the treatment of high blood pressure.
• Sertraline 20 mg tablet by mouth every night at bedtime for the treatment of depression.
• Famotidine 20 mg tablets by mouth every night at bedtime for the prevention of acid reflux.
• Omeprazole 20 mg capsule by mouth every morning before breakfast for prevention of acid reflux.

Review of Resident 4's December MAR, dated 12/12/2025-12/23/2025, showed their high blood pressure medications (amlodipine, metoprolol and losartan) were late 12 times, their reflux prevention medication (famotidine and omeprazole) was late 13

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times, pain medications (gabapentin and methocarbamol) were late 13 times, and their mental health support medications (buspirone and sertraline) were late 10 times.

Further record review of Resident 4's blood pressure log showed Resident 4 had their blood pressure measured six out of the scheduled 12 days. There were no blood pressure readings for 12/13/2025, 12/16/2025, 12/17/2025, 12/18/2025, 12/19/2025 and 12/21/2025.

In an interview on 12/31/2025 at 3:08 PM, Resident 4 stated that they continued to have trouble with their medications being late and occasionally being missed due to late reordering. Resident 4 stated that they had certain medications that were to be given at the scheduled time as ordered by the doctor but that did not always happen. Resident 4 stated that they lived at the facility for over four years and said they felt like the facility is an unsafe place to live.

In an interview on 01/06/2026 at 1:40 PM, Staff B, Director of Clinical Operations/Facility Nurse, stated they had purchased equipment for each of the medication carts to monitor vital signs so they were unsure why staff had not been taking them. Staff B stated that they noticed issues with staff being able to sign off the medications in the computer system at times due to technical issues and were working with staff to improve the delayed medication delivery times and the missed medications.

This is an uncorrected deficiency from 10/23/2025 and 07/29/2025, and a recurring deficiency previously cited on 04/15/2025 subsection (1)(a) (2)(a)(b), 10/10/2024 subsections (2)(a)(b), 11/17/2022 subsection (2)(a).

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) 5.01.2026.

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

Administrator (or Representative) 3.31.2026 Date

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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 follow-up on 09/26/2025 and 10/23/2025 of:
Royal Columbian Senior Living
5615 W Umatilla Ave
Kennewick, WA 99336

This document references the following SOD dated: 10/23/2025

The following sample was selected for review during the unannounced on-site visit: 6 of 98 current residents and 0 former residents.

The department staff that inspected 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

This document was prepared by Residential Care Services for the Locator website.

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

10/29/2025
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.

Rachael Guess
Administrator (or Representative)

11/7/25
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to ensure residents who were identified as needing medication assistance received medications as ordered for 3 of 4 residents (Resident 1, 2, & 4.) These failures resulted in missed and late medications (on time defined as within one hour before or after ordered time) for residents and placed them at risk of health complications.

Findings included...

Review of the facility's policy titled, "Medication Incidents and Errors," revised on 02/15/2024, showed that medication administration or assistance would be provided to residents in a manner that is safe and consistently free of errors. The policy showed

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that all medication incidents and errors would be investigated thoroughly and reported consistently. The policy further showed that corrective action would be taken with every error and that staff members who commit medication errors would receive appropriate re-training and disciplinary action as indicated.

Resident 1

Review of Resident 1's Negotiated Service Agreement (NSA), dated 08/07/2025, that showed the resident had multiple sclerosis (a chronic neurological disorder), high blood pressure and insulin dependent diabetes mellitus. Further review showed Resident 1 required staff assistance to administer their medications.

Review of Resident 1's current physician orders showed:
• Metoprolol (medication for high blood pressure) One tablet by mouth every morning for blood pressure management. The Medication Administration Record (MAR) showed instruction to take blood pressure and pulse measurements and to hold the metoprolol for a systolic (top number) blood pressure was less than 110 or the pulse was less than 60 per minute.
• Further review showed 17 other prescription medication orders including additional blood pressure medication.

