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

03/19/2026

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) 74560 (Completion Date 03/19/2026) and 69952 (Completion Date 01/27/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/19/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

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

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.

Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 69952
Investigator: Laurel Knight
Provider Type: Assisted Living Facility
Intake ID: 204871
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 12/11/2025 through 01/27/2026
Complainant Contact Date(s): 01/28/2026, 12/11/2025

Allegation(s):

1. Doctor's orders are being thrown away.
2. The regional nurse and administrator knew there were medication issues and did not do anything about it.
3. Multiple residents were saying they were not getting their medications, despite medication records showing medications were given.
4. Numerous medications delivered for November were still sitting on the shelf.
5. A male resident was not getting their insulin and was sent to the hospital multiple times due to high blood sugar.
6. Medications and medication records are not correct and the facility does not have a system for medications. The facility is currently in violation for medication errors from a previous survey.

Investigation Methods:

Sample:
Total residents: 98
Resident sample size: 12
Closed records sample size: 0

Observations:
Identified resident
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Medication administration
Medication storage
General facility environment

Interviews:
Identified resident
Identified staff
Nursing staff
Residents
Family members
Administrator

Record Reviews:
Medical records (care plans, face sheets, medication administration records (MARS), progress notes, medication exception reports)

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

Incident investigation
Facility policies

Investigation Summary:

1. Interviews showed that a former staff member was presumed to have purposely removed the medication orders from the facility premises. The facility obtained new orders for the residents. No failed provider practice identified.
2. Interviews showed that the regional nurse was under the impression that medication issues were improving at the facility. Record review showed that the regional nurse followed up on issues presented to them. The administrator was not aware of medication issues. No failed provider practice identified.
3. Interviews with residents and staff showed that several residents had medications not available to be given to them. Record review showed that several residents had medications not available to be given to them. Failed provider practice identified on the statement of deficiencies dated 01/27/2026, under WAC 388-78a-2240.
4. Observation showed that there were several bins of leftover unused medications in the medication storage room of the facility. Interviews showed that several of the medications needed to be destroyed, and the facility had recently switched to a cycle fill system with the pharmacy, creating extra medications. Facility staff stated they planned to keep a small supply of the over flow of medications in case a resident runs out of their medications, and the rest would be sent back to the pharmacy. Failed provider practice identified. The facility is currently within their plan of correction (POC) period, no new Statement of Deficiencies are written within the POC period under Washington Administrative Code 388-78a-2210.
5. Interviews with facility staff showed that the resident was non-compliant with dietary recommendations and medications which contributed to poor blood sugar control. Record review showed that the resident frequently went out of the facility without taking their medications with them. No failed provider practice identified
6. Record reviews showed that the medication records reflected current orders on the premises. Interviews showed that a former staff member was presumed to have purposely removed medication orders from the facility premises which may have created a short term discrepancy in medications. The facility obtained new orders for the residents. The facility did not have a system in place to ensure resident receive medications as ordered. Failed provider practice identified. The facility is currently within in their plan of correction (POC) period, no new Statement of Deficiencies are written within the POC period under Washington Administrative Code 388-78a-2210.

Conclusion / Action:

- [x] 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
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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 12/11/2025 and 12/12/2025 of:

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

This document references the following complaint number(s): 204871, 204516

The following sample was selected for review during the unannounced on-site visit: 12 of 98 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator
Robin Barnes, Assisted Living Facility Licensor

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

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Statement of Deficiencies	License # 2581	Compliance Determination #69952
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 2 of 8	Licensee: Greenlake Management Columbian, LLC	01/27/2026

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

02/09/2026
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)

2/9/26
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that residents' medications were obtained when staff were responsible for ordering medications, for 7 of 7 residents (Residents 1, 2, 3, 4, 5, 6 and 7). This failure resulted in 7 residents not getting their medications as ordered, caused Resident 1 to have pain, and placed the residents at risk for complications of their chronic health conditions.

Findings included...

Review of a facility policy titled, "Medication Non-Availability," dated 02/15/2024, showed that medication refills would be requested when the supply was down to ten days remaining.

<Resident 1>

Review of Resident 1's facility admission orders from their doctor, dated [redacted]/2025, showed that the resident's diagnoses included [redacted] and [redacted]. The orders indicated that the doctor who signed the orders would not continue to prescribe medication to Resident 1 upon admission to the facility. The orders showed that Resident 1's medications would be filled for only 30 days. Review of Resident 1's Negotiated Service Agreement (NSA), dated 12/03/2025, showed that the resident required extensive staff assistance for their medication.

