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 Richland
1629 GEORGE WASHINGTON WAY
RICHLAND, WA 99352

RE: Brookdale Richland License # 1696

Dear Administrator:

This letter addresses Compliance Determination(s) 45469 (Completion Date 08/13/2024) and 42253 (Completion Date 06/19/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/13/2024 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2100-2-a, WAC 388-78A-2120-1, WAC 388-78A-2120-2-a, WAC 388-78A-2140-2-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2660-2, RCW 70.129.140.1, WAC 388-78A-2660-1, RCW 70.129.030.4, WAC 388-78A-2730-1-b, WAC 388-78A-2466-1-a, WAC 388-78A-24701-1, WAC 388-78A-2480-1

The Department staff who did the on-site verification:
Elaine Lopez, Licensor
Jessica Clapp, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Richland
Provider Type: Assisted Living Facility
License/Cert.#: 1696
Compliance Determination #: 42253
Intake ID: 132127
Investigator: Elaine Lopez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 06/10/2024 through 06/19/2024
Complainant Contact Date(s): 06/06/2024, 06/24/2024

Allegation(s):
The named resident had an injury to their left foot due to their footrest not used by the facility during escorts.

Investigation Methods:

Sample:
Total residents: 91
Resident sample size: 12
Closed records sample size: 0

Observations:
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Dining

Interviews:
Residents
Family members
Staff
Others not associated with the facility

Record Reviews:
Medical records
Incident investigation
Facility policies
Personnel files
Resident records

Investigation Summary:
Based on interview and record review, the Assisted Living Facility failed to investigate and rule out abuse and neglect. Failed practice identified WAC 388-78A-2371 (1)(2)(3).

Conclusion / Action:

☐ 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

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Richland
1629 GEORGE WASHINGTON WAY
RICHLAND, WA 99352

RE: Brookdale Richland # 1696

Dear Administrator:

This document references the following complaint numbers 131660, 133111, 132889, 132127.

The Department completed a full inspection of your Assisted Living Facility on 06/19/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Michelle Closner, Field Manager

Residential Care Services
Region 1, Unit G
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 246-215-03200 Sources Compliance with food law (FDA Food Code 3-201.11).

(2) food prepared in a private home may not be used or offered for human consumption in a food establishment except as otherwise provided in this chapter.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(3) Ensure a resident obtains a food worker card according to chapter 246-217 WAC whenever:

(a) The resident is routinely or regularly involved in the preparation of food to be served to other residents;

The Assisted Living Facility failed to ensure residents obtained food worker cards when they prepared food for other residents, and failed to ensure foods were obtained from an approved source and not prepared in a private home. The facility ensured that they would develop a plan for residents to prepare food when that was their preference to do so.

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.

The Assisted Living Facility failed to review the nurse delegation every 90 days for a resident. The facility had a plan to ensure that nurse delegation was reviewed every 90 days.

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

The Assisted Living Facility (ALF) had twenty-six missing screens on operable resident windows. The ALF had a plan to replace all of the missing screens.

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

The Assisted Living Facility (ALF) failed to maintain a clean and well-maintained environment throughout the home. The facility had a plan for increasing housekeeping services and having the carpets cleaned in the common areas.

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to

sign on its behalf.

The Assisted Living Facility (ALF) failed to provide documentation of a family assistance with medication plan for a resident. The ALF had reached out to the resident's family to complete the documentation.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit G
Residential Care Services

Enclosure

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 the unannounced on-site full inspection and complaint investigation on 06/10/2024, 06/11/2024, 06/12/2024 and 06/13/2024 of:

Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following complaint numbers: 131660, 133111, 132889, 132127.

The following sample was selected for review during the unannounced on-site visit: 12 of 91 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor
Robin Rainville, Assisted Living Facility Licensor
Tracy Ramirez, Assisted Living Facility Licensor
Elaine Lopez, Licensor

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.

Statement of Deficiencies	License #: 1696	Compliance Determination # 42253
Plan of Correction	Brookdale Richland	Completion Date
Page 6 of 25	Licensee: BROOKDALE SENIOR LIVING	06/19/2024

Michelle Cloaner — Residential Care Services

07/01/2024 — 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.

Administrator (or Representative)

7.9-24 — Date

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

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(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 observation, interview and record review, the Assisted Living Facility failed to investigate and document investigative actions of a resident with injuries for 1 of 2 resident (Resident 5). These failures placed residents at risk of further injuries and or falls.

Findings included...

Review of the facility's policy, "Conduct Internal & External Investigations," revised 10/2018, showed that the facility was to investigate and document when a resident had an incident. The policy showed that the facility needed to determine the circumstances of the event to better care for the residents

Review of Resident 5's Negotiated Service Agreement (NSA), dated 02/02/2024, showed that the resident used a wheelchair for mobility and required staff assistance with transport to and from the dining room.

Review of Resident 5's progress notes, dated 05/23/2024, showed the resident had a bruised left foot and that their left foot's second toe had likely been fractured. Resident 5's progress note did not show an investigation of the incident had been conducted.

Michelle Closner
Residential Care Services

07/01/2024
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.

Administrator (or Representative)

Date

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(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(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 observation, interview and record review, the Assisted Living Facility failed to investigate and document investigative actions of a resident with injuries for 1 of 2 resident (Resident 5). These failures placed residents at risk of further injuries and or falls.

Findings included...

Review of the facility's policy, "Conduct Internal & External Investigations," revised 10/2018, showed that the facility was to investigate and document when a resident had an incident. The policy showed that the facility needed to determine the circumstances of the event to better care for the residents.