Review of Resident 1's September 2025 MAR and variance report dated 09/11/2025-09/26/2025 showed that the resident had 178 instances of late medication. Resident 1 had late blood pressure medications 43 times in the 16-day period.
Review of Resident 1's personal medication log showed that Resident did not have their blood pressure and pulse measured prior to giving their metoprolol on 09/13/2025 and 09/15/2025. The log showed that on 09/12/2025 and 09/20/2025 they did not receive their 12:00 PM metoprolol dose.

In an interview on 09/26/2025 at 1:12 PM, Resident 1 stated that the facility continued to struggle with late and missed medications and had tracked the number of times they went and picked up the medications from the Medication Technician (MT). Resident 1 stated that they felt it was risky to not know what their blood pressure measured prior to receiving the medication.

Resident 2

Review of Resident 2's NSA, dated 04/01/2025, showed the resident had diagnoses of [redacted] and [redacted]. The NSA showed the resident required total staff assistance to administer their medication as the resident cannot take medication without assistance.

Review of Resident 2's current physician orders showed:

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• Methadone (pain medication to treat pain and pain medication addiction). Take 100 milligrams (mg) by mouth every morning except Mondays for treatment of pain.
• Further review showed 12 other prescription medication orders including additional pain medications, medication for treatment of mental health disorders, antibiotics for treating infections and high blood pressure medications.

Review of Resident 2's September 2025 MAR, dated 09/11/2025-09/26/2025, showed Resident 2 had 83 instances of their medications being administered late. Resident 2's methadone was late six times, other pain medication was late 32 times, and their antibiotic medication was late six times.

In an interview on 09/26/2025 at 11:31 AM, Resident 2 stated they were on many different medications and needed help with their medications. Resident 2 stated they had a lot of times their medications were administered later than ordered.

Resident 4

Review of Resident 4's NSA, dated 04/03/2025, showed the resident had type 2 diabetes, dementia, anxiety and depression. Further review showed Resident 1 required total staff assistance to administer their medications as the resident could not take their medications as ordered.

Review of Resident 2's current physician orders showed:
• Lisinopril (medication for high blood pressure) one tablet by mouth daily for treatment of high blood pressure.
• Metformin (medication for diabetes) one tablet twice daily for treatment of diabetes.
• Quetiapine (medication for anxiety) one tablets twice daily by mouth for treatment of anxiety.
• Vitamin B-12 1,000 MCG tablet by mouth One time per day at 12:00 PM for treatment of vitamin deficiency.
• Mirtazapine 30 mg tablet by mouth every evening at 8:00 PM for treatment of sleeplessness.

Review of Resident 4's September 2025 MAR, dated 09/11/2025-09/26/2025, showed Resident 4 had 15 instances of their anxiety, diabetes and blood pressure medications being administered late and nine instances of missed vitamin B-12 tablets.

In an interview on 09/26/2025 at 9:55 AM, Staff A, Director of Operations, and Staff B, Director of Clinical Operations/Facility Nurse stated that they continued to work with staff to improve the delayed medication delivery times and medication errors.

This is an uncorrected deficiency from 07/29/2025, and a recurring deficiency previously cited on 04/15/2025 subsection (1)(a) (2)(a)(b), 10/10/2024 subsections (2)(a)(b), 11/17/2022 subsection (2)(a).

This document was prepared by Residential Care Services for the Locator website.

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) ~~12/5/25~~ 12/12/2025.

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

Rachael Guess
Administrator (or Representative)

11/7/25
Date

Per Laura Williams-Davis, RCS Field Manager, and Facility Manager, Rachel Guess, via telephone one 12/03/2025, the BIC date has been changed to 12/12/2025. ME

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 60906
Investigator: Laurel Knight
Provider Type: Assisted Living Facility
Intake ID: 182526
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 06/10/2025 through 07/29/2025
Complainant Contact Date(s): 06/11/2025, 07/22/2025

Allegation(s):
Identified resident is not receiving their medications as ordered.