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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.

Residential Care Services _____ 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) _____ Date _____

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This requirement was not met as evidenced by:

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Findings included…

Review of a facility policy titled, "Medication Non-Availability," dated 02/15/2024, showed that medication refills would be requested when the supply was down to ten days remaining.

<Resident 1>

Review of Resident 1's facility admission orders from their doctor, dated [redacted]/2025, showed that the resident's diagnoses included [redacted] and [redacted]. The orders indicated that the doctor who signed the orders would not continue to prescribe medication to Resident 1 upon admission to the facility. The orders showed that Resident 1's medications would be filled for only 30 days. Review of Resident 1's Negotiated Service Agreement (NSA), dated 12/03/2025, showed that the resident required extensive staff assistance for their medication.

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Review of Resident 1's December 2025 Medication Administration Record (MAR) showed that the resident had an order for Tramadol (pain medication) to be given three times daily. The MAR showed that Resident 1 did not receive their Tramadol 12/04/2025 through 12/16/2025, for a total of 21 doses. The MAR showed the reasons the medication wasn't given to Resident 1 included, "Drug not available."

Review of a facility report titled, "Order Administration Record," showing medications that were signed in Resident 1's MAR as "Drug not given" and/or "Drug not available," for the dates from 12/04/2025 through 12/16/2025, showed several entries when Resident 1's Tramadol was not given. The report showed that the reasons Resident 1 was not given the medication included, "out of med not given," "needs appointment for refill," "not on hand," and "need to have doc refill."

Review of progress notes in Resident 1's record showed that the resident admitted to the facility on [redacted]/2025 with medications on hand. On 12/07/2025 a Medication Technician (MT) documented that the resident was out of their Tramadol and would need to see their new doctor the next day to get a refill order. The notes showed that on 12/09/2025, a MT documented that they had sent a fax to Resident 1's doctor to get the Tramadol refilled. The notes further showed that on 12/14/2025, Resident 1's tramadol was still not available but that it had been reordered. Finally, the notes showed that on 12/16/2025, Resident 1's doctor denied the request to refill their Tramadol so the order was discontinued from the MAR.

In an interview on 12/11/2025 at 1:12 PM, Resident 1 stated that the facility ran out of their medication for the pain in their feet. Resident 1 stated that they were in pain when they didn't get their pain medication. On 12/23/2025 at 12:30 PM, Resident 1 added that their pain was so terrible in their feet that they had to buy new shoes to see if it helped.

In an interview on 12/11/2025 at 2:43 PM, Staff B, Resident Care Coordinator, stated that Resident 1's Tramadol (pain medication) had been unavailable to give to the resident since 12/04/2025, due to the resident's previous doctor not providing refill orders for Resident 1. Staff B stated that the facility was getting Resident 1 set up with the facility's house doctor.

In an interview on 12/12/2025 at 9:34 AM, Staff A, Registered Nurse/Clinical Services Director, stated that Resident 1 admitted with enough Tramadol to last until the resident could see their new doctor at the facility. Staff A stated that the new doctor did not come to the facility to see Resident 1 on 12/01/2025 as scheduled, therefore the resident's Tramadol did not get refilled.

<Resident 2>

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Review of Resident 2's NSA, dated 04/01/2025, showed that the resident required staff assistance for their medication. The NSA showed that Resident 2's medications were to be ordered through the facility's house pharmacy and kept in the facility medication carts. The NSA showed that Resident 2 had diagnoses which included arthritis (painful swollen joints) and other unspecified pain. Additionally, the NSA showed that Resident 2 was on blood thinning medication due to a heart valve replacement (increases risk of blood clots).

Review of Resident 2's November 2025 and December 2025 MAR showed that the resident had an order dated 11/17/2025 for Oxycodone (a strong narcotic pain medication) to be given once daily routinely. The MAR showed that Resident 2 did not receive their Oxycodone from 11/30/2025 through 12/16/2025, for a total of 17 doses. The MAR showed the reasons the medication wasn't given to Resident 2 included, "Drug not available."

Review of a facility report titled, "Order Administration Record," showing medications that were signed in Resident 2's MAR as "Drug not given" and/or "Drug not available," for the dates from 12/01/2025 through 12/27/2025, showed several entries when Resident 2's Oxycodone was not given. The report showed that the reasons Resident 1 was not given the medication included, "out of med not given," "needs appointment for refill," "not on hand," and "need to have doc refill."

