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

07/16/2026

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) 80539 (Completion Date 07/16/2026) and 76340 (Completion Date 06/01/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/16/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

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

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

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

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

WAC 388-78A-2371 Investigations. The assisted living facility must:

(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

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The Department staff who did the On Site verification:
Jessica Clapp, 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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 76340
Investigator: Jessica Clapp
Provider Type: Assisted Living Facility
Intake ID: 221547
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/23/2026 through 06/01/2026
Complainant Contact Date(s): 04/23/2026

Allegation(s):
Allegation of neglect of a resident.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 4 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 Family members Administrator Health Wellness Director Regional Nurse
Record Reviews:	Medical records (face sheet, assessment, care plan, progress notes) Hospital records Incident investigation Facility policies

Investigation Summary:
Record review showed that the facility responded and transferred the named resident to the emergency department when there was a change of condition. Interviews showed that the facility did not notify the named resident's primary

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physician when the named resident had a change of condition. Additional record review showed that the facility responded when a resident had multiple falls at the facility and showed that the facility did not thoroughly investigate the circumstances of the fall. Failed practice was identified. Refer to Washington State Administrative Code (WAC) 388-78A-2640(1)(a)(3)(a)(b) and WAC 388-78A-2371(2)(3).

Conclusion / Action:

- [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
HOME AND COMMUNITY LIVING ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 04/23/2026 of:

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

This document references the following complaint number(s): 221547

The following sample was selected for review during the unannounced on-site visit: 4 of 90 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

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

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Statement of Deficiencies	License #: 2581	Compliance Determination # 76340
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 2 of 6	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

06/03/2026
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)

6/3/24
Date

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

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

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

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the resident's healthcare provider when a significant change of condition occurred for 1 of 3 residents (Resident 2). This failure resulted in Resident 2's healthcare provider not being notified when the resident had a fall, a significant change of condition and was transferred to the hospital.

Findings included...

Review of the facility's Fall Management policy, dated 02/15/2024, showed that the facility would notify the resident's healthcare provider when a fall occurred.

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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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(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

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(a) The date and time each individual was contacted; and

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This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the resident’s healthcare provider when a significant change of condition occurred for 1 of 3 residents (Resident 2). This failure resulted in Resident 2’s healthcare provider not being notified when the resident had a fall, a significant change of condition and was transferred to the hospital.

Findings included…

Review of the facility’s Fall Management policy, dated 02/15/2024, showed that the facility would notify the resident’s healthcare provider when a fall occurred.

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Review of Resident 2's facility demographic sheet, undated, showed that the resident moved into the facility on [redacted]/2026.

Review of Resident 2's Negotiated Service Plan (NSA), dated 02/20/2026 showed that the resident was not disruptive, aggressive and did not have anxiety symptoms. The NSA showed that Resident 2 was able to transfer (ability to move from one surface to another) without assistance from staff, was at risk of falling and that they used a wheelchair for mobility (moving from place to place). The NSA showed that Resident 2 did not required assistance when using the bathroom.

Review of Resident 2's facility incident report, dated 4/16/2026, showed that the resident was found sitting on the floor of their apartment and that they required no medical treatment.

Review of Resident 2's progress note, dated 4/18/2026, showed that the resident was monitored for changes in their condition after a fall that occurred on 4/16/2026.

Review of Resident 2's progress notes for the date of 04/21/2026 showed the following:

- At 4:57 AM, Resident 2 required staff assistance to a standing position and that they had been incontinent of urine.
- At 1:03 PM, Resident 2 had complaints of pain, had difficulty dressing, became agitated and refused their shower.
- At 9:26 PM, Resident 2 required two staff to help them with transfers, using the bathroom and dressing. The note showed that staff assisted Resident 2 to the bathroom three times within an hour and showed that the resident had difficulty moving their feet during transfers.

Review of Resident 2's progress note, dated 04/22/2026, showed that the resident complained of pain in their legs. The note showed that Resident 2 was transferred to the emergency department after the resident's representative contacted Resident 2's health care provider.