Investigation Methods:

Sample:	Total residents: 98 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms
Interviews:	Identified resident Nursing staff Hospital staff Residents
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations. Hospital and EMS records Staffing schedules

Investigation Summary:
Identified resident stated they missed three says of insulin and pain meds and had to go to the hospital as a result. Facility staff stated the medication orders in the computer were not active and the resident missed their pain and diabetic medications. Facility documentation showed the missed medications and need for hospitalization. Failed practice identified. Please see the Statement of Deficiency for medication systems Washington Administrative Code 388-78A-2210.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

This document was prepared by Residential Care Services for the Locator website.

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 60906
Investigator: Laurel Knight
Provider Type: Assisted Living Facility
Intake ID: 185017
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 06/10/2025 through 07/29/2025
Complainant Contact Date(s): 07/09/2025, 07/22/2025

Allegation(s):
Identified resident is not receiving their medications as ordered.

Investigation Methods:

Sample:	Total residents: 98 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms
Interviews:	Identified resident Nursing staff Hospital staff Residents
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations. Hospital and EMS records Staffing schedules

Investigation Summary:
Identified resident stated they had numerous missing and late medications. The resident stated that one of their medication required it be given on an empty stomach and it was not being done all the time. Facility staff stated there were multiple order changes which made the process difficult. Facility documentation showed the multiple late medications and missed medications. Failed practice identified. Please see the Statement of Deficiency for medication systems Washington Administrative Code 388-78A-2210.

Conclusion / Action:

This document was prepared by Residential Care Services for the Locator website.

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 60906
Investigator: Laurel Knight
Investigation Date(s): 06/10/2025 through 07/29/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 181059
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Identified resident is not receiving their medications as ordered.

Investigation Methods:

Sample:	Total residents: 98 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms
Interviews:	Identified resident Nursing staff Hospital staff Residents
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations. Hospital and EMS records Staffing schedules

Investigation Summary:
Identified resident stated they had numerous late medications which caused their medication for high blood pressure to be given too close together. The resident stated that one of their medication required a blood pressure prior to the administration and it was not being done all the time. Facility staff stated the medications were late a few times as well as some missed blood pressure readings. Facility documentation showed the multiple late medications and missed blood pressure measurements. Failed practice identified. Please see the Statement of Deficiency for medication systems Washington Administrative Code 388-78A-2210.

Conclusion / Action:

This document was prepared by Residential Care Services for the Locator website.

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

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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 # 60906
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 13	Licensee: Greenlake Management Columbian, LLC	07/29/2025

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 06/10/2025 and 07/09/2025 of:

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

This document references the following complaint number(s): 182526, 181698, 181059, 185017

The following sample was selected for review during the unannounced on-site visit: 4 of 98 current residents and 0 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

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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

08/11/2025
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.

Emily G. Ng
Administrator (or Representative)

8/11/25
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure residents who were identified as needing medication assistance received medications as ordered for 3 of 4 residents (Resident 1, 2, & 3.) These failures resulted in pain and discomfort requiring emergency hospitalization for Resident 1, missed and late medications for Resident 2, and late medication administration for Resident 3 and placed the residents at risk of health complications.

Findings included...

Review of the facility's policy titled, "Medication Incidents and Errors," revised on 02/15/2024, showed that medication administration or assistance would be provided to

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residents in a manner that is safe and consistently free of errors. The policy showed that all medication incidents and errors would be investigated thoroughly and reported consistently. The policy further showed that corrective action would be taken with every error and that staff members who commit medication errors would receive appropriate re-training and disciplinary action as indicated.

Resident 1

Review of Resident 1's Negotiated Service Agreement (NSA), dated 03/27/2025, showed the resident had a history of a recent pelvis fracture, anorexia nervosa (psychiatric illness in which patients restrict their food intake), insulin dependent diabetes mellitus (metabolic disease that causes high blood sugar due to a defect in their body's insulin production), and pancreatitis (inflammation of the pancreas). The NSA showed Resident 1 required staff assistance with diagnosis monitoring and total medication management.

