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) 36401 (Completion Date 02/06/2024) and 32797 (Completion Date 12/20/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/06/2024 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-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2320-2-b, WAC 388-78A-2320-3-a, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b

The Department staff who did the on-site verification:
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, 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 #: 32797
Intake ID: 105265
Investigator: Felicia Cantu
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/20/2023 through 12/20/2023
Complainant Contact Date(s):

Allegation(s):
A named staff member is administering insulin without being delegated to administer insulin.

Investigation Methods:

Sample:
Total residents: 51
Resident sample size: 7
Closed records sample size:

Observations:
Residents
Staff to resident interactions
Medication administration
Resident rooms
Facility environment

Interviews:
Residents
Staff members
Others not associated with the facility

Record Reviews:
Characteristic roster
Facility policies
Nurse delegation records
Staff records
Resident records(medication administration records, face sheets, care plans, assessments).

Investigation Summary:
Interviews and record review showed that their were two named staff members administering insulin without being delegated. Failed Practice identified 388-78A-2320.

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 #: 32797
Intake ID: 107259
Investigator: Felicia Cantu
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/20/2023 through 12/20/2023
Complainant Contact Date(s):

Allegation(s):

1) Staff did not contact a named resident's health care provider to notify them of a change of condition.
2) Call light responses are too long.
3) Facility staff are not giving the residents medications as ordered and not on time.

Investigation Methods:

Sample:
Total residents: 51
Resident sample size: 7
Closed records sample size:

Observations:
Identified residents
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Medication administration
Facility environment

Interviews:
Identified residents
Residents
Facility staff
Others not associated with the facility

Record Reviews:
Characteristic roster
Facility policies
Staff records
Resident records (face sheets, care plans, assessments, chart notes, doctor orders)
Medications administration records(mars)

Investigation Summary:

1) Interviews and record review showed that the facility did not contact a named resident's health care provider to notify them of high blood sugars. Failed Practice identified. 388-78A-2640.
2) Observations and interviews showed that care staff responded to call lights timely. No failed practice identified.

3) Interviews and record review showed that the sampled residents did not miss scheduled doses of medications. No failed practice identified.

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 #: 32797
Intake ID: 110016
Investigator: Felicia Cantu
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/20/2023 through 12/20/2023
Complainant Contact Date(s):

Allegation(s):

1) Staff members are giving medications who are not delegated to give medications.
2) A named staff member is giving medications who is not qualified.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 7 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Staff records Facility policies Nurse delegation records Resident records(face sheet, care plans, assessments, doctor orders, medication administration records).

Investigation Summary:

1) Record review and interviews showed that there were two staff members giving delegated medications who were not delegated. Failed practice identified. 388-78A-2320.
2) Record review and interviews showed that the named staff member was qualified to administer medications, and was not giving delegated medications. No failed practice identified.

Conclusion / Action:

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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

Statement of Deficiencies	License #: 1695	Compliance Determination # 32797
Plan of Correction	Brookdale Yakima	Completion Date
Page 1 of 7	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	12/20/2023

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 11/20/2023 and 12/20/2023 of:

Brookdale Yakima
4100 Englewood Ave
Yakima, WA 98908

This document references the following complaint number(s): 105265, 103677, 106471, 104867, 107259, 110016

The following sample was selected for review during the unannounced on-site visit: 7 of 51 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, Community Complaint Investigator

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.

Gwin Kaercher — Residential Care Services

12/21/2023 — 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.

Statement of Deficiencies	License #: 1695	Compliance Determination # 32797
Plan of Correction	Brookdale Yakima	Completion Date
Page 2 of 7	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	12/20/2023

Lisa Owen
Administrator (or Representative)

12/29/2023
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(a) Chapter 18.79 RCW, Nursing care;

This requirement was not met as evidenced by:

Based on interview and record review, the
Assisted Living Facility (ALF) failed to ensure 2 of 2 care staff (Staff A, B) were delegated to perform required nurse tasks for 2 of 2 residents (Resident 1,2) reviewed for nurse delegation.
This failure contributed to a hospitalization for Resident 1 and placed Resident 2 and other residents at risk of receiving services incorrectly and injury.

Findings included..

