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

AMENDED
06/26/2024

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) 43127 (Completion Date 06/25/2024) and 39473 (Completion Date 04/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/25/2024 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-2474-2-a, WAC 388-112A-0220-1, WAC 388-112A-0220-2-a, WAC 388-78A-2474-5, WAC 388-78A-2474-4, WAC 246-980-030-1-b, WAC 388-78A-2450-2-h, WAC 388-78A-2450-2-h-i, WAC 388-78A-2450-2-h-ii, WAC 388-78A-2450-2-h-iii, WAC 388-78A-2450-2-h-iv, WAC 388-78A-2450-2-h-v, WAC 388-78A-2450-2-h-vi, WAC 388-78A-2450-2-h-vii

The Department staff who did the on-site verification:
Laurel Knight, Community Complaint Investigator
Michelle Closner, Complaint Nurse Field Manager

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

Sincerely,

Michelle Closner, 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 #: 39473
Intake ID: 125901
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/09/2024 through 04/29/2024
Complainant Contact Date(s): 04/09/2024, 04/30/2024

Allegation(s):

1. Unknown residents did not get their insulin (injections to regulate blood sugars), and the management team was aware of the incident.
2. A named resident was being mean to their spouse.
3. A named resident was not getting the help they needed, and the reporter wasn't sure if the resident's sheets got changed or if they were being helped with eating.
4. A named resident's window was left open due to them having diarrhea, and the resident was on end-of-life care services.
5. A named resident had a swollen left hand, was on comfort meds, but there wasn't a care plan for them, and staff were told not to feed, change or provide care to them.
6. A named resident who was a fall risk was not getting changed, was being neglected, didn't get meals and had to shower themselves due to missing a bath. Resident is a fall risk.
7. A named resident was feeling neglected and only night shift checked on them.
8. A named resident didn't get their briefs changed and had sores on their bottom.

Investigation Methods:

Sample:
Total residents: 85
Resident sample size: 19
Closed records sample size: 1

Observations:
Identified resident
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
General facility environment

Interviews:
Identified resident
Identified staff
Nursing staff
Residents
Family members
Business office manager
Administrator
Others not associated with the facility

Record Reviews: Resident characteristic roster
Medical records (face sheets, care plans, temporary care plans, progress notes, medication administration records)
Incident investigation
Facility policies
Personnel files
Staff training records
Staff patterns

Investigation Summary:

1. Interview and record review showed that during one evening shift, the Medication Technician (MT) who worked that shift was not delegated to be able to give insulin, so 10 residents did not get their insulin. The residents did not display adverse outcome as a result of missing their doses. The ALF investigated the incident and implemented preventative measure. The ALF made the required notifications and followed their policies and procedures. Investigation showed that staff did not have did not have the required trainings for long term care workers. Failed practice identified see WAC 388-78a-2474/WAC 246-980-030; WAC 388-78a-2450; WAC 388-78a-2450/388-112a-0220.
2. Interview and record review showed that the ALF investigated the incident, separated the two residents, and protected residents during the course of the investigation. The spouse was placed on one-to-one care until they could be moved to a different facility. The ALF followed their policies and procedures and made all required notifications. No failed provider practice identified.
3.. Observation showed that the resident's room was clean, sheets clean and dry. The resident denied feeling neglected. Interviews showed that the ALF had gotten behind on laundry due to staffing issues but was able to catch up. The named resident was independent with eating. The ALF followed the resident's care plan. No failed provider practice identified.
4. Identified resident stated that they had no concerns with care or treatment by staff. Their representative stated they frequently observed care and were satisfied. Facility staff stated that the resident had been declining and needed more care and services. Facility documentation showed the resident was being monitored. No failed practice identified.
5. Facility staff stated that the Named Resident was on end-of-life care and experienced severe pain with being repositioned. Facility documentation showed a negotiated service agreement (NSA) and progress notes showed an order that stated the resident was allowed to remain in bed for all Activities of Daily Living (ADL's) and to offer ADL's and repositioning as allowed due to pain. The documentation showed the resident was receiving medication for pain as well as left arm swelling. No failed practice identified.
6. Observation, interview and record review showed that the named resident was clean well groomed, their brief