In an interview on [redacted]/2025 at 2:15 PM, Staff B, Health and Wellness Director, stated that Resident 1 had returned to the facility on [redacted]/2025 from a rehabilitation facility where they were recovering from a pelvis fracture. Staff B stated that they were notified by medication technicians on 06/08/2025 that Resident 1 had not been receiving their new ordered medication since returning from rehabilitation to include insulin (injectable medication used to lower sugar in the blood) and blood pressure medication.

Review of Resident 1's physician orders, dated 06/05/2025, showed fax machine data markings that verified the facility had been faxed the document on 06/05/2025 at 12:58 PM. The physician orders showed :

- Insulin glargine (long-acting injected medication used to control blood sugar) every morning.
- Insulin Lispro (rapid acting injected medication used to control blood sugar) three times daily with meals.
- Insulin lispro sliding scale (dose based on blood sugar measurements) three times daily.
- Midodrine (used to treat high blood pressure) three times daily.
- Oxycodone (narcotic pain medication) every four hours as needed for pain.

Reviews of Resident 1's June 2025 MAR showed Resident 1 missed the following medications 06/06/2025, 06/07/25 and 06/08/25.

- Insulin glargine. Resident 1 missed three doses .
- Insulin Lispro. Resident 1 missed nine doses .
- Insulin lispro sliding scale. Resident 1 missed seven doses.
- Midodrine 5 mg tablets. Resident 1 missed seven doses
- Oxycodone 5 mg tablets. Resident 1 did not receive any pain medication

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Review of Resident 1's progress note, dated 06/09/2025 at 5:52 AM, written by Staff D, Medication Technician (MT), showed Resident 1 requested to be transported to the hospital due to pain.

Resident 1's progress note, dated 06/09/2025 at 1:34 PM, written by Staff E, MT, showed that the resident had very high blood sugar levels and they had been added to the house doctor's list .

Review of Resident1's Emergency Medical Services (EMS) record, dated 06/09/2025, showed that the resident reported on a pain scale of 1 to 10 a 9 for pain and had nausea and vomiting. The record showed that Resident 1's initial blood pressure was 170/106 (normal range is below 120/80) and blood sugar result was 564 (normal range for diabetics is under 120mg/dL). The records showed that the facility administered the resident's insulin and pain medication (for the first time in three days) at that time. The record showed that EMS stayed onsite to monitor and that the resident ultimately chose to remain at the facility.

In an interview on [redacted]/2025 at 2:20 PM, Staff C, Resident Care Coordinator, stated that Resident 1 had been sent to the hospital earlier that day at 11:00 AM after being found on the floor after a fall. Staff C stated that they had been told that Resident 1 had another fracture from the fall.

Review of Resident 1's EMS record, dated [redacted]/2025, showed that the resident had a fall and was being transported to the hospital with hip pain, and continued nausea and vomiting.

Review of Resident 1's hospital record showed the resident was admitted to the hospital on [redacted]/2025 at 1:33 PM for severe hip pain, critically low blood sugar and blood pressure. The record showed Resident 1 had a high probability of imminent or life-threatening deterioration due to the low blood sugar, low blood pressure, elevated lactic acid (a chemical produced by the body when glucose [sugar] is broken down for energy), and elevated heart enzymes (proteins found in the bloodstream with heart muscle is damaged) that required the physician's direct attention, intervention and personal management. The record further showed Resident 1 was admitted to the hospital with a displaced fracture of their pelvis due to fall, elevated lactic acid levels, acute kidney injury and elevated cardiac enzymes. The record showed the resident was treated for dehydration with intravenous fluids (fluids given directly into the bloodstream). The record showed Resident 1 was discharged on [redacted]/2025 after 30 days in the hospital.

In an interview on 06/11/2025 at 10:40 AM, Collateral Contact 2(CC 2), Hospital Nurse, stated that Resident 1 had arrived at the hospital very ill, had a low blood sugar and another pelvis fracture in a different location than the previous fracture. CC2 stated

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that they had difficulty trying to control the nausea and vomiting that Resident 1 was experiencing.