Review of Resident 5's Negotiated Service Agreement (NSA), dated 02/02/2024, showed that the resident used a wheelchair for mobility and required staff assistance with transport to and from the dining room.

Review of Resident 5's progress notes, dated 05/23/2024, showed the resident had a bruised left foot and that their left foot's second toe had likely been fractured. Resident 5's progress note did not show an investigation of the incident had been conducted.

Statement of Deficiencies	License #: 1696	Compliance Determination # 42253
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In an interview on 06/10/2024 at 11:49 AM Staff G, Registered Nurse/Health Wellness Director, stated the incident was not investigated or reported to them.

In an interview on 06/12/2024 at 9:51 AM Staff B, Licensed Practical Nurse/Health and Wellness Director, stated that they had assessed Resident 5's bruised left foot and second toe and determined that the second toe had been fractured. Additionally, Staff B stated that they had 11 years of experience at an orthopedic clinic (a clinic that corrects bone injuries) and they used that knowledge when they had assessed Resident 5's left foot. Staff B stated that they had reported the incident to Staff G. In addition, Staff B stated that they were a new employee, new to assisted living, and was unaware of the process for investigations.

In an interview on 06/13/2024 at 11:02 AM, Staff K, Resident Care Coordinator, stated that they were informed of Resident 5's injuries by other care staff and Staff G.

In an interview on 06/12/2024 at 8:58 AM, Staff A, Administrator, stated that they were unaware that an investigation had not been completed.

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 Richland is or will be in compliance with this law and / or regulation on (Date) 7-31-2024

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

Administrator (or Representative) 7-9-24 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;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete focused assessments on identified safety considerations for 2 of 2 residents (Residents 7 and 8) who had access to and/or used systems or devices that posed a safety risk to the resident. This failure placed the residents at risk of unmet care needs and a

In an interview on 06/10/2024 at 11:49 AM Staff G, Registered Nurse/Health Wellness Director, stated the incident was not investigated or reported to them.

In an interview on 06/12/2024 at 9:51 AM Staff B, Licensed Practical Nurse/Health and Wellness Director, stated that they had assessed Resident 5's bruised left foot and second toe and determined that the second toe had been fractured. Additionally, Staff B stated that they had 11 years of experience at an orthopedic clinic (a clinic that corrects bone injuries) and they used that knowledge when they had assessed Resident 5's left foot. Staff B stated that they had reported the incident to Staff G. In addition, Staff B stated that they were a new employee, new to assisted living, and was unaware of the process for investigations.

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In an interview on 06/12/2024 at 8:58 AM, Staff A, Administrator, stated that they were unaware that an investigation had not been completed.

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

_____ _____

Administrator (or Representative) Date

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(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;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete focused assessments on identified safety considerations for 2 of 2 residents (Residents 7 and 8) who had access to and/or used systems or devices that posed a safety risk to the resident. This failure placed the residents at risk of unmet care needs and a

decline in chronic medical conditions.

Findings included...

Resident 7

Observation on 06/11/2024 at 11:09 AM showed that Resident 7's bedside showed a mobility rail (a device installed at the side of a bed to aid in bed mobility and getting in and out of bed, which posed a safety risk to the resident).

In an interview on 06/11/2024 at 11:10 AM, Resident 7 stated that they could not get up by themselves from their chair but could get in and out of bed by themselves with the use of the rail.

Review of Resident 7's full facility assessment, dated 03/13/2024, showed that the resident had a history of falls and walked with a walker, and that they had, "some memory loss or cognitive impairment." The assessment did not show that Resident 7 had been assessed for the use of the side rail that was observed in their apartment.

On 06/12/2024 at 3:38 PM, Staff G, Registered Nurse/Health Wellness Director, stated that they did not know Resident 7 had a mobility rail installed on their bed.

Resident 8

In an interview on 06/12/2024 at 3:08 PM, Resident 8 stated that they did their own blood sugar testing and gave themselves their insulin (an injected medication to regulate blood sugars).

Review of Resident 8's full facility assessment, dated 03/21/2024, showed that Resident 8 required staff assistance with their oral medication, but the resident administered their own blood sugar testing and insulin injections. Resident 8's assessment did not include documentation that they had been assessed for the ability to safely administer their insulin and blood sugar tests.

On 06/12/2024 at 2:44 PM, Staff J, Licensed Practical Nurse/Area Nurse Manager, stated that Staff B, Licensed Practical Nurse/Health Wellness Director, had been updating all self-medication assessments for residents but that Resident 8's assessment must have gotten missed.

Statement of Deficiencies	License #: 1696	Compliance Determination # 42253
Plan of Correction	Brookdale Richland	Completion 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, Brookdale Richland is or will be in compliance with this law and / or regulation on (Date) 7-31-24.

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

Administrator (or Representative) 7-9-24 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to observe and evaluate residents who had changes in condition and incidents, for 2 of 2 residents (Resident 4 and 8). This failure placed the residents at risk of unmet needs and harm from potential ongoing incidents.

Findings included...

Review of the facility's policy titled, "Alert Charting," revised in 12/2020, showed that alert charting should be completed for incidents such as falls, medication changes, and infections and illnesses. The document showed that caregivers, "Should observe and document the resident's response/condition for 72 hours in the Resident Record."

Resident 8

In an interview on 06/12/2024 at 3:00 PM, Resident 8 stated that the staff helped them with their medication.

Review of Resident 8's full facility assessment, dated 03/21/2024, showed that the resident had diagnoses which included [redacted], and that they required staff assistance with their medication. The assessment further showed that Resident 8 required

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 Richland 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-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to observe and evaluate residents who had changes in condition and incidents, for 2 of 2 residents (Resident 4 and 8). This failure placed the residents at risk of unmet needs and harm from potential ongoing incidents.

