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

07/30/2026

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) 81140 (Completion Date 07/30/2026) and 75580 (Completion Date 06/01/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/30/2026 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.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

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

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 #: 75580
Investigator: Robin Barnes
Investigation Date(s): 04/09/2026 through 06/01/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 225306
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A named resident had suspected substance use in their apartment.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Housekeeping staff Business office manager Administrator Health Services Director Regional Administrator Regional Registered Nurse
Record Reviews:	Medical records (face sheet, care plan, progress notes) Incident investigation Facility policies

Investigation Summary:
Record review showed that the facility investigated, monitored and made the required notifications when the named resident was suspected of using substances in their apartment. Observations of photos showed that the facility had confiscated

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

multiple combustible materials from the named resident's apartment. Interview and record review showed that the facility removed the items, initiated frequent checks, reviewed the facility smoking policy and advised the named resident that they would be discharged. The facility failed to reassess the named resident for the ability to smoke cigarettes safely and for the unsafe behaviors with using combustible items in their apartment. The facility failed to maintain a safe environment when the named resident repeatedly smoked and used combustible items in their apartment. Failed practice was identified. Refer to Washington State Administrative Code (WAC) 388-78A-2100(2)(a)(b)m WAC 388-78A-3090 (1)(d) and WAC 388-78A-2600(1)(a)(b)(c).

Conclusion / Action:

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

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 #: 75580
Investigator: Robin Barnes
Investigation Date(s): 04/09/2026 through 06/01/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 220256
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A named resident was found smoking cigarettes in their room.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions Medication administration General facility environment
Interviews:	Identified staff Nursing staff Residents Administrator Identified resident
Record Reviews:	Medical records (face sheets, care plans, progress notes, medication records, temporary care plans) Incident investigations Facility policies Maintenance logs Characteristic roster

Investigation Summary:
Observations of pictures showed that the resident had combustible materials and burnt cigarettes in their room. Observation also showed that the facility had confiscated numerous combustible materials from named residents' rooms. Interview and record review showed that the facility removed the items and placed the resident on frequent checks. The facility reviewed the facility smoking policy with the resident and advised the resident that they could be at risk of discharge for

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

further violations. The facility failed to reassess the resident for the ability to safely smoke cigarettes when they were found to smoke unsafely. The facility failed to follow their policies to maintain a safe environment when the named resident repeatedly smoked in their room. Failed practice identified on the statement of deficiencies dated 06/01/2026, for Washington Administrative Codes (WAC) 388-78a-2100 subsections (2)(a)(b)(i), and 388-78a-2600 subsections (1)(a)(b)(c).

Conclusion / Action:

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

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 #: 75580
Investigator: Robin Barnes
Investigation Date(s): 04/09/2026 through 06/01/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 219079
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A named resident was found smoking cigarettes in their room.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions Medication administration General facility environment
Interviews:	Identified staff Nursing staff Residents Administrator Identified resident
Record Reviews:	Medical records (face sheets, care plans, progress notes, medication records, temporary care plans) Incident investigations Facility policies Maintenance logs Characteristic roster

Investigation Summary:
Observations of pictures showed that the resident had combustible materials and burnt cigarettes in their room. Observation also showed that the facility had confiscated numerous combustible materials from multiple Named Resident's rooms. Interview and record review showed that the facility removed the items and placed the resident on frequent checks. The facility reviewed the facility smoking policy with the resident. and advised the resident that they could be at risk of

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

discharge for further violations. The facility failed to reassess the resident for the ability to safely smoke cigarettes when they were found to smoke unsafely. The facility failed to follow their policies to maintain a safe environment when the named resident repeatedly smoked in their room. Failed practice identified on the statement of deficiencies dated 06/01/2026, for Washington Administrative Codes (WAC) 388-78a-2100 subsections (2)(a)(b)(i), and 388-78a-2600 subsections (1)(a)(b)(c).