During an interview on 6/11/2025 at 10:55 AM, Resident 1 stated that they fell the previous day from being weak and dehydrated. Resident 1 stated that they returned to the facility and the medications that were supposed to be given were not approved so they went without insulin and pain pills. Resident 1 stated "I had a fractured pelvis and it's really painful. Friday , Saturday, Sunday and Monday [06/06/2025-06/09/2025] were pretty bad for me." Resident 1 stated that Monday (06/09/2025) they started the medications, but the nausea and vomiting did not improve and instead they started to feel terrible. Resident 1 stated that they now had another break in their pelvis and were waiting to see if they had to return to the rehabilitation facility for therapy.

Observation on 06/11/2025 at 11:05 AM, showed Resident 1 lying in a hospital bed, their face was pale and drawn. Resident 1 had an emesis (vomit) bag next to them in bed, and they had a wet washcloth on their forehead. The rooms whiteboard listed a goal of the day to reduce nausea.

Resident 2

Review of Resident 2's NSA, dated 05/15/2025, showed the resident had Parkinson's disease (progressive neurological disorder that primarily affects movement), thyroid disease (any disfunction of the thyroid gland at the base of the neck) and insulin dependent diabetes mellitus (when the body does not make or use insulin needed to maintain blood sugar readings within normal limits.) The NSA showed the resident required total staff assistance to administer the insulin (medication given just under the skin to keep their blood sugar readings within normal limits) and oral medications.

Review of Resident 2's current physician orders showed :
• Levothyroxine (thyroid hormone medication) . Take one capsule by mouth every morning on an empty stomach 30-60 minutes before food or other medication for treatment of thyroid deficiency.
• Further review showed 27 other prescription medication orders including insulin (injectable medication to lower sugar in the blood that is required to give at specific times).

Review of Resident 2's May 2025 MAR, dated 05/15/2025-05/31/2025, showed Resident 2 had 193 instances of their medications being administered late (on time defined as within one hour before or after ordered time).

Review of Resident 2's June 2025 MAR and variance report (medication report that logged times medications given) showed the resident had 536 instances of late medication.

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Review of Resident 2's July 2025 MAR and variance report, dated 07/01/2025-07/09/2025, showed 121 instances of late medications.

In an interview on 07/09/2025 at 8:51AM, Resident 2 stated they had missed or had multiple late medication instances since moving into the facility. Resident 2 stated they had been most concerned about their missed and late doses of their levothyroxine. Resident 2 stated that they had been told they would be getting their levothyroxine at 5:00 AM every morning but they did not receive the medication on 06/22/2025, 6/23/2025, 06/24/205 or 06/25/2025.

In an interview on 07/09/2025 at 9:49, Staff A stated that Resident 2 had numerous medication order changes that made it hard to track.

Resident 3

Review of Resident 3's NSA, dated 01/06/2025, that showed the resident had multiple sclerosis(a chronic neurological disorder), high blood pressure and insulin dependent diabetes mellitus. Further review showed Resident 3 required staff assistance to administer the insulin injections and oral medications.

Review of Resident 4's current physician orders showed :

• Metoprolol (medication for high blood pressure) One tablet by mouth every morning for blood pressure management. The MAR showed instruction to take blood pressure and pulse measurements and to hold the metoprolol for systolic (top number) blood pressure was less than 110 or the pulse was less than 60 per minute.
• Further review showed 21 other prescription medication orders including additional blood pressure medication.

Review of Resident 3's May 2025 MAR and variance report showed that the resident had 412 instances of late medication

Review of Resident 3's June 2025 MAR and variance report showed that the resident had 292 instances of late medication

Review of Resident 3's June 2025 MAR showed that Resident 3 did not have their blood pressure and pulse measured prior to giving their metoprolol on three separate occasions.

In an interview on 06/10/2025 at 3:15 PM, Resident 3 stated that they constantly received their blood pressure medications late and that sometimes the medications

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were given too close together. Resident 3 stated that they had blood pressure medications scheduled at 8:00 AM and 12:00 PM. The resident stated that the 8:00 AM blood pressure medications were given around 10:00 AM which was only two hours before the next administration time at 12:00 PM and resulting in feeling "funny". Resident 3 stated that they did not always have their blood pressure taken before their medications were given.