Findings included...

Review of the facility's policy titled, "Alert Charting," revised in 12/2020, showed that alert charting should be completed for incidents such as falls, medication changes, and infections and illnesses. The document showed that caregivers, "Should observe and document the resident's response/condition for 72 hours in the Resident Record."

Resident 8

In an interview on 06/12/2024 at 3:00 PM, Resident 8 stated that the staff helped them with their medication.

Review of Resident 8's full facility assessment, dated 03/21/2024, showed that the resident had diagnoses which included [redacted], and that they required staff assistance with their medication. The assessment further showed that Resident 8 required

monitoring due to their chronic diagnoses.

Review of a doctor's order in Resident 8's record, dated 03/05/2024, showed that the resident had a refill prescription for amlodipine (a medication to regulate high blood pressure).

Review of Resident 8's May through June 2024 Medication Administration Records (MARs) showed that the resident did not receive their amlodipine from 05/27/2024 - 06/11/2024.

Review of Resident 8's record showed no documentation as to why they did not receive their medication. Resident 8's record did not show that the resident had been monitored after not receiving their blood pressure medication for 15 days.

In an interview on 06/12/2024 at 3:50 PM, Staff G stated that staff were not documenting in residents' progress notes when there were exceptions such as missed medication, as they should have been doing. Staff G stated that they were not aware that Resident 8 had missed their amlodipine.

Resident 4

On 06/11/2024 at 2:58 PM, Resident 4 stated that they used a motorized scooter for ambulation and that they could not walk due to a recent hip fracture.

Review of Resident 4's full facility assessment, dated 06/11/2024, showed that the resident had a history of falls.

Review of a facility incident report, dated 04/14/2024, showed that Resident 4 had a fall in their apartment.

Review of Resident 4's records did not show that the resident had been monitored following the resident's fall on 04/14/2024.

In an interview on 06/12/2024 at 3:14 PM, Staff G stated that monitoring of a resident was supposed to be documented in their process of alert charting, on the back of a Temporary Service Plan (TSP). Staff G stated that there was not a TSP or documentation of monitoring for Resident 4 when they fell on 04/14/2024.

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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, Brookdale Richland is or will be in compliance with this law and / or regulation on (Date) 7-31-24.

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

Administrator (or Representative) 7-9-24 Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop a Negotiated Service Agreement (NSA) that addressed the resident's needs and interventions for their blood pressure recording for 1 of 1 resident (Residents 1). This failure placed the resident at risk of unmet needs.

Findings included...

Resident 1

Review of Resident 1's doctor's orders, dated 03/05/2024, showed that their blood pressure was to be checked three times a week and the results were to be faxed to the doctor monthly.

Review of Resident 1's assessment, dated 06/10/2024, showed that the resident required their blood pressure to be checked and recorded three times per week. Additionally, their medical doctor was to be notified monthly of the results.

Review of Resident 1's negotiated service agreement, dated 06/10/2024, showed no documentation of instructions to check the resident's blood pressure three times a week or

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 Richland 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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop a Negotiated Service Agreement (NSA) that addressed the resident's needs and interventions for their blood pressure recording for 1 of 1 resident (Residents 1). This failure placed the resident at risk of unmet needs.

Findings included...

Resident 1

Review of Resident 1's doctor's orders, dated 03/05/2024, showed that their blood pressure was to be checked three times a week and the results were to be faxed to the doctor monthly.

Review of Resident 1's assessment, dated 06/10/2024, showed that the resident required their blood pressure to be checked and recorded three times per week. Additionally, their medical doctor was to be notified monthly of the results.

Review of Resident 1's negotiated service agreement, dated 06/10/2024, showed no documentation of instructions to check the resident's blood pressure three times a week or

Statement of Deficiencies	License #: 1696	Compliance Determination # 42253
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to notify the resident's doctor of the results monthly.

In an interview on 06/12/2024 at 10:02 AM, Resident 1 stated that their blood pressure was not checked three times a week and stated, "Not even once a month."

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 Richland is or will be in compliance with this law and / or regulation on (Date) 7-31-24.

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

Administrator (or Representative) 7.9.24 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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure residents received their medication as prescribed for 2 of 9 residents (Residents 7 and 8) who required assistance with their medication. This failure placed the residents at risk of complications from their diagnoses due to medication not being given as prescribed and/or assistance not provided.

Findings included...

Review of the facility's policy titled, "Medications & Treatments- Medication Error," dated 07/2023, showed that if a resident received an incorrect dose or missed a dose of medication, the staff were to notify the Health Wellness Director and document the error in the resident's progress notes.

to notify the resident's doctor of the results monthly.

In an interview on 06/12/2024 at 10:02 AM, Resident 1 stated that their blood pressure was not checked three times a week and stated, "Not even once a month."

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 Richland 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-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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure residents received their medication as prescribed for 2 of 9 residents (Residents 7 and 8) who required assistance with their medication. This failure placed the residents at risk of complications from their diagnoses due to medication not being given as prescribed and/or assistance not provided.

Findings included...

Review of the facility's policy titled, "Medications & Treatments- Medication Error," dated 07/2023, showed that if a resident received an incorrect dose or missed a dose of medication, the staff were to notify the Health Wellness Director and document the error in the resident's progress notes.

Resident 7

Review of Resident 7's full facility assessment, dated 03/13/2024, showed that the resident required medication assistance from the facility staff.

Review of Resident 7's admission orders, dated 02/27/2024, showed that they had an order for gabapentin (a medication used to treat nerve pain and numbness) with instructions to take one capsule in the morning and evening, and two capsules at bedtime.

