STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Yakima
4100 W ENGLEWOOD
YAKIMA, WA 98908

RE: Brookdale Yakima License # 1695

Dear Administrator:

This letter addresses Compliance Determination(s) 51054 (Completion Date 12/05/2024) and 48895 (Completion Date 10/31/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/05/2024 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-2210-1-b, WAC 388-78A-2240

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Yakima
Provider Type: Assisted Living Facility
License/Cert.#: 1695
Compliance Determination #: 48895
Intake ID: 150344
Investigator: Anna Cairns
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/21/2024 through 10/31/2024
Complainant Contact Date(s):

Allegation(s):
The named resident did not receive their short acting insulin in the morning or afternoon due to a medication error.

Investigation Methods:

Sample:	Total residents: 63 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Staff to resident interactions Resident apartment
Interviews:	Administrator Resident Care Coordinator Medication Technician Residents
Record Reviews:	Incident investigation Resident records (care plan, MARs, progress notes, demographic sheet) Facility medication policy Hospital discharge summary Physician's orders

Investigation Summary:
Record review and interview showed that the named resident did not receive their short acting or long acting insulin, that resulted in hospitalization. Failed practice identified, WAC 388-78A-2210 (1)(b). This is a recurring deficiency previously cited on 02/15/2023 for subsection 1(b).

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Yakima
Provider Type: Assisted Living Facility
License/Cert.#: 1695
Compliance Determination #: 48895
Intake ID: 152227
Investigator: Anna Cairns
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/21/2024 through 10/31/2024
Complainant Contact Date(s): 10/23/2024, 11/01/2024

Allegation(s):

The facility received pain medication and new orders that were not entered into the named resident's Medication Administration Record (MAR) for administration for the resident, which resulted in the pain medication not being documented as given, causing additional pain for the resident. In addition, the named resident had two other medications that had been discontinued that were showing up on the medication administration and given to the named resident.

Investigation Methods:

Sample:	Total residents: 63 Resident sample size: 6 Closed records sample size: 0
Observations:	Staff to resident interactions Common areas Resident apartment Medication cart
Interviews:	Regional nurse Administrator Medication technician Resident care coordinator Residents
Record Reviews:	Characteristic roster Incident investigation Resident record (care plan, medication administration, progress notes, hospice notes) Facility policies Staff list

Investigation Summary:

The facility received the pain medication and new orders from hospice for the named resident. The pain medication was given to the named resident and was documented in the narcotic log. The pain medication and new orders were not added to the named resident's 2024 October MAR and the blood thinner and potassium medications that were discontinued, were not removed from MAR.

Additional resident sample included showed that the facility missed multiple doses of a thyroid medication for that resident. Failed practice identified, WAC 388-78A-2210 1(b) and 388-78A-2240. This is a recurring deficiency previously cited on 02/15/2023 for 388-78A-2210 subsection 1(b).

Conclusion / Action:

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

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 complaint investigation on 10/21/2024 and 10/21/2024 of:

Brookdale Yakima
4100 Englewood Ave
Yakima, WA 98908

This document references the following complaint number(s): 150344, 151046, 151386, 152227

The following sample was selected for review during the unannounced on-site visit: 6 of 63 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

J Salquist
Residential Care Services

11/13/2024
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.

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
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Residential Care Services

Date

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Lisa Owen
Administrator (or Representative)

11.20.24
Date

WAC 388-78A-2210 Medication services.

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

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement a safe medication system for residents who required assistance and administration with their medication for 2 of 3 residents (Residents 1 and 4). This failure resulted in Resident 1 being hospitalized for high blood sugar and placed residents at risk for further complications due to medications not being given as ordered.

Findings included...

<Resident 1>

Review of Resident 1's Negotiated Service Agreement (NSA), dated 08/27/2024, showed that the resident had a diagnosis of [redacted], that required fast and long-acting insulin (injectable medications used to regulate blood sugar).

Review of Resident 1's October 2024 Medication Administration Record (MAR) showed that the resident did not receive their Admelog (fast- acting) insulin on 10/05/2024 at 8:00 AM and 12:00 PM.