In an interview on 06/10/2025 at 2:30 PM, Staff A stated that there had been some shifts when medications were given late.

This is a recurring deficiency previously cited on 04/15/2025 subsection (1)(a) (2)(a)(b), 10/10/2024 subsections (2)(a)(b), 11/17/2022 subsection (2)(a)

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) 9/11/25.

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

Emily A. Ng — Administrator (or Representative)

8/11/25 — Date

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 interviews and record reviews, the Assisted Living Facility (ALF) failed to investigate and document investigative actions to determine the circumstances of medication errors and failed to develop preventive measures for medication errors for 2 of 3 residents (Resident 1 and 2). These failures resulted in no appropriate measure to

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prevent future medication error, discomfort and missed medication for Resident 1, late and missed medication for Resident 2 and placed the residents at risk of worsening chronic medical conditions.

Findings included...

Resident 1

Review of Resident 1's Negotiated Service Agreement (NSA), dated 3/27/25, showed that Resident 1 had a history of a recent pelvis fracture and insulin dependent diabetes mellitus (metabolic disease that causes high blood sugar due to a defect in their body's insulin production.) The NSA further showed Resident 1 required staff assistance with diagnosis monitoring and total medication management.

In an interview on [redacted]/2025 at 2:15 PM, Staff B, Health and Wellness Director, stated that Resident 1 had returned to the facility from rehabilitation for a pelvis fracture on [redacted]/2025. Staff B stated that they were notified by a medication technician on 06/08/2025 in the afternoon that the medication orders in the computer were not active and that Resident 1 had not received their medications since their return to the facility.

In an interview on 6/11/2025 at 10:55 AM, Resident 1 stated that they fell the previous day after feeling weak and dehydrated. Resident 1 stated that they had recently returned to the facility after being in a rehabilitation center for several weeks. Resident 1 stated that they were not given their ordered insulin and pain medication on [redacted]/2025 (the day of their return to the facility), 06/07/2025 and 06/08/2025. Resident 1 further stated that on 06/09/2025 (the day the medications were given) they experienced nausea and vomiting and felt terrible.

Review of Resident 1's medical record showed no incident reports or investigations were completed to determine the cause of the missed medications.

In an interview on [redacted]/2025 at 2:22 PM, Staff A, Executive Director stated no investigation had been initiated to determine the cause of the missed medications.

Resident 2

Review of Resident 2's NSA, dated 05/15/2025, showed the resident had Parkinson's disease (progressive neurological disorder that primarily affects movement), thyroid disease (hormone condition), insulin dependent diabetes mellitus, and required staff assistance to administer their medications.

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Review of Resident 2's Medication Administration Records (MARs), dated 05/15/2025-07/09/2025, showed that Resident 2 had 850 instances of their medications being administered late and outside of the physician ordered time (within one hour before or after the ordered time).

In an interview on 07/09/2025 at 8:51AM, Resident 2 stated since they moved in the facility had taken over medication management and they had multiple missed or late medications given. Resident 2 stated they had been most concerned about their missed and late doses of levothyroxine (thyroid medication that is crucial for proper bodily function). Resident 2 stated that they had been told they would be getting their levothyroxine at 5:00 AM every morning but they did not receive the medication on 06/23/2025, 06/24/205 or 06/25/2025.

Review of Resident 2's record showed no incident reports or investigations were completed to determine the cause of the late and missed medications.
In an interview on 07/09/2025 at 9:49 AM, Staff A stated that they had not started an investigation to determine the cause of the missed and late medications.

This is a recurring deficiency previously cited on 10/31/2023 and 04/25/2023.

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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) 9/11/25.

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

Administrator (or Representative) 8/11/25 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to immediately report medication errors with negative outcome to the Department's Complaint Resolution Unit for 1of 3 residents (Resident 1). This failed practice resulted in a delayed investigation by the Department and placed residents in the facility at risk of harm.

Findings included...