Review of Washington
Administrative Code (WAC) 246-840-0010 showed that delegation meant that a Licensed Nurse could assign specific nursing tasks to staff by following the nurse delegation process (RCW 18.79.260)

Review of the ALF's policy titled "Nurse Delegation Policy" dated 01/01/2023 showed that as per Washington State regulations 246-840-700 the Registered Nurse (RN) was responsible to review and understand the Washington delegation rules in the Nursing Practice Act and will follow them. Before performing any delegated task, the RN must verify that the nursing assistant has completed core delegation training before performing any delegated task, obtain written consent from the resident or representative to the delegation process within thirty days of the delegation tasks. The delegated nursing task is specific to one resident and is not transferable to another resident. The delegated employee should know the nature of the condition requiring treatment, the purpose of the nursing task, predictable outcomes of the nursing task and how to effectively deal with them. They should know how to observe and report complications, unexpected outcomes, and appropriate actions to deal with them, including specific parameter for notifying the registered nurse delegator or health care provider.
Review and documentation of the delegation process must be completed at least every 90 days.

Resident 1

Review of Resident 1's face sheet showed that Resident 1 was admitted to the ALF on [redacted]/2023 with diagnosis of [redacted].

Review of Resident 1's Negotiated Service Agreement (NSA) updated 08/08/2023 showed that Resident 1 required medication assistance with insulin (medication for blood sugar, delegated medication) injections, needed blood sugar monitoring three or more times a week, and needed to be alert for signs of high or low blood sugar.

On 12/05/2023 at 11:30 AM, Collateral Contact 1(CC1), Resident 1's Health Care Provider, stated that the ALF's Medication Technician Aides (Med Tech) did not have appropriate knowledge on how to use a glucose monitor machine (machine that reads blood sugar levels) and how to monitor Resident 1 for "high" blood sugars. Resident 1's blood sugar was reading "high" on the glucose monitor for three days prior to hospitalization on [redacted]/2023. CC1 stated that they felt like the Med Techs ignored the "high" alert on the glucose monitor and did not know what to do. CC1 expressed that the staff should have known that a "high" read on a glucose monitor means that blood sugar is too high to record on the glucose monitor machine and that Resident 1 needed immediate attention.

On 12/05/2023 at 12:11 PM, Collateral Contact 2 (CC2), Resident's Representative, stated that they felt that the Med Techs in the ALF did not know what to do when the glucose monitor machine read "high" when checking Resident 1's blood sugar. Resident 1's blood sugar reading on blood sugar machine read "high" and the resident was feeling ill for three days before they were sent to the hospital.

Review of Resident 1's Consent for Delegation Process, Instructions for Nursing Tasks were completed on [redacted]/2023 (after Resident 1's hospitalization due to high blood sugar).

Review of Resident 1's Medication Administration Record (MAR) showed that Staff A, Med Tech gave Resident 1 insulin on 11/01/2023, 11/02/2023, 11/07/2023, 11/08/2023, and 11/09/2023. Staff B, Med Tech gave Resident 1 insulin on 11/09/2023 and 11/12/2023.

Review of Nurse Delegation visit form showed that Staff A and Staff B were delegated on insulin injections and blood glucose monitoring on [redacted]/2023, after Resident 1's hospitalization and after insulin was administered by Staff A and Staff B.

Resident 2

Review of Resident 2's admission record showed that they were admitted to the ALF on [redacted]/2023 with a diagnosis that included [redacted].

Review of Resident 2's Negotiated Service Plan dated 07/11/2023 showed that Resident 2 required medication assistance with insulin injections.

Review of Resident 2's required consent for delegation process form was signed by Resident 2 on 11/30/2023 (required after 30 days of delegated tasks).

Review of Resident 2's MAR showed that Staff B, administered insulin injections to Resident 2 on 11/03/2023, 11/06/2023, 11/07/2023, 11/09/2023, and 11/12/2023. Staff A administered an insulin injection to Resident 2 on 11/01/2023.

Review of Staff B and Staff A's nurse delegation verification forms showed that the nurse delegation certification was completed on 11/13/2023 and 11/16/2023 (after insulin injections were administered).

On 12/19/2023 at 4:45 PM Staff C, Administrator acknowledged that all nurse delegation requirements for residents and staff members should have been up to date prior to care staff performing delegated tasks such as monitoring blood sugar and administering insulin.

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) 02/03/2024 .

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

Lisa Roen
Administrator (or Representative)

12/29/2023
Date

Statement of Deficiencies	License #: 1695	Compliance Determination # 32797
Plan of Correction	Brookdale Yakima	Completion Date
Page 6 of 7	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	12/20/2023

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

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to report a change in medical condition for 1 of 2 residents (Resident 1). This failure resulted in delay of medical treatment and hospitalization for Resident 1placed the resident at risk of unmet care needs and contribution to thier hospitalization.

Findings included...

Review of the ALF's policy titled "Change of Condition" revised 02/01/2021 showed that a change in medical condition should be evaluated and documented. Residents with unstable or potentially life-threatening medical condition should be evaluated by a Health Care Provider. The Health Care Provider and legal responsible party should be notified of the resident's change of condition.

Review of Resident 1's face sheet showed that Resident 1 was admitted to the ALF on [redacted]/2023 with a diagnosis of [redacted].

Review of Resident 1's Negotiated Service Agreement (NSA) updated 08/08/2023 showed that Resident 1 required blood sugar monitoring three or more times a week, and to be on alert for signs of high or low blood sugar.

Review of Provider Communication orders dated 10/23/2023 showed that care staff were to call provider if blood sugar was greater than 400.

On 12/05/2023 at 11:30 AM, Collateral Contact 1(CC1), Resident 1's Health Care Provider, stated that the facility was supposed to notify them when Resident 1's blood sugars were greater than 400. CC1 stated that they found out that Resident 1 was hospitalized on [redacted]/2023 with a diagnosis of [redacted] and that Resident 1 was having "high" blood sugars three days prior from Resident 1's daughter who found out from the hospital. "I never received a call that [Resident 1] was having high blood sugars, until [Resident 1] was already hospitalized".

Review of Resident 1's facility chart notes from 10/24/2023 thru [redacted]/2023 did not show that Resident 1's Health Care Provider was notified of "high" readings on glucometer (machine that monitors blood sugars).

Review of Resident 1's hospital discharge summary dated [redacted]/2023 showed that Resident 1 was admitted for DKA that included symptoms of fatigue, feeling thirsty, increased urination, nausea, vomiting, and abdominal pain.

Review of Resident 1's post hospital Health Care Provider notes dated 11/17/2023 showed that Resident 1 was hospitalized [redacted]/2023 thru [redacted]/2023 for high blood sugar. Blood sugar was greater than 1,000 on arrival to the hospital. (normal blood sugar is 70-100). Blood sugar readings were reading "high" days prior to hospitalization, and Resident 1's Health Care Provider was not notified.

On 12/06/2023 at 12:11 PM, Resident 1 stated that they had been having high blood sugars that led to a hospitalization on [redacted]/2023. "My blood sugars were reading high on the glucose monitor machine for three days, and I was not feeling well days prior to the hospitalization". Resident 1 stated that their Health Care provider or representative was not notified of the "high" blood sugar readings. Resident 1 stated they were unsure if the facility nurse was notified days prior.

On 12/19/2023 at 4:45 PM Staff C, Administrator acknowledged that Resident 1's Health Care Provider should have been notified of "high" glucose monitor readings.

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) 02/03/2024 .

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

Lisa Owen — 12/29/2023

Administrator (or Representative) — Date

Gwin Kaercher, Field Manager
Residential Care Services Region 1, Unit G
1200 Alder St
Union Gap, WA 98903

The following is the Plan of Correction for Brookdale Yakima regarding the Statement of Deficiencies dated 12/20/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Deficiency #1: WAC 388-78A-2320 intermittent nursing services systems

(Resident 1 and Resident 2)

Element 1. What corrective actions will be taken for those residents found to have been affected by the deficient practice: The Health and Wellness Director and/or designee to re-educate associates on the community policy and procedure for insulin administration to be completed by 01/15/2024

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken: The HWD or designee to review residents who receive nurse delegated tasks. The HWD or RN to review nurse delegation forms to confirm associates have been educated on these tasks and review of quarterly assessments on delegated residents to be completed by 02/02/2024.

Element 3. Who is responsible for the corrective action: Executive Director or Designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); Discussion of nurse delegation and/or delegated residents during Collaborative Care Review (CCR) Meeting monthly.

Element 5. Date by which the correction will be made: 02/02/2024

Deficiency #1: WAC 388-78A-2640 Reporting significant change of condition

(Resident 1)

Element 1. What corrective actions will be taken for those residents found to have been affected by the deficient practice: Health and Wellness Director or nurse designee will provide training to Med Techs on

reporting to Licensed Nurse and physician, when/if monitoring falls outside of parameters identified by the physician, such as blood glucose parameters.

RN Delegator will retrain delegated med. techs on each individual resident who has physician orders for blood sugar checks by 02/02/2024

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken: Executive Director to provide retraining on Change of Condition Policy and Alert Charting policy, which includes follow up communication with physician and legally responsible parties by 02/02/2024

ED and/or HWD will re-educate associates on communicating changes in resident status, including documentation on Daily Shift Report Form. The ED, HWD or designee will review the Daily Shift Report for further assessment or action.

Element 3. Who is responsible for the corrective action: Executive Director or Designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); Discuss significant change of condition at morning stand-up meeting.

Element 5. Date by which the correction will be made: 02/02/2024