Further review of Resident 2's December 2025 MAR showed that the resident had an order for Warfarin (blood thinner) dated 09/06/2025. The MAR showed that Resident 2 did not receive their Warfarin on 12/07/2025 and 12/09/2025. The MAR showed the reasons the medication wasn't given to Resident 2 included, "Drug not given."

Further review of the facility "Order Administration Record" report showed that on 12/07/2025 Resident 2 was not given their Warfarin due to the medication being "on order." The report showed that on 12/09/2025, Resident 2 was not given their Warfarin due to the order being discontinued. Finally, the report showed that on 12/10/2025, Resident 2 was not given their Warfarin due to the medication being, "not on hand, will follow up with pharmacy."

Review of progress notes in Resident 2's record showed that an MT documented on 11/30/2025, that the resident did not receive their Oxycodone due to the facility not having the medication available. The progress notes showed that on 12/05/2025, a MT documented that Resident 2 told the MT that they ran out of their Oxycodone because their doctor did not write a refill prescription. Finally, a progress note dated 12/17/2025 showed that the resident's doctor was sent a fax to discontinue Resident 2's Oxycodone due to not having the medication available. Additionally, there was no documentation in Resident 2's progress notes regarding their missed doses of Warfarin.

In an interview on 12/11/2025 at 1:45 PM, Resident 2 stated that the facility often ran

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out of their medications. Resident 2 stated that the facility had ran out of their blood thinner and seizure medications in the past.

In an interview on 12/12/2025 at 9:37 AM, Staff A stated that they thought Resident 2 missed Warfarin due to an insurance issue.

<Resident 3>

Review of Resident 3's NSA, dated 04/03/2025, showed that the resident required staff assistance for their medication. The NSA showed that Resident 3 had a diagnosis of [redacted].

Review of Resident 3's December 2025 MAR, showed that the resident had an order for Pregabalin (nerve pain medication) to be given three times daily. The MAR showed that Resident 3 did not receive their Pregabalin between 12/09/2025 and 12/13/2025, for a total of 8 doses. The MAR showed the reasons the medication wasn't given to Resident 3 included, "Drug not available."

Review of the facility "Order Administration Record" report showed that from 12/09/2025 through 12/13/2025, Resident 3 was not given their Pregabalin due to "waiting for refill."

Review of progress notes in Resident 3's record showed that on 12/09/2025, a MT documented that the pharmacy was faxed for a refill of an unspecified medication. There were no entries that were specific to Resident 3's Pregabalin.

In an interview on 12/11/2025 at 12:56 PM, Resident 3 stated that sometimes the facility did not give them their medications.

<Resident 4>

Review of Resident 4's NSA dated 04/03/2025, showed that the resident required extensive staff assistance for their medication.

Review of Resident 4's December 2025 MAR showed that the resident had an order for Trazodone (medication for sleep) to be given once daily. The MAR showed that Resident 4 did not receive their Trazodone between 12/10/2025 and 12/17/2025, for a total of 6 doses. The MAR showed the reasons the medication wasn't given to Resident 4 included, "Drug not available."

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Review of a facility report titled, “Order Administration Record,” showed Resident 4’s Trazodone was not given six times between 12/11/2025 through 12/20/2025. The report showed that the reasons Resident 4 was not given the medication included, “out of med,” “on order,” “not on hand,” and “we are looking for it.”

Review of progress notes in Resident 4’s record showed that on 12/20/2025, a MT documented that the resident’s Trazodone was delivered on 12/11/2025 from the pharmacy, but that the MT could not find the Trazodone to give to Resident 4. There was no other documentation regarding Resident 4’s Trazodone in their record.

<Resident 5>

Review of Resident 5’s NSA, dated 04/01/2025, showed that the resident required staff assistance for their medication. The NSA showed that Resident 5’s medications were ordered through the facility’s house pharmacy and kept in the facility medication carts. The NSA showed that Resident 5 had a diagnosis which included diabetes (a disease in which the body does not regulate sugar in the blood stream properly).

Review of Resident 5’s December 2025 Medication Administration Record (MAR), showed that the resident had an order for Tresiba (injected medication that helps regulate blood sugar), 62 units to be given daily. The MAR showed that Resident 5 did not receive their Tresiba between 12/02/2025 and 12/06/2025, for a total of five doses. The MAR showed the reasons the medication wasn’t given to Resident 5 included, “Drug not available.”

Review of a facility report titled, “Order Administration Record,” showed Resident 5’s Tresiba was not given five days from 12/02/2025 through 12/06/2025. The report showed that the reasons Resident 5 was not given the medication included, “waiting for refill,” and “waiting for new order.”