Review of Resident 1's hospital discharge paperwork, dated [redacted]2024, showed that the resident was seen for hyperglycemia (high blood sugar) and a urinary tract infection.

Review of Resident 1's facility incident investigation from 10/05/2024, dated 10/07/2024, showed that the resident had a blood sugar (BS) level of 550 (normal BS 70-100), low blood pressure (BP) of 90/50 (normal BP 120/80), headache, and dizziness. Additionally, the incident investigation showed that Resident 1 had not been given their morning dose of long-acting insulin or their dose of fast-acting insulin that day.

Administrator (or Representative) Date

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Review of Resident 1's physician's notes, dated 10/11/2024, showed that the resident was sent to the emergency room on [redacted]/2024 for a blood sugar level of 500. Additionally, the physician note showed that facility staff realized that Resident 1 did not receive any insulin which resulted in elevated blood sugar.

In an interview on 10/23/2024 at 11:55 AM, Staff B, Licensed Nurse/Area Nurse Manager, stated Resident 1 did not get their fast-acting or long-acting insulin on 10/05/2024.

<Resident 4>

Review of Resident 4's NSA, dated 10/11/2024, showed that the resident had a diagnosis of [redacted] and pain levels that required monitoring.

Review of Resident 4's October 2024 MAR showed that the resident had been given lovastatin (high cholesterol) and potassium (supplement) medications from 10/11/2024 through 10/21/2024.

In an interview on 10/21/2024 at 8:10 AM, Collateral Contact 1 (CC1), hospice health care provider, stated that Resident 4's October 2024 MAR had not been updated with their oxycodone order and that their lovastatin and potassium had been discontinued on 10/10/2024. CC1 further stated the medications were on the MAR at the facility and were still being given.

Review of Resident 4's facility incident investigation, dated 10/23/2024, showed that Staff A, Administrator, stated that the oxycodone medication orders, dated 10/19/2024, were not processed timely. Resident 4's incident investigation showed that the resident received lovastatin and potassium from 10/11/2024 through 10/23/2024 (were discontinued on 10/10/2024).

In an interview on 10/23/2024 at 11:50 AM, Staff B stated that Resident 4 continued to receive lovastatin and potassium until 10/21/2024 (11 days after it should have been discontinued).

This is a recurring deficiency previously cited on 02/15/2024.

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, Brookdale Yakima is or will be in compliance with this law and / or regulation on (Date) 11.30.24 .

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

Lisa Owen 11.20.24
Administrator (or Representative) 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 Assisted Living Facility (ALF) failed to ensure that residents' medications were obtained for 1 of 4 residents (Residents 6). This failure placed the residents at risk of complications with their health conditions.

Findings included...

Review of the facility policy, titled, "Medications and Treatments-Availability," dated 08/2022, showed that all current medications would be available to the resident and the facility was responsible for obtaining medication refills.

Review of Resident 6's undated demographic sheet, showed that the resident had diagnoses of [redacted] ([redacted]).

Review of Resident 6's Negotiated Service Agreement (NSA), dated 09/05/2024, showed that the resident required assistance with ordering and administration of their medication.

Review of Resident 6's October 2024, Medication Administration Record (MAR), showed that the resident was prescribed levothyroxine every morning for hypothyroidism. Additionally, Resident 6's MAR showed that the resident missed 17 doses of their medication from 10/01/2024 through 10/23/2024.

In an interview on 10/23/2024 at 12:39 PM, Resident 6 stated that they took a medication to regulate their thyroid, and that medication had not been obtained.
Review of Resident 6's progress notes, dated 10/06/2024 and10/23/2024, confirmed

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Administrator (or Representative) Date

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levothyroxine was not available to the resident.

In an interview on 10/23/2024 at 1:05 PM, Staff B, Licensed Nurse/Area Nurse Manager confirmed that Resident 6 had missed 17 doses of Levothyroxine.

Plan/Attestation Statement

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Lisa Owen — Administrator (or Representative)

11.20.24 — Date

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