Conclusion / Action:

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

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 # 75580
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 13	Licensee: Greenlake Management Columbian, LLC	06/01/2026

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 complaint investigation on 04/09/2026, 05/09/2026, 06/01/2026 and 04/22/2026 of:

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

This document references the following complaint number(s): 219079, 218245, 216482, 219717, 220256, 225306

The following sample was selected for review during the unannounced on-site visit: 6 of 93 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Robin Barnes, Assisted Living Facility Licensor
Jessica Clapp, 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

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

Statement of Deficiencies	License #: 2581	Compliance Determination # 75580
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 2 of 13	Licensee: Greenlake Management Columbian, LLC	06/01/2026

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

06/11/2026
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)

6/15/26
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement policies to ensure residents smoked safely and maintained their apartments in a safe manner, for 3 of 3 residents (Resident 1, 2 and 3). This failure placed the residents, staff and visitors at risk of an unsafe environment.

Findings included...

Review of a facility policy titled, "Smoking by Residents, Staff or Visitors," dated 02/15/2024, showed that no smoking was allowed in the facility. The policy showed that residents must smoke outside at least 25 feet away from the facility. Failure to comply with the policy and putting others at risk of harm could result in a discharge notice to the resident. The policy also showed residents would be assessed to be able to access their rights to smoke if they demonstrated capability to do so without jeopardizing the, safety of the residents and the environment.

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

Review of the facility's Disclosure of Services, dated 12/23/2024, showed that the facility permitted smoking outside in designated areas. The disclosure showed that actions by a resident which posed significant risk to the health and safety of others could result in the resident being issued a 30-day or less discharge notice if reasonable accommodations could not be made.

Review of an email sent to the facility from the Deputy State Fire Marshall (DSFM), dated 01/10/2026, showed that the facility's fire alarm system had been in failure since November 2025.

Review of a facility letter issued to all residents, dated 03/31/2026, showed that the facility had received multiple reports of residents smoking in their rooms. The letter showed that any resident in violation of their smoking policy could result in a 30-day discharge notice being issued.

Observation on 04/09/2026 at 9:07 AM, showed that in the administrator's office, there were three large torches with lighter fluid cannisters attached and five different bottles of lighter fluid. One tall slim bottle had a label with the words, "whip it" on it.

<Resident 1>

Review of Resident 1's demographics sheet, undated, showed that they were admitted to the facility on [redacted]/2024.

Review of Resident 1's full facility assessment, dated 03/24/2025, showed that the resident smoked cigarettes. The assessment showed that Resident 1 showed or had behaviors that required special training or assistance, increasing the amount of time needed from staff.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/03/2025, showed that Resident 1 did not have current or history of disruptive or inappropriate behavior, and that they may resist care at times. The NSA showed that Resident 1 needed supervision because they made unsafe or inappropriate decisions. The NSA showed that Resident 1 was independent with smoking.

Review of Resident 1's smoking assessment, dated 12/04/2025, showed that the resident could smoke independently with no concerns.

Review of a facility incident investigation, dated 04/03/2026, showed that upon opening Resident 1's apartment door, smoke came, "billowing out." Resident 1 had been found lying in their bed, smoking cigarettes. Pictures included with the investigation showed that there was a used soup can full of cigarette butts at Resident 1's bedside, as well as

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

four metal cans of lighter fluid. The investigation showed that any further policy violations could result in Resident 1 being issued a 30-day discharge notice.

In an interview on 04/09/2026 at 9:38 AM, Staff A, Administrator, stated that Resident 1 refused to allow staff to care for the resident. Staff A stated that Resident 1 was difficult to manage and smoked in their room.

In an interview on 04/09/2026 at 10:28 AM, Resident 1 stated that they had smoked in their room in the past but that they would not do that anymore.

In an interview on 04/09/2026 at 11:39 AM, Staff A stated that Resident 1 was non-compliant with facility policies and refused care.

Review of a facility investigation, dated 04/13/2026, showed that the DSFM had requested the facility to inspect Resident 1's room for safety hazards while in the DSFM's presence. Pictures taken by Staff A and included in the investigation showed that there were cigarette butts littering Resident 1's apartment floor as well as a plastic bottle of lighter fluid. The investigation showed that Resident 1 was in continued violation of facility policy and would no longer be able to be independent in possession of smoking materials.

