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) 32332 (Completion Date 11/09/2023) and 27300 (Completion Date 09/05/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/09/2023 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-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Laurel Knight, 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 Richland
Provider Type: Assisted Living Facility
License/Cert.#: 1696
Compliance Determination #: 27300
Intake ID: 91438
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 07/28/2023 through 09/05/2023
Complainant Contact Date(s):

Allegation(s):

1. Identified Resident did not receive diabetic medications as ordered.

Investigation Methods:

Sample:	Total residents: 95 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Residents Identified staff
Record Reviews:	Medical records including negotiated service agreement, assessments, notes, medication administration records, , temporary updates to the service plan, incident reports and investigations.

Investigation Summary:

1. Identified resident interview confirmed they had high and low blood sugars that required an ambulance trip to the emergency department. Facility staff stated that there was a transcription and insulin administration error that caused the resident to receive extra insulin. Facility investigation showed the resident was given incorrect insulin doses twice and that the resident required intervention and medical evaluation. Deficient practice identified, please see the statement of deficiency dated 09/05/2023 for citations related to medication services 388-78a-2210.

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 # 27300
Plan of Correction	Brookdale Richland	Completion Date
Page 1 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	09/05/2023

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 07/28/2023 and 08/07/2023 of:

Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following complaint number(s): 89820, 91438, 91140

The following sample was selected for review during the unannounced on-site visit: 5 of 95 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, 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

09/14/2023
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) 9-22-23 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 interview, and record review, the Assisted Living Facility (ALF) failed to ensure safe medication systems were implemented for 1 of 3 residents (Resident 1) reviewed for medication services. This failure resulted in Resident 1 being sent to the hospital's emergency department after receiving their prescribed medications incorrectly and placed other residents at risk for medication errors.

Findings included...

Review of the facility's policy titled, "Medication and Treatment Administration Assistance," revised on 03/31/2022, showed that medication assistance and administration would be in accordance with the prescriber's order. Staff would perform the checks to ensure that the right medication, and right dosage was given at the right time to the right resident by the right method prior to giving the medication.

Review of the facility's policy titled "Transcription of Orders," dated August 2022 showed that new physician/healthcare provider orders received by the community would be reviewed by the nurse or designee and transcribed in the appropriate electronic medication administration record, (E-MAR) and the designated staff would sign and date the order upon completion of the transcription. The nurse would review the transcription for accuracy and co-sign and date the order if accurate.

The Centers for Disease Control and Prevention resources from September 2022, showed blood sugar typical target range levels are 80-130 milligrams per deciliter, (mg/dL) (unit of measure that shows the concentration of a sugar in the blood) prior to eating and less than 180 mg/dL two hours after eating.

Resident 1

Review of Resident 1's Negotiated Service Agreement (NSA) dated 07/03/2023 showed that the facility managed and assisted Resident 1 with their medications. Resident 1's diagnoses included [redacted]

Review of a physician's order dated 07/26/2023 Lispro Insulin (short acting insulin given pre-meal) 100 units/ml sliding scale: inject subcutaneously per sliding scale (progressive increase in insulin dose dependent on blood sugar level) three times daily before meals:

If 150-200 = 2 units
201-250 = 4 units
251-300 = 6 units
301-350 = 8 units
351-400 = 12 units, give 12 units and call provider

Review of the July 2023 Medication Administration Record (MAR) showed a Lispro Insulin 100 units/ milliliter (ml) order entered on 07/26/2023 by Staff C, Medication Technician (MT) that showed the resident was to receive 12 units of Lispro Insulin injection solution 100 units/milliliter (ml) with meals three times daily. The MAR showed only the 12 units dose and did not show the sliding scale portion of the order.

Review of the facility's incident report dated, 07/27/2023, showed that Resident 1 had a blood sugar of 173 mg/dl and received 12 units of Lispro Insulin 100 units/ml at 7:30 AM on 07/27/2023. The resident's blood sugar was rechecked at 10:07 AM when they finished breakfast and Resident 1 reported feeling dizzy and shaky. Resident 1 had a blood sugar of 58 mg/dL, and the resident was sent to the hospital emergency department for evaluation. The sliding scale dose should have been 2 units for a blood sugar of 173. Resident 1 received 10 units more of Lispro insulin than ordered.

The facility's investigation dated 07/27/2023 completed by Staff B, Health and Wellness Director/facility licensed nurse showed the resident received two incorrect dosages of insulin on 07/27/2023. Staff D, MT gave the resident 4 units of Lispro Insulin 100 units/ml from memory at 6:30 AM and did not document the administration on the MAR. Further, the investigation showed that Staff E, MT followed the incorrectly transcribed MAR order dated 07/26/2023 to give 12 units of Lispro Insulin 100 units/ml On 07/27/2023 at 7:30 AM causing the blood sugar levels to decrease. Resident 1 received a total of 14 units more insulin than ordered.

During an interview on 09/05/2023 at 11:03 AM Staff A, Executive Director stated that Resident 1 had new orders that were not transcribed correctly to show the sliding scale on 07/26/2023 by Staff C. Staff A stated that the orders were reviewed and corrected by Staff B on 07/27/2023 after the resident had already received a dose of insulin from both Staff D and E. Staff D had not referred to the MAR for the correct insulin dose and recalled from memory an incorrect insulin dose that was administered to Resident 1.

Statement of Deficiencies	License #: 1696	Compliance Determination # 27300
Plan of Correction	Brookdale Richland	Completion Date
Page 4 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	09/05/2023

This is a recurring deficiency previously cited on 04/05/2023.

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) 10-20-23.

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

Administrator (or Representative) — Date: 9-22-23