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) 25206 (Completion Date 06/12/2023) and 22853 (Completion Date 04/20/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/12/2023 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-2260-1; WAC 388-78A-2260-2-d

The Department staff who did the on-site verification:
Laurel Knight, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Richland
Provider Type: Assisted Living Facility
License/Cert.#: 1696
Compliance Determination #: 22853
Intake ID: 76631
Investigator: Nancy Mullins
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/18/2023 through 04/20/2023
Complainant Contact Date(s):

Allegation(s):
1. Medications were not stored securely and in a clean manner.

Investigation Methods:

Sample:	Total residents: 97 Resident sample size: 3 Closed records sample size: 0
Observations:	Secure and clean medication storage Environment
Interviews:	Three residents Medication Aides Nurse Facility Director
Record Reviews:	Facility policy on medication storage Sample residents medication administration records

Investigation Summary:
1. As observed medications were stored unlocked and in an unclean area. Per interview with medication aide they did not know who left the area unlocked and unclean. Medication storage policy showed the facility did not follow its policy for storage of medications in a locked and clean area. Failed facility practice was found. Failed practice was documented in a Statement Of Deficiencies under Washington Administration Code 388-78A-2260 (1) (2) (d) Storing, securing, and accounting for medications.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 1696	Compliance Determination # 22853
Plan of Correction	Brookdale Richland	Completion Date
Page 1 of 3	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	04/20/2023

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 04/18/2023, 04/18/2023 and 04/20/2023 of:

Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following complaint number(s): 76631

The following sample was selected for review during the unannounced on-site visit: 3 of 97 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nancy Mullins
Jessica Salquist, Regional Administrator
Craig Prinn

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

04/27/2023
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.

Administrator (or Representative) — Date: 5-5-23

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure medications were properly stored in a secured/locked area only accessible to designated responsible staff persons for 1 of 1 (Medication Room 1). This failure placed residents at risk by allowing access to medications that could potentially be harmful if taken.

Findings included...

Review of the facility policy titled "Medication & Treatment -Storage Policy" dated 10/2006 showed the facility should store medications locked when not in use or when not attended and the medication storage should be clean and orderly.

A tour of the facility began on 04/18/2023 that at 10:00 AM, Department staff had been accompanied by Staff A, Nurse. During the tour the Medication Room 1's door was observed to be propped open with a gallon jug of hand sanitizer. Further observation showed the night shift medication cart had been left unlocked with resident medications inside the cart within the Medication Room. The cabinet located inside the medication room was observed to be unlocked with numerous packets of bubble pack medications inside the medication cabinet from previous residents already discharged.

Further observations continued on the tour, showed the night shift medication cart to be unlocked with no staff nearby. Observation of medication cart showed two bottles of over-the-counter medication (Calcium 500mg D3 and D3 50 mcg) both missing lids from the top of the containers.

An interview was conducted at the facility on 04/18/2023 at 10:45 AM with Staff A. Staff A gave no explanation why the medications and Medication Room 1's door had been left unlocked/unsecured. Staff A stated the medication cabinet did not have a key to fit the lock on the cabinet. Staff A stated, medications should have been locked and the medication of previous residents should have been destroyed.

Interviews were conducted on 04/18/2023 with Staff B, Medication Tech at 10:20 AM and Staff C, Medication Tech at 10:25 AM, who both stated they did not know who propped Medication Room 1's door open or why the night shift medication cart had been left unlocked.

Review of the undated night shift Medication Tech duties hanging on the wall inside the Medication Room 1, showed it was the duty of the night shift Medication Tech to sanitize the medication cart at the beginning of shift, mid shift, and end of shift.

A telephone interview was conducted on 04/18/2023 at 11:50 AM with the Night Shift Staff E, Med Tech. Staff E gave no explanation why the nightshift medication cart was left unlocked.

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) 6-2-23 .

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

H Davis — 5-5-23

Administrator (or Representative) — Date