Review of progress notes in Resident 5’s record showed that on 12/01/2025, a MT documented that the resident was only given 8 units of their Tresiba because they had run out of the medication. The notes showed that on 12/03/2025 and on 12/04/2025, the MT documented that the pharmacy told them that Resident 5 needed a refill order for the Tresiba from their doctor. The notes did not show any further documentation regarding Resident 5’s Tresiba.

<Resident 6>

Review of Resident 6’s NSA, dated 04/03/2025, showed that the resident required extensive staff assistance for their medication. The NSA showed that Resident 6 had diagnoses which included [redacted] and [redacted].

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Review of Resident 6's December 2025 MAR showed that the resident had an order for Amitriptyline (medication to elevate mood) to be given daily. The MAR showed that Resident 6 did not receive their Amitriptyline between 12/09/2025 and 12/14/2025, for a total of 5 doses. The MAR showed the reasons the medication wasn't given to Resident 6 included, "Drug not available."

Review of a facility report titled, "Order Administration Record," showed Resident 6's Amitriptyline was not given between 12/09/2025 through 12/14/2025. The report showed that the reasons Resident 6 was not given the medication included, "out of med," "med on reorder," "spoke with pharmacy again," and "pharmacy is open Mon-Fri will call tomorrow."

Review of progress notes in Resident 6's record, showed that on 12/08/2025, a MT documented that the resident was out of their Amitriptyline and the pharmacy said they needed a new refill order.

<Resident 7>

Review of Resident 7's NSA, dated 11/19/2025, showed that the resident required extensive staff assistance for their medication, which included nurse delegation for management of their diabetes.

Review of Resident 7's December 2025 MAR showed that the resident had an order for Pioglitazone (medication to regulate blood sugars) to be given daily. The MAR showed that Resident 7 did not receive their Pioglitazone eight doses between 12/14/2025 and 12/27/2025. The MAR showed the reasons the medication wasn't given to Resident 7 included, "Drug not available."

Review of the facility "Order Administration Record" showed that on 12/16/2025, 12/17/2025, 12/20/2025 and 12/26/2025, Resident 7 was not given their Pioglitazone. The reasons Resident 7's medication was not given included, "waiting on med order" and "not on hand."

Review of progress notes in Resident 7's record showed that on 12/20/2025 and 12/21/2025, a MT documented that the resident needed a new doctor's order for their Pioglitazone. Resident 7's notes showed that on 12/22/2025, a MT documented that the pharmacy said the medication should be covered on insurance, and that the resident's doctor would send a refill order.

In an interview on 12/12/2025 at 9:43 AM, Staff A stated that the facility nurse was supposed to be pulling medication non-availability reports routinely. Staff A stated that the nurse was to follow up on what the MT did when medication was not available.

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Statement of Deficiencies	License #: 2581	Compliance Determination #:63952
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 8 of 8	Licensee: Greenlake Management Columbian, LLC	01/27/2026

In an interview on 12/31/2025 at 3:02 PM, Staff B stated that regarding Resident 6's Amitriptyline, there was an issue with the pharmacy not delivering the medication despite multiple requests. Staff B stated that for Resident 2's Oxycodone the doctor refused to refill the prescription until after Resident 2 had a mammogram. Staff B stated that Resident 5's Tresiba required a refill, and their doctor hadn't responded to the pharmacy's refill requests. Lastly, Staff B stated that Resident 4's Trazodone had been found in the wrong area of the medication cart and was resumed once it was located.

This is a recurring deficiency, written on the Statement of Deficiencies dated 10/10/2024 and on 08/09/2023 for Washington Administrative Code 388-78a-2240

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) 3/11/26

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

Administrator (or Representative) 2/9/26 Date

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In an interview on 12/31/2025 at 3:02 PM, Staff B stated that regarding Resident 6's Amitriptyline, there was an issue with the pharmacy not delivering the medication despite multiple requests. Staff B stated that for Resident 2's Oxycodone the doctor refused to refill the prescription until after Resident 2 had a mammogram. Staff B stated that Resident 5's Tresiba required a refill, and their doctor hadn't responded to the pharmacy's refill requests. Lastly, Staff B stated that Resident 4's Trazodone had been found in the wrong area of the medication cart and was resumed once it was located.

This is a recurring deficiency, written on the Statement of Deficiencies dated 10/10/2024 and on 08/08/2023 for Washington Administrative Code 388-78a-2240.

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) Date

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