Review of a progress note in Resident 1's record, dated 04/13/2026 showed that the resident's cigarettes and smoking materials had been confiscated by the facility per the direction of the DSFM. Resident 1's progress note dated 04/22/2026 showed that the resident was being monitored due to behaviors. Resident 1 was agitated that their cigarettes had been taken away.

In an interview on 04/22/2026 at 10:28 AM, Staff A stated that Resident 1 had been found smoking in their room again on 04/13/2026. Staff A stated that a bottle of lighter fluid was confiscated from Resident 1's room. Staff A also stated that the facility's fire suppression system was not working on the floor of which Residents 1 and 2 resided.

In an interview on 05/08/2026 at 1:40 PM, Staff A confirmed that Resident 1 still lived in the facility. Staff A stated that Resident 1 was in the process of being moved to a new assisted living facility. Staff A did not identify if Resident 1 had been issued a discharge notice per the facility's smoking policy.

<Resident 2>

Review of Resident 2's full facility pre-admission assessment, dated 12/30/2025, showed that the resident had diagnoses including [redacted] and [redacted]

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

[redacted]. The assessment showed that Resident 2 had a history of methadone (a long-acting controlled medication to treat drug overdose) abuse and disruptive behaviors. The assessment showed that Resident 2 smoked cigarettes.

Review of Resident 2's demographics sheet, undated, showed that they were admitted to the facility on [redacted]/2026.

Review of Resident 2's smoking assessment, dated 01/07/2026, showed that the resident was safe to smoke with no concerns identified.

Review of Resident 2's NSA, dated 12/30/2025, showed that the resident required assistance with medication and bathing. The NSA did not show that Resident 2 had hallucinations, resisted care or had disruptive behaviors, or what the staff were to do about it. The NSA showed that Resident 2 was independent with smoking.

Record review of photographs provided by Staff A, dated 03/09/2026, showed a hole in the mattress and bedding belonging to Resident 2. The hole was charred on the outer edges, indicating it had been burnt.

Review of progress notes in Resident 2's record, dated 03/09/2026, showed that the resident refused to let staff into their room but staff observed that there was a hole burned in the resident's mattress. On 03/15/2026, during a two-hour safety check, staff found there was a strong chemical smell in resident 2's room. On 03/17/2026, staff found Resident 2 to be more animated and active than their baseline, and the chemical smell was present in the resident's room. The police were called to speak to Resident 2 concerning illicit drug use.

Review of a facility investigation, dated 03/17/2026, showed that the facility found a torch in Resident 2's room. Also included in the investigation were photos of a metal box containing butane lighter fluid and various attachments for a torch.

A progress note dated 04/07/2206 showed that Resident 2 refused to let staff in their room and was agitated because they now had to ask staff to give them a cigarette.

In an interview on 04/09/2026 at 9:33 AM, Staff B, Health Services Director/Licensed Practical Nurse, stated that they had to confiscate Resident 2's smoking materials which included a large butane torch and their cigarettes, because Resident 2 had burned their mattress and their floor. Staff B stated that Resident 2 also refused housekeeping and their room was very messy.

In an interview on 04/09/2026 at 9:39 AM, Staff A stated that they had found and

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

confiscated blow torches and drug paraphernalia in Resident 2's room twice. Staff A stated that they had pictures of the burned mattress and floor in Resident 2's room.

In an interview on 04/09/2026 at 9:48 AM, Staff A stated that they were trying to issue Resident 2 a 30-day discharge notice for failure to comply with facility policies. Staff A stated that the discharge notice was being held up by the facility's corporation and legal teams. Staff A also stated that the facility had a lot of problems with residents smoking cigarettes, marijuana and methamphetamines in their rooms. Finally, Staff A stated that the corporation applied significant pressure to the facility to maintain a high census of residents, limiting the facility's ability to discharge residents who were non-compliant.

In an interview on 04/09/2026 at 11:00 AM, Resident 2 stated that their room smelled like smoke because they would smoke half of a cigarette and bring the other half back in their pocket. Resident 2 stated that they burned their floor because there were bugs on the floor which the facility staff did not believe to be true.

In an interview on 05/01/2026 at 1:45 PM, Staff A stated that they were still waiting to hear from corporate office regarding Resident 2's 30-day discharge notice.

In an interview on 05/01/2026 at 1:46 PM, Staff B stated that Resident 2 had visual hallucinations about bugs which the resident had tried to burn, resulting in the burn marks on their apartment floor. Staff B stated that Resident 2's family reported that the resident had a history of hallucinations when they used illicit drugs.

Review of Resident 2's progress notes, dated 05/19/2026, showed that there was a chemical smell coming from the resident's apartment. The note showed that staff entered Resident 2's apartment and found glass pipes (used to smoke paraphernalia) that were "covered in tar", small torches (fueled by butane or propane and used for the high heat flames) and an empty can of butane. In addition, there were burn marks on Resident 2's apartment floor.

Review of Resident 2's facility investigation, dated 05/21/2026, showed that an investigation was completed because the resident had been involved in multiple incidents involving suspected substance use, possession of flammable materials and unsafe behaviors. Also included in the investigation were photos of the glass pipes, small torches and can of butane that was found in Resident 2's apartment.

<Resident 3>

Review of Resident 3's demographics sheet, undated, showed that they were admitted to the facility on [redacted]/2025.

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

Review of Resident 3's full facility assessment, dated 01/16/2025, showed that the resident had diagnoses which included [redacted] and [redacted]. The assessment showed that Resident 3 smoked cigarettes.

Review of Resident 3's smoking assessment, dated 02/12/2025, showed that the resident was safe to smoke with no concerns. Review of Resident 3's smoking assessment, updated on 04/30/2026, showed that the resident had moderate vison impairment and a history of, "isolated" smoking incidents.

Review of Resident 3's NSA, dated [redacted]/2025, showed that the resident had a history of a traumatic brain injury which caused them to become anxious and repetitive. The NSA showed that Resident 3 could not smell, was vision impaired, and sometimes made inappropriate decisions. The NSA also showed that Resident 3 smoked cigarettes independently.

Review of Resident 3's progress notes showed that there were no notes for January 2026 through April 2026.

In an interview on 04/09/2026 at 11:39 AM, Staff A stated that Resident 3 was known to smoke in their room in the past. Staff A stated that Resident 3 voluntarily turned in a bottle of butane lighter fluid.

Observation on 04/09/2026 at 10:49 AM found that Resident 3's room smelled strongly of cigarette smoke.

In an interview on 04/09/2026 at 10:49 AM, Resident 3 stated that they did not smoke in their room. Resident 3 stated that they had a bottle of butane to refill their lighter, which they turned into the facility. Resident 3 apologized repeatedly and stated that they smelled of smoke because it was stuck in their clothes and coat.

As of 04/22/2026, review of the facility's characteristic roster, undated, showed that Resident 1, Resident 2 and Resident 3 continued to reside in the facility.

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) 7/15/24 .

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

Administrator (or Representative) 6/15/24 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure an assessment was completed for residents who had identified issues, for 3 of 3 residents (Resident 1, 2 and 3). Additionally, the facility failed to ensure a full assessment was completed annually, for 2 of 2 residents (Resident 1 and 3). These failures placed residents at risk of unmet needs, contributed to Residents 1 and 2 unsafely handling flammable materials and placed all residents in the facility at risk of harm.

Findings included...

Review of the facility's Disclosure of Services, dated 12/23/2024, showed that the facility permitted smoking outside in designated areas.

Review of an email sent to the facility from the Deputy State Fire Marshall (DSFM), dated 01/10/2026, showed that the facility's fire alarm system had been in failure since November 2025.

<Resident 1>

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

Review of Resident 1's demographics sheet, undated, showed that they admitted to the facility on [redacted]/2024.

Review of Resident 1's smoking assessment, dated 12/04/2025, showed that the resident could smoke independently with no concerns.

Review of Resident 1's full facility assessment, dated 03/24/2025, showed that the resident smoked cigarettes. The assessment showed that Resident 1 walked independently with a walker. Additionally, the assessment showed that Resident 1 had behaviors that required special training or assistance, increasing the amount of time needed from staff.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/03/2025, showed that the resident did not have current or history of disruptive or inappropriate behavior, and that they may resist care at times. The NSA showed that Resident 1 needed supervision because they made unsafe or inappropriate decisions. Additionally, the NSA showed that Resident 1 walked independently with a walker.

