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

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

RE: Royal Columbian Senior Living License # 2581

Dear Administrator:

This letter addresses Compliance Determination(s) 82760 (Completion Date 08/26/2026) and 78224 (Completion Date 06/17/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/26/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2350-1, WAC 388-78A-2350-7-b

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 Z
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: Royal Columbian Senior Living
License/Cert.#: 2581
Compliance Determination #: 78224
Investigator: Jessica Clapp
Provider Type: Assisted Living Facility
Intake ID: 224605
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 06/01/2026 through 06/17/2026
Complainant Contact Date(s): 05/29/2026, 06/23/2026

Allegation(s):
Named resident did not receive correct insulin orders.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 7 Closed records sample size: 1
Observations:	Facility common areas were clean and orderly. Resident to resident and resident to staff interactions were respectful.
Interviews:	Facility staff, sampled residents, and others not associated with the facility.
Record Reviews:	Facility characteristic roster, resident records (demographics, assessments, care plans, progress notes, medication administration record), incident investigations, and hospital notes.

Investigation Summary:
Record review showed that the facility checked the named resident's blood sugars and provided the correct insulin as ordered. Further record review showed that the facility did not notify the physician when the named resident's blood sugar's were outside the established parameters. Interviews showed that facility staff process was to notify the physician of blood sugars outside the established parameters and that they did not have documentation showing notifications were completed. Failed practice was identified. Refer to Washington Administrative Code (WAC) 388-78A-2350(1)(7)(b).

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2581	Compliance Determination # 78224
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 1 of 4	Licensee: Greenlake Management Columbian, LLC	06/17/2026

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 06/01/2026 of:

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

This document references the following complaint number(s): 223710, 224605, 225523, 225778

The following sample was selected for review during the unannounced on-site visit: 7 of 80 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Jessica Clapp, Assisted Living Facility Licensor
Elaine Lopez, 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 # 78224
Plan of Correction	Royal Columbian Senior Living	Completion Date
Page 2 of 4	Licensee: Greenlake Management Columbian, LLC	06/17/2026

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

06/25/2026
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)

6/26/24
Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on observation, interview and record review showed that the facility failed to coordinate services with the external health care provider consistent with residents' negotiated service agreement for 1 of 5 residents (Resident 1). This failure prevented timely involvement of the healthcare provider when Resident 2 had a medical change in condition that required hospitalization.

Findings included...

Review of Resident 2's undated demographic sheet showed that the resident moved into the facility on [redacted]/2025.

Review of Resident 2's Negotiated Service Agreement (NSA), dated 03/27/2025, showed that Resident 2 was diagnosed with [redacted]. The NSA showed that staff would notify the healthcare provider for health measurements outside of normal parameters.

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Review of the facility's undated physician standing orders showed that the facility was to notify the physician when their residents' blood sugar (measurement of sugar in the blood) test results were below 70 and above 400.

Review of Resident 2's physician orders, dated 05/29/2026, showed that the resident had orders for glucagon (medication used to increase the body's blood sugar when it is too low). The orders showed that the medication was to be given when Resident 2's blood sugar test result was less than 60 and to notify the healthcare provider.

Review of Resident 2's Medication Administration Record (MAR) for May 2026 showed the residents blood sugar was tested four times a day. The MAR showed the following:

- On 05/06/2026, the resident's morning test result was 432.
- On 05/06/2026, the resident's noontime test result was 55 and that they were given glucagon.
- On 05/09/2026, the resident's morning test result was 524.
- On 05/12/2026, the resident's morning test result was 27. Resident 2 was unresponsive and was transferred to the hospital.

Review of Resident 2's progress notes for May 2026 showed no documentation of staff contact to the resident's healthcare provider on 05/06/2026 and 05/09/2026.

Review of Resident 2's hospital records, dated 05/13/2026, showed that the resident was admitted to the intensive care unit after they were found unresponsive at the facility. The record showed that Resident 2 was diagnosed with [redacted] and [redacted].

Observation on 06/01/2026 at 10:00 AM, showed that Resident 2 was in the hospital's intensive care unit, laying on a hospital bed and was unresponsive. The observation showed that Resident 2 had a surgically placed tube in their neck to assist them with breathing. In addition, Resident 2 was observed to have a surgically placed tube in their abdomen to provide nutrition.

In an interview on 06/12/2026 at 10:14 AM, Staff C, Health Services Director/Licensed Practical Nurse, stated that the facility had orders to report to the facility's health care provider when a residents' blood sugars were outside of the established parameters. Staff C stated medication technicians would fax a notification to the healthcare provider when a residents' blood sugar was below or above the established parameters. Staff C stated that the expectation would be that notification and the provider's response would be documented.

Review of an electronic message dated 06/17/2026 at 4:27 PM, from Staff A, Director of

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Operations, showed that the facility was unable to locate documentation showing that Resident 2's healthcare provider was notified when their blood sugar was outside of the established parameters.

This is a recurring deficiency previously cited on 04/10/2024 for subsection (7)(b).

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) 8/1/26.

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

Administrator (or Representative) Date 6/26/26

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