Review of Resident 2's progress note, dated 04/23/2026, showed that the resident was admitted to the hospital for a severe urinary tract infection.

As of 05/18/2026, Resident 2's progress notes did not show that the facility contacted the resident's healthcare provider when a significant change of condition occurred.

In an interview on 05/14/2026 at 1:33 PM, Staff B, Health Services Director/Licensed Practical Nurse, stated that the incident report has a checklist to show tasks completed and that this includes notifications to healthcare providers. Staff B stated it was the responsibility of MT's to complete the notifications.

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Plan/A

umbian Senior
(Date) 7/13/24

6/3/24

Review of Resident otiated
resident moved into lity on [redacted]

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In an interview on 05/15/2026 at 2:14 PM, Collateral Contact 2 (CC2), Outside Provider/Registered Nurse, stated that there was no record of the facility notifying them of Resident 2's fall, significant change of condition and their transfer to the hospital.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Royal Columbian Senior Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(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 interview and record review, the facility failed to determine the circumstances and develop interventions when incidents occurred for 1 of 3 residents (Resident 3). This failure put the resident at risk of harm and resulted in multiple incidents.

Findings included…

Review of the facility's Fall Management policy, revised 02/15/2024, showed an incident report would be completed and given to the facility's licensed nurse when a resident had a fall. The document showed, "Repeated falls by a resident will have follow up to include a Fall Risk Analysis and progressive measures to help avoid future falls."

Review of Resident 3's Negotiated Service Agreement (NSA), dated 04/02/2025, showed that the resident moved into the facility on [redacted]/2022 and that they had medical conditions that included seizures (sudden uncontrolled movements such as muscle stiffness and jerking) and Parkinson's (condition that affects the body's movement). The NSA showed that Resident 3 required the use of oxygen and was at risk of falls.

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Review of Resident 3's progress notes for April 2026, showed that the resident had the following unwitnessed falls:

- On 04/15/2026, the resident was found lying on the floor next to the bed in their bedroom.
- On 04/16/2026, the resident was found sitting on the floor next to the bed in their bedroom.
- On 04/18/2026, the resident was found lying on the floor near the kitchen in their apartment.
- On 04/21/2026, the resident was found on the floor next to the bed in their bedroom.
- On 04/23/2026, the resident was found trying to get up from the floor in their apartment.
- 0n 04/24/2026, the resident was found on the floor in their apartment and was transferred to the hospital for evaluation.
- On 04/29/2026, the resident was found sitting on the floor next to the recliner in their apartment.

Review of Resident 3's investigation summaries for the resident's unwitnessed falls that occurred on 04/15/2026, 04/16/2026 and 04/18/2026, showed that the facility ruled out abuse and neglect. The investigative documentation did not describe the circumstance of the repeated unwitnessed falls.

As of 05/18/2026, review of Resident 3's records did not show what measures were in place to prevent further occurrences and did not show that an investigation had been completed when the resident fell on 04/21/2026, 04/23/2026 and 04/24/2026.

Review of Resident 3's progress notes for April 2026, documentation did not describe the circumstance of the repeated unwitnessed falls.

In an interview on 05/14/2026 at 1:33 PM, Staff B, Health Services Director/Licensed Practical Nurse, stated that the Medication Technician (MT) completes an incident report when there is an incident with a resident. Staff B stated that the MT notifies them of the incident and they meet with the resident for follow up. Staff B stated that they try to follow up on all incidents.

This is a recurring citation previously cited on 07/29/2025 and 10/31/2023 for subsections (2)(3).

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Statement of Deficiencies	License #: 2581	Compliance Determination # 76340
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 6 of 6	Licensee: Greenlake Management Columbian, LLC	06/01/2026

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) 7/13/26 .

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

Rachel [illegible] 6/3/26

Administrator (or Representative) Date

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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)_____ .

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

_____ _____

Administrator (or Representative) Date

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