Review of Resident 1's Negotiated Service Agreement (NSA), dated 03/27/2025, showed the resident had a history of a recent pelvis fracture, insulin dependent diabetes mellitus (metabolic disease that causes high blood sugar due to a defect in their body's insulin production) and pancreatitis (inflammation of the pancreas that is a primary aid in digestion of food and blood sugar regulation that can be fatal if not treated.) The NSA showed Resident 1 required total medication management from staff.

Review of Resident 1's progress notes, dated 05/19/2025 showed that Resident 1 went to the hospital for hip pain due to a fall, was diagnosed with [redacted] and then was discharged to a rehabilitation center (facility with focus on various healing therapies) to regain mobility.

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Facility progress notes dated 06/09/2025, showed the resident requested to be transported to the hospital due to pelvic pain and that the resident had very high blood sugar levels.

During an interview on [redacted]/2025 at 2:15 PM, Staff B, Health and Wellness Director, stated that Resident 1 had returned to the facility on [redacted]/2025 from a rehabilitation facility where they were recovering from a pelvis fracture. Staff B stated that the resident was sent to the hospital on [redacted]/2025 for evaluation of hip pain after a fall that morning.

Review of Resident 1's hospital records showed the resident was admitted to the hospital on [redacted]/2025 at 1:33 PM, for severe hip pain and critically low blood sugar and blood pressure. The record further showed that Resident 1 was admitted to the hospital again with a displaced fracture of their pelvis due to a fall, elevated lactic acid (a chemical produced by the body when glucose [sugar] is broken down for energy) levels, acute kidney injury and elevated cardiac enzymes (proteins found in the bloodstream when the heart muscle is damaged).

In an interview at the hospital on 6/11/2025 at 10:55 AM, Resident 1 stated that they fell the previous day from being weak and dehydrated after experiencing nausea and vomiting. Resident 1 stated that when they returned to the facility from the rehabilitation center, they were not given their ordered insulin (medication used to lower sugar in the blood) and pain medication on [redacted]/25, 06/07/25 and 06/08/25. Resident 1 stated that they now had another break in their pelvis and were waiting to see if they had to return to the rehabilitation for therapy.

During an interview on 06/10/2025 at 2:22 PM Staff A, Executive Director, (ED) stated that they had not done an investigation to rule out abuse/neglect or reported the information regarding the incidents to the CRU.

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Plan/Attestation Statement

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

Emily M. Ng 8/11/25

Administrator (or Representative) Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(2) The assisted living facility must notify any agency responsible for paying for the resident's care and services as soon as possible whenever:

(a) The resident is relocated to a hospital or other health care facility; or

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report to the department case manager that the resident had returned to the facility and that they had then been sent to the hospital again for 1of 1 resident (Resident 1). This failed practice resulted in an overpayment of funds to the facility.

Findings included...

Review of Resident 1's Comprehensive Assessment Reporting and Evaluation (CARE) authorization details summary showed that Resident 1 had a bed hold from [redacted]/2025 to [redacted]/2025, returned to the facility on [redacted]/2025 and was transferred to the hospital on [redacted]/2025.

In an interview on 06/11/2025 at 8:00 AM, Collateral Contact 3 (CC3), Case Manager, stated that they were not notified by the facility of Resident 1's return to the community from the rehabilitation center or their transfer to the hospital on [redacted]/2025. CC3 stated that facility notifications ensure that payments were accurate and that the facility had regular inconsistencies with their notifications. CC3 stated that when Resident 1 was sent to the hospital the facility would be paid a special rate to hold the bed for their return. CC3 stated that the special rate was a different rate compared to when the resident was in the facility. CC3 further stated that the proper notifications were not made, and adjustment request forms (ARF's) had to be submitted to correct the multiple errors in payments made to the facility.

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In an interview on [redacted]/2025 at 2:22 PM, Staff A, Executive Director, stated that they had been aware of some inaccuracies with notifications to the department and they were trying to make the process more efficient.

Plan/Attestation Statement

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

Administrator (or Representative) 8/11/25 Date

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