Review of a facility incident investigation, dated 04/03/2026, showed that upon opening Resident 1's apartment door, smoke came, "billowing out." Resident 1 had been found lying in their bed, smoking cigarettes. Pictures included with the investigation showed that there was a used soup can full of cigarette butts at Resident 1's bedside, as well as four metal cans of lighter fluid. The investigation showed that any further policy violations could result in Resident 1 being issued a 30-day discharge notice.

In an interview on 04/09/2026 at 9:38 AM, Staff A, Administrator, stated that Resident 1 was difficult to manage and smoked in their room. Staff A stated that Resident 1 had recently obtained a powered wheelchair.

In an interview on 04/09/2026 at 10:28 AM, Resident 1 stated that they had smoked in their room in the past but that they would not do that anymore.

In an interview on 04/09/2026 at 11:39 AM, Staff A stated that Resident 1 was non-compliant with facility rules.

Review of a facility investigation, dated 04/13/2026, showed that the Deputy State Fire Marshal (DSFM) had requested the facility to inspect Resident 1's room for safety hazards while in the DSFM's presence. Pictures included in the investigation showed that there were cigarette butts littering Resident 1's apartment floor as well as a plastic bottle of lighter fluid.

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

Review of a progress note in Resident 1's record, dated 04/13/2026 showed that the resident's cigarettes and smoking materials had been confiscated by the facility per the direction of the DSFM. Resident 1's progress note dated 04/22/2026 showed that the resident was being monitored due to behaviors. Resident 1 was agitated that their cigarettes had been taken away.

In an interview on 04/22/2026 at 10:28 AM, Staff A stated that Resident 1 had been found smoking in their room on 04/13/2026. Staff A stated that a bottle of lighter fluid was confiscated from Resident 1's room. Staff A also stated that the facility's fire alarm system was not working on the floor of which Residents 1 and 2 resided.

Observation on 04/09/2026 at 10:48 AM, showed Resident 1 driving a large electric wheelchair. Resident 1 was observed to have difficulty turning the chair. While the resident was seated in their power wheelchair, the resident quickly pushed the throttle forward. The wheelchair immediately accelerated, causing a sudden forward action and the resident ran into an accent table, nearly knocking it over.

Observation on 04/22/2026 at 1:20 PM, showed Resident 1 drove their electric wheelchair faster than a person walking down the facility hallway.

As of 05/14/2026, review of Resident 1's medical record for showed the assessment from 03/24/2025 had not been updated annually. The resident records also showed no assessment for the resident's capabilities with an electric wheelchair or reassessment of a change of condition when the resident smoking became a safety risk.

<Resident 2>

Review of Resident 2's demographics sheet, undated, showed that the resident admitted to the facility on [redacted]/2026.

Review of Resident 2's full facility assessment, dated 12/30/2025, showed that the resident had diagnoses including [redacted]. The assessment showed that Resident 2 had a history of drug abuse and disruptive behaviors. The assessment showed that Resident 2 smoked cigarettes.

Review of Resident 2's NSA, dated 12/30/2025, showed that the resident was independent with smoking. The NSA showed that Resident 2 had no mental health concerns noted.

Review of Resident 2's smoking assessment, dated 01/07/2026, showed that the

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

resident was safe to smoke with no concerns identified.

Review of progress notes in Resident 2's record, dated 03/09/2026, showed that the resident refused to let staff into their room but staff observed that there was a hole burned in the resident's mattress. A progress note dated 04/07/2026 showed that Resident 2 refused to let staff in their room and was agitated because they now had to ask staff to give them a cigarette.

In an interview on 04/09/2026 at 9:33 AM, Staff B, Health Services Director/Licensed Practical Nurse, stated that they had to confiscate Resident 2's smoking materials which included a large butane torch and their cigarettes, because Resident 2 had burned their mattress and their floor. Staff B stated that Resident 2 also refused to let staff in their room and their room was very messy.

In an interview on 04/09/2026 at 9:39 AM, Staff A stated that they had found and confiscated blow torches and drug paraphernalia in Resident 2's room twice. Staff A stated that they had pictures of the burned mattress and floor in Resident 2's room.

In an interview on 04/09/2026 at 9:48 AM, Staff A stated that the facility had a lot of problems with residents smoking cigarettes, marijuana and methamphetamines in their rooms.

In an interview on 04/09/2026 at 11:00 AM, Resident 2 stated that their room smelled like smoke because they would smoke half of a cigarette and bring the other half back in their pocket. Resident 2 stated that they burned their floor because there were bugs on the floor which the facility staff did not believe to be true.

In an interview on 05/01/2026 at 1:46 PM, Staff B stated that Resident 2 had visual hallucinations about bugs which the resident had tried to burn, resulting in the burn marks on their apartment floor. Staff B stated that Resident 2's family reported that the resident had a history of hallucinations when they used illicit drugs.

Review of Resident 2's progress note, dated 05/19/2026, showed that there was a chemical smell coming from the resident's apartment. The note showed that staff entered the room and found glass pipes (used for drug paraphernalia) covered in tar, empty small torches (used with propane or butane for high heat flame) and an empty can of butane. In addition, the note showed that Resident 2's apartment floor had burn marks.

Review of Resident 2's facility investigation, dated 05/21/2026, showed that the resident had been involved in multiple incidents with suspected drug paraphernalia, flammable materials and unsafe behaviors. The investigation included photos of glass pipes, torches and a can of butane that had been found in Resident 2's room.

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

As of 06/01/2026, review of Resident 2's medical record showed that the facility had not reassessed Resident 2 when they had an identified safety issue of handling flammable items and cigarettes, and their potential use of illicit drugs and mental health concerns.

<Resident 3>

Review of Resident 3's demographics sheet, undated, showed that the resident admitted to the facility on [redacted]/2025.

Review of Resident 3's full facility assessment, dated 01/16/2025, showed that the resident had diagnoses which included [redacted] and [redacted]. The assessment showed that Resident 3 smoked cigarettes. The assessment had not been updated annually.

Review of Resident 3's smoking assessment dated 02/12/2025, showed that the resident was safe to smoke with no concerns.

Review of Resident 3's NSA, dated [redacted]/2025, showed that the resident had a history of a traumatic brain injury which caused them to become anxious and repetitive. The NSA showed that Resident 3 could not smell, was vision impaired, and sometimes made inappropriate decisions. The NSA also showed that Resident 3 smoked cigarettes.

Review of Resident 3's progress notes showed that there were no notes for January 2026 through April 2026.

In an interview on 04/09/2026 at 11:39 AM, Staff A stated that Resident 3 was known to smoke in their room in the past. Staff A stated that Resident 3 voluntarily turned in a bottle of butane lighter fluid.

Observation on 04/09/2026 at 10:49 AM showed that the palms of Resident 3's hands were observed to be black as were the outer edge of their lips. Resident 3 and their room smelled strongly of cigarette smoke.

In an interview on 04/09/2026 at 10:49 AM, Resident 3 stated that they did not smoke in their room. Resident 3 stated that they had a bottle of butane to refill their lighter, which they turned into the facility. Resident 3 apologized repeatedly and stated that they smelled of smoke because it was stuck in their clothes and coat.

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

As of 04/09/2026, a review of Resident 3's medical record showed that the facility had not completed a full annual assessment since 01/16/2025. The record showed the facility had not reassessed Resident 3 when they had an identified safety issue of the observation, use and handling of flammable items and cigarettes.

In an interview on 04/09/2026 at 9:54 AM, Staff B stated that the residents had prior smoking assessments done with their annual assessments. Staff B stated that they did not reassess Residents 1, 2 and 3 when they had identified smoking and safety concerns.

Review of Resident 3's smoking assessment, updated on 04/30/2026, showed that the resident had moderate vison impairment and a history of, "isolated" smoking incidents.

This is a recurring deficiency cited on the Statement of deficiencies dated 12/12/2024 and 10/10/2024 for WAC 388-78a-2100 subsections (2)(a)(2)(b)(i).

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) 7/15/26.

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

Administrator (or Representative) 6/15/26 Date

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