Review of Resident 7's February through April 2024 Medication Administration Record (MAR) showed that the resident's gabapentin was given as one capsule three times daily. The MAR showed that the gabapentin order entry was changed on 04/09/2024 to one capsule twice daily and two capsules at bedtime.

In an interview on 06/12/2024 at 3:40 PM, Staff G, Registered Nurse/Health and Wellness Director, stated that Resident 7's gabapentin order had been entered onto the MAR incorrectly by themselves when the resident moved into the ALF. Staff G stated that they realized they had missed the bedtime dose of the gabapentin when they initially transcribed the order onto the MAR. Staff G stated that they corrected the MAR when they found the error on 04/08/2024 but did not document the error in the resident's progress notes.

Resident 8

In an interview on 06/12/2024 at 3:00 PM, Resident 8 stated that the staff helped them with their medication.

Review of Resident 8's full facility assessment, dated 03/21/2024, showed that the resident had diagnoses which included [redacted], and that they required staff assistance with their medication.

Review of a doctor's order in Resident 8's record, dated 03/05/2024, showed an order for amlodipine (a medication to regulate high blood pressure). Additionally, there was a 05/29/2024 refill order for the amlodipine in Resident 8's record.

Review of Resident 8's May through June 2024 MARs showed that the resident did not receive their amlodipine from 05/27/2024 through 06/11/2024.

Resident 8's record did not show documentation as to why they did not receive their medication.

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In an interview on 06/12/2024 at 3:50 PM, Staff G stated that staff did not refill the amlodipine and they were not documenting in the residents' progress notes when there were exceptions on a MAR such as missed medication, as they should have been doing. Staff G stated that they were not aware that Resident 8 had missed their amlodipine.

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 Richland is or will be in compliance with this law and / or regulation on (Date) 7.31.24.

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

Administrator (or Representative) 7.9.24 Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

In an interview on 06/12/2024 at 3:50 PM, Staff G stated that staff did not refill the amlodipine and they were not documenting in the residents' progress notes when there were exceptions on a MAR such as missed medication, as they should have been doing. Staff G stated that they were not aware that Resident 8 had missed their amlodipine.

Plan/Attestation Statement

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

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Administrator (or Representative) Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure that staff responded to the residents' call lights timely for 4 of 12 residents (Resident 1, 4, 6 and 12). The ALF failed to inform residents at least every 24 months in writing of the service items, activities available in the facility, and the rules of the facility's operation for 5 of 5 residents (Residents 1, 2, 3, 5 and 8). This failure resulted in residents having to wait extended periods of time for assistance with care needs and did not allow residents to make informed decisions regarding living choices.

Findings included...

<Call lights>

Review of the facility's policy titled, "Resident Call System and Door Alarm Response" revised in 05/2023, showed staff should respond to the call light within a timely manner.

In a resident group meeting dated 06/11/2024 at 1:30 PM, 11 of 32 residents in attendance agreed that the staff response to call lights was slow.

Resident 4

Review of Resident 4's Negotiated Service Agreement (NSA), showed that the resident had diagnoses of [redacted], and that they had a risk of falling.

In an interview on 6/11/2024 at 2:50 PM, Resident 4 stated that the staff response to their call light was slow and that they had to wait an hour or more at times. Resident 4 stated that the slow response was frequent and that it didn't matter what time of day.

Review of the facility's call light report, dated 05/31/2024 through 06/13/2024, showed that Resident 4 had multiple times that they had to wait longer than 45 minutes for staff to respond. The document showed the following:

- On 06/02/2024 Resident 4 turned on their call light at 11:38 PM and it was turned off (indicating staff response to the call) on 06/03/2024 at 2:00 AM, 2 hours and 22 minutes after it was activated.
- On 06/03/2024 Resident 4 turned on their call light at 5:46 AM and it was turned off at 7:05 AM, 1 hour and 19 minutes after it was activated.
- On 06/06/2024 Resident 4 turned on their call light at 5:56 AM and it was turned off at 6:47 AM, 51 minutes after it was activated.
- On 06/06/2024 Resident 4 turned on their call light at 8:35 AM and it was turned off at 7:08 PM, 10 hours and 32 minutes after it was activated.
- On 06/06/2024 Resident 4 turned on their call light at 7:58 PM and it was turned

off at 8:54 PM, 55 minutes after it was activated.
- On 06/07/2024 Resident 4 turned on their call light at 5:06 PM and it was turned off at 5:51 PM, 45 minutes after it was activated.
- On 06/09/2024 Resident 4 turned on their call light at 1:03 PM and it was turned off at 1:58 PM, 54 minutes after it was activated.
- On 06/11/2024 Resident 4 turned on their call light at 2:52 PM and it was turned off at 3:45 PM, 52 minutes after it was activated.
- On 06/12/2024 Resident 4 turned on their call light at 2:08 PM and it was turned off at 3:14 PM, 1 hour and 5 minutes after it was activated.

Resident 12

Review of Resident 12's NSA, dated 05/21/2024, showed that the resident had diagnoses that included [redacted] and [redacted].

In an interview on 06/12/2024 at 11:34 AM, Resident 12 stated that they had to wait an hour for staff to respond to their call light. Resident 12 stated that the slow response happened often.

Review of the facility's call light report, dated 05/14/2024 through 06/13/2024, showed that Resident 12 had to wait longer than one hour for staff to respond. The document showed the following:

- On 05/14/2024 Resident 12 turned on their call light at 7:46 PM and it was turned off on 05/14/2024 at 8:51 PM, 1 hour and 4 minutes after it was activated.
- On 05/22/2024 Resident 12 turned on their call light at 7:17 PM and it was turned off at 8:17 PM, 1 hour after it was activated.
- On 05/23/2024 Resident 12 turned on their call light at 2:59 AM and it was turned off at 5:3 4 AM, 2 hours and 35 minutes after it was activated.
- On 05/30/2024 Resident 12 turned on their call light at 1:10 AM and it was turned off at 2:18 AM, 1 hour and 8 minutes after it was activated.
- On 05/31/2024 Resident 12 turned on their call light at 6:01 AM and it was turned off at 7:11 AM, 1 hour and 9 minutes after it was activated.
- On 06/01/2024 Resident 12 turned on their call light at 06:52 AM and it was turned off at 7:53 AM, 1 hour and 1 minute after it was activated.
- On 06/08/2024 Resident 12 turned on their call light at 2:10 AM and it was turned off at 4:02 AM, 1 hour and 52 minutes after it was activated.
- On 06/09/2024 Resident 12 turned on their call light at 12:48 AM and it was turned off at 2:18 AM, 1 hour and 29 minutes after it was activated.
- On 06/10/2024 Resident 12 turned on their call light at 6:15 AM and it was turned off at 8:09 AM, 1 hour and 54 minutes after it was activated.
- On 06/11/2024 Resident 12 turned on their call light at 8:21 PM and it was turned off at 9:30 PM, 1 hour and 8 minutes after it was activated.
- On 06/12/2024 Resident 12 turned on their call light at 6:28 AM and it was turned off at 7:30 AM, 1 hour and 2 minutes after it was activated.

Resident 6

Review of Resident 6's NSA, dated 03/12/2024, showed that the resident had diagnoses that included [redacted], and [redacted].

In an interview on 06/12/2024 at 23:16 PM, Resident 6 stated that staff were slow to respond to call lights. Resident 6 stated that they often had to wait more than 30 minutes.

Review of the facility's call light report, dated 05/15/2024 through 06/13/2024, showed that Resident 6 had to wait longer than 45 minutes for staff to respond. The document showed the following:

- On 05/17/2024 Resident 6 turned on their call light at 12:58 PM and it was turned off at 3:10 PM, 2 hours and 12 minutes after it was activated.
- On 06/08/2024 Resident 6 turned on their call light at 8:13 AM and it was turned off at 12:00 PM, 3 hours and 46 minutes after it was activated.

Resident 1

Review of Resident 1's NSA, dated 06/10/2024, showed that the resident had diagnoses that included [redacted], and [redacted].

In an interview on 06/12/2024 at 10:02 AM, Resident 1 stated that response time for call lights was slow. Resident 1 stated that they would have to wait for up to an hour for staff to respond.

Review of the facility's call light report, dated 05/15/2024 through 06/13/2024, showed that Resident 1 had to wait longer than 40 minutes for staff to respond. The document showed the following:

- On 05/15/2024 Resident 1 turned on their call light at 7:54 AM and it was turned off at 8:34 AM, 40 minutes after it was activated.
- On 05/16/2024 Resident 1 turned on their call light at 2:55 AM and it was turned off at 4:33 AM, 1 hour and 38 minutes after it was activated.
- On 05/23/2024 Resident 1 turned on their call light at 1:26 PM and it was turned off at 2:19 PM, 52 minutes after it was activated.
- On 5/24/2024 Resident 1 turned on their call light at 11:22 PM and it was turned off on 05/25/2024 at 12:03 AM, 40 minutes after it was activated.

In an interview on 06/13/2024 at 11:55 AM, Staff A, Administrator, stated that the

responses to call lights were too long and that they were notified that the staff did not have pagers to alert them of activated call lights.

<24-month admission agreements>

In an interview on 06/13/2024, Staff I, Business Office Coordinator (BOC), stated that they were responsible for maintaining and tracking resident rental agreements.

Resident 1

Resident 1's personnel file contained an admission agreement, dated 07/19/2017, that documented services, items, activities, and charges as well as rules of operation. The file did not contain an admission agreement completed and reviewed with the resident and or representative within the last 24 months.

In an interview on 06/13/2024 at 11:00 AM, Staff I stated that there was no current admission agreement on file for Resident 1.

Resident 2

Resident 2's personnel file contained an admission agreement, dated 06/13/2024, that documented services, items, activities, and charges as well as rules of operation. Additionally, the previous signed and dated admission agreement was completed 05/24/2022.

In an interview on 06/13/2024 at 11:00 AM, Staff I stated that they knew the admission agreement was late and the facility had completed an audit and found that the resident's admission agreement needed to be completed.

Resident 3

Resident 3's personnel file contained an admission agreement, dated 06/12/2024, that documented services, items, activities, and charges as well as rules of operation. Additionally, the previous signed and dated admission agreement was completed 07/19/2017.

Resident 5

Resident 5's personnel file contained an admission agreement, dated 02/06/2024 that

documented services, items, activities, and charges as well as rules of operation. Additionally, the previous signed and dated admission agreement was completed 09/2017.

Resident 8

Resident 8's personnel file contained an admission agreement, dated 09/16/2020, that documented services, items, activities, and charges as well as rules of operation. The file did not contain an admission agreement completed and reviewed with the resident and or representative within the last 24 months.

In an interview on 06/13/2024 at 11:00 AM, Staff I stated that during this week's inspection, the ALF had completed an audit and noticed that the admission agreements were not completed and they started to update them.

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

Administrator (or Representative) 7.9.24 Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that staff had completed respirator mask medical clearance and respirator fit testing prior to providing care and services to residents for 5 of 5 staff (Staff A, B, C, D, and E). This failure placed residents, staff, and visitors at risk for exposure to respiratory infection.

Findings included...

Plan/Attestation Statement

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WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that staff had completed respirator mask medical clearance and respirator fit testing prior to providing care and services to residents for 5 of 5 staff (Staff A, B, C, D, and E). This failure placed residents, staff, and visitors at risk for exposure to respiratory infection.

Findings included...

Per WAC 296-842-15005, facilities must conduct fit testing (test completed by specially trained personnel to ensure N95 mask seals effectively to reduce the chance of exposure to respiratory viruses) before employees are assigned duties that may require the use of respirators and at least every twelve months after initial testing.

Review of a Department of Social and Health Services provider letter, dated 09/14/2023, showed that employers in long term care settings are responsible to "follow regulations pertaining to respiratory protection."

Findings included...

Review of Staff A's personnel file showed that they were hired on 03/11/2024 as the administrator. Further review of the file showed no documentation of medical clearance or respirator fit testing.

Review of Staff B's personnel file showed that they were hired on 02/13/2024 as the licensed practical nurse/Health and Wellness Director. Further review of the file showed no documentation of medical clearance or respirator fit testing.

Review of Staff C's personnel file showed that they were hired on 4/24/2024 as a day shift caregiver. Further review of the file showed no documentation of medical clearance or respirator fit testing.

Review of Staff D's personnel file showed that they were hired on 04/02/2023 as an evening shift caregiver. Further review of the file showed no documentation of medical clearance or respirator fit testing.

Review of Staff E's personnel file showed that they were hired on 08/09/2020 as a day and night shift caregiver. Further review of the file showed no documentation of medical clearance or respirator fit testing.

In an interview on 06/13/2024 at 10:00 AM, Staff I, Business Office Coordinator, was asked if the ALF had an respiratory protection plan (RPP), which included medical clearance and respirator fit testing for staff. Staff I stated that the ALF did not have an RPP yet.

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Administrator (or Representative) 7-9-24 Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a valid Washington state name and date of birth background check was submitted every two years when staff worked in the ALF for more than two years, for 2 of 2 staff (Staff E, F). This failed practice placed residents at risk of being cared for by a disqualified staff member.

Findings included...

Review of Staff E's business file showed that they were hired on 08/09/2020 as a caregiver. Their file showed a Washington state name and date of birth background check result that was completed on 07/29/2020 and expired on 07/29/2022. Their file showed the next Washington state name and date of birth background check was completed on 05/17/2024 (659 days after the expiration date).

Review of Staff F's business file showed that they were hired on 09/24/2017 as a caregiver. Their file showed a Washington state name and date of birth background check result that was completed on 04/02/2020 and expired on 04/02/2022. Their file showed the next Washington state name and date of birth background check was completed on 11/06/2023 (583 days after the expiration date).

On 06/13/2024 at 11:11 AM, Staff I, Business Office Coordinator, stated that they were unsure why the two-year background checks were not completed as required.

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 Richland is or will be in compliance with this law and / or regulation on (Date)_____ .

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(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a valid Washington state name and date of birth background check was submitted every two years when staff worked in the ALF for more than two years, for 2 of 2 staff (Staff E, F). This failed practice placed residents at risk of being cared for by a disqualified staff member.

Findings included...

Review of Staff E's business file showed that they were hired on 08/09/2020 as a caregiver. Their file showed a Washington state name and date of birth background check result that was completed on 07/29/2020 and expired on 07/29/2022. Their file showed the next Washington state name and date of birth background check was completed on 05/17/2024 (659 days after the expiration date).

Review of Staff F's business file showed that they were hired on 09/24/2017 as a caregiver. Their file showed a Washington state name and date of birth background check result that was completed on 04/02/2020 and expired on 04/02/2022. Their file showed the next Washington state name and date of birth background check was completed on 11/06/2023 (583 days after the expiration date).

On 06/13/2024 at 11:11 AM, Staff I, Business Office Coordinator, stated that they were unsure why the two-year background checks were not completed as required.

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WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a review to determine the Character, Competency, and Suitability (CCS) to work with vulnerable adults for 2 of 2 staff (E and F) reviewed for non-disqualifying background checks. This failure placed all residents at risk of being cared for by potential unqualified staff.

Findings included...

Review of Staff E's personnel file showed that they were hired on 08/09/2020 as a caregiver. Staff E's file had a Washington state name and date of birth background check result, dated 05/17/2024, which showed that Staff E had a non-disqualifying crime, and a review was required. Staff E's file did not include a CCS review to determine their ability to work with vulnerable adults in the ALF.

Review of Staff F's personnel file showed that they were hired on 09/24/2017 as a caregiver. Staff F's file had two Washington state name and date of birth background check results dated 04/02/2020 and 11/06/2023, both of which showed that Staff F had a non-disqualifying crime, and a review was required. Staff F's file did not include a CCS review to determine their ability to work with vulnerable adults in the ALF.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a review to determine the Character, Competency, and Suitability (CCS) to work with vulnerable adults for 2 of 2 staff (E and F) reviewed for non-disqualifying background checks. This failure placed all residents at risk of being cared for by potential unqualified staff.

Findings included...

Review of Staff E's personnel file showed that they were hired on 08/09/2020 as a caregiver. Staff E's file had a Washington state name and date of birth background check result, dated 05/17/2024, which showed that Staff E had a non-disqualifying crime, and a review was required. Staff E's file did not include a CCS review to determine their ability to work with vulnerable adults in the ALF.

Review of Staff F's personnel file showed that they were hired on 09/24/2017 as a caregiver. Staff F's file had two Washington state name and date of birth background check results dated 04/02/2020 and 11/06/2023, both of which showed that Staff F had a non-disqualifying crime, and a review was required. Staff F's file did not include a CCS review to determine their ability to work with vulnerable adults in the ALF.

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In an interview on 06/13/2024 at 11:11 AM, Staff I, Business Office Coordinator, stated that the facility had a process in place to ensure CCS reviews were completed although the process had not been followed.

Plan/Attestation Statement

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Administrator (or Representative) 7-9-24 Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure screening for Tuberculosis (TB) was completed within three days of hire for 2 of 4 staff (Staff A and B). This failed practice placed residents at risk of potential exposure to a communicable disease.

Findings included...

Review of Staff A's personnel file showed that they were hired on 03/11/2024 as the Administrator. Staff A's file showed that they had a first step TB skin test completed on 04/22/2024, 42 days after their hire date and not within three days of hire as required.

Review of Staff B's personnel file showed that they were hired on 02/13/2024 as a Health and Wellness Director. Staff B's file showed that they had a first step TB skin test completed on 03/06/2024, 22 days after their hire date and not within three days of hire as required.

In an interview on 06/13/2024 at 10:24 AM, Staff I, Business Office Coordinator, stated that they did not know that the TB testing needed to be done within three days of hire.

In an interview on 06/13/2024 at 11:11 AM, Staff I, Business Office Coordinator, stated that the facility had a process in place to ensure CCS reviews were completed although the process had not been followed.

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 Richland 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-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure screening for Tuberculosis (TB) was completed within three days of hire for 2 of 4 staff (Staff A and B). This failed practice placed residents at risk of potential exposure to a communicable disease.

Findings included...

Review of Staff A's personnel file showed that they were hired on 03/11/2024 as the Administrator. Staff A's file showed that they had a first step TB skin test completed on 04/22/2024, 42 days after their hire date and not within three days of hire as required.

Review of Staff B's personnel file showed that they were hired on 02/13/2024 as a Health and Wellness Director. Staff B's file showed that they had a first step TB skin test completed on 03/06/2024, 22 days after their hire date and not within three days of hire as required.

In an interview on 06/13/2024 at 10:24 AM, Staff I, Business Office Coordinator, stated that they did not know that the TB testing needed to be done within three days of hire.

Statement of Deficiencies	License #: 1696	Compliance Determination # 42253
Plan of Correction	Brookdale Richland	Completion Date
Page 25 of 25	Licensee: BROOKDALE SENIOR LIVING	06/19/2024

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 Richland is or will be in compliance with this law and / or regulation on (Date) 7-31-24.

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

Administrator (or Representative) Date 7-9-24

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 Richland 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

Michelle Closner

Region 1, Unit G
Residential Care Services
1200 Alder St
Union Gap, WA 98903

The following is the Plan of Correction for Brookdale Richland regarding the Statement of Deficiencies dated 6/19/2024. 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.

WAC 388-78A-2371: Investigations

(Resident 5)

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice:

- *Resident 5: Investigation completed on 6/11/24. Resident is on hospice. Foot rests have been added to the resident's wheelchair.*

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:

- *Staff education on investigation policies and procedures and reporting responsibilities to be completed on or before 7/12/2024.*
- *Testing will be administered after training to ensure competency and understanding education of investigation policies and procedures and reporting responsibilities, completed on or before 7/12/2024.*

Element 3.
Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *Med Tech on shift will complete incident report when incidents occur and report to HWD.*
- *ED or designee to note incidents on incident report log and ensure investigation is complete*

• **Element 5**. Date by which the correction will be made. 7.12.2024

WAC 388-78A-2100: Ongoing Assessments

(Resident 7)

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice:

- Resident 7 Health & Wellness Director (HWD) or Designee to complete mobility assessment on before 7/5/24
- Resident 8 – Health & Wellness Director (HWD) or Designee to complete Self-Medication assessment on before 7/5/24

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:

- ED, HWD or Designee will complete audit of occupied resident rooms for mobility aids or devices on or before 7/12/24
- ED, HWD or Designee to review audit and ensure that Mobility Device Assessment are completed or device has been removed by 7/19/24
- ED, HWD or Designee will complete audit of residents for self-medication assessments by 7/12/2024

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee.*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *ED or Designee to educate new Residents and POA/family member on admission for mobility device policy.*
- *Staff will report any new mobility device during clinical meeting to Executive Director, Health Wellness Director, or Designee.*

Element 5. Date by which the correction will be made 7/19/2024

WAC 388-78A-2120: Monitoring Residents Well-Being

(Residents 8,4)

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice;

- *Resident 8– Correction made and medication received on 6/12/24 notification to doctor made 7/2/2024 HWD/ED*
- *Resident 4- Was assessed on 6/11/24 after returning from rehab. Assessment for mobility device completed on 6/24/24*
- *HWD, RCC or Designee will complete education* on documentation of falls and incident reports completed by 7/12/24

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:

- *HWD, RCC or Designee will review PCC Dashboard daily for medications not administered.*
- *HWD, RCC or Designee will document, contact physician/primary care provider and contact pharmacy for medication.*
- *HWD, RCC or Designee will review documentation on TSPs during clinical meeting*
- *HWD, RCC or Designee will complete education on documentation for Med Techs on incidents by 7/12/24*

Element 3. Who is responsible for the corrective action; *Executive Director or Designee, Health & Wellness Director*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *Medication Technicians will compete LMS Medication Management Modules prior to administering Medications on or before 7/12/24*
- *Medication Observation Form will be completed on Medication Technicians by HWD, HWC or Designee*
- *In-service to be conducted on Med Passer PCC Workflow for success on or before 7/12/24*
- *HWD, RCC or Designee will review PCC Dashboard daily for medications not administered.*
- *HWD, RCC or Designee will document, contact physician and contact pharmacy for medication when needed.*
- *HWD, RCC or Designee will review new progress notes during daily clinical meeting*
- *Brookdale Clinical Guideline for Fall Interventions will be available in the communication book for immediate interventions after falls*

Element 5. Date by which the correction will be made: *7.12.2024*

WAC 388-7A-2140: Negotiated service agreement contents

(Resident 1)

Element 1: What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice;

- *NSA was updated to reflect the instructions of when to check blood pressure and directions on follow-up. Corrected 7.3.24.*

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:

- *HWD, RCC or Designee will pull order listing report in Point Click Care and identify any other residents that have blood pressure checks that require reporting to assigned primary care provider by 7/12/24*
- *HWD, RCC or Designee will audit current orders of residents to assure accuracy in PCC by 7/31/24*

Element 3. Who is responsible for the corrective action;

- *Executive Director, Health & Wellness Director, or Designee.*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *HWD, RCC or Designee will pull the order listing report will at end of each month and residents that were identified that require blood pressure monitoring and reporting will be faxed to the provider at that time.*

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

- *Resident 1 was corrected 7.5.24. For other resident's identified will pull report monthly and will be corrected by 07.31.24*

WAC 388-7A-2210: Medication Services

Residents 7,8

(Resident 7)

Element 1: What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice;

Resident 7: this was corrected by HWD on 04.08.24 and noted in PCC and Physician was notified

Element 2: How will the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken:

- *HWD, RCC or Designee will run non-administered medication list daily and will follow-up on any missing medications 7 days prior to last dose.*
- *HWD, RCC or Designee have implemented the double check system for new orders to verify transcription is correct.*

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *HWD, RCC or Designee will complete quarterly recaps and during clinical meeting with review of new medications entered into Point Click Care.*

Element 5.

Date by which the correction will be made:

- *Resident 7 was corrected 7.5.24. For other resident's identified will pull report monthly and will be corrected by 07.31.24.*

(Resident 8)

Element 1: What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice;

- *Resident 8: physician was notified that resident had missed medication. RCC faxed to pharmacy 6/12/24 and resident received medication same day*

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:

- *HWD, RCC or Designee* will review PCC Dashboard daily for medications not administered. *HWD, RCC or Designee* will document, contact physician and contact pharmacy for medication.

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *HWD, RCC or Designee* will review Point Click Care Dashboard daily for medications not administered.
- *HWD, RCC or Designee* will document, contact physician and contact pharmacy for medication.
- Residents that have missing medications will be subject to monitoring for well-being if medications not available are prescribed medications.

Element 5.

Date by which the correction will be made:

- Resident 8 was corrected 6/12/24. For other resident's identified will pull report monthly and will be corrected by 07.31.24.

WAC 388-78A-2660 Resident Rights: RCW 70. 129.030: Notice of Rights and Services: RCW 70.129.140: Quality of Life

Element 1: What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice;

- *Residents 1,2, 4, 5, 6,8, & 12 NSA's were reviewed for accuracy and care needs and will be corrected if applicable by the 07.12.24.*
- *Call light reports pulled and reviewed multiple days in a row and reviewed with staff; including education on the call light policy - corrected on 06.27.24.*

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:

- *Call report for residents will be pulled, reviewed and discussed at stand-up meeting.*

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *HWD, RCC or Designee will conduct ongoing monitoring by pulling report daily to review call light times.*
- *Clinical team to evaluate call light reports weekly to determine potential interventions*

Element 5.

Date by which the correction will be made: 7.12.24

RCW-70.129.040: Admission Agreements:

(Residents 1, 2, 3, 5, & 8)

Element 1: What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice;

Identified residents were corrected on or by 7/3

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:

- *A full audit will be completed on other residents*

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Business Office Coordinator, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *ED, BOC or Designee will pull rent roll report monthly to identify resident's agreement signing no greater than 22 months.*

Element 5.

Date by which the correction will be made: 7.31.24

WAC-388-78A-2730: Licensees Responsibilities & WAC 296-842-15005: Fit Testing

(Staff A, B, C, D, E)

Element 1: What corrective actions will be taken for the current staff members found to have been affected by the alleged deficient practice;

- *Staff identified during survey will be corrected by 7.26.24*

Element 2: How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken:

- *Personnel files were audited to correct this deficient practice and identified associates will be scheduled for Fit Testing.*

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *New staff members will have Fit Testing completed within 3 days of hire and prior to resident contact.*

Element 5.

Date by which the correction will be made: *Fit Testing for other identified staff members will be completed by 7.31.24*

WAC-388-78-A-2466: Background Checks

(Staff E&F)

Element 1: What corrective actions will be taken for the current staff members found to have been affected by the alleged deficient practice;

- *Staff E & F Backgrounds checks were out of compliance and were corrected upon Survey exit 06.13.24.*

Element 2: How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken:

- *An audit will be conducted and completed by 7.12.24 for any other deficient practices.*

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);

- *Auditing will be completed for the first of the month for the following 60 days.*

Element 5. Date by which the correction will be made: 7.12.24

WAC 388-78A-24701: Background Checks

Staff E&F

Element 1: What corrective actions will be taken for the current staff members found to have been affected by the alleged deficient practice;

- *Staff E & F Character, Competency, and Suitability were out of compliance and were corrected upon exit 06.13.24*

Element 2: How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken:

- *A full audit will be conducted and completed by 7.12.24 for any other deficient practices.*

Element 3. Who is responsible for the corrective action; *Executive Director, Health & Wellness Director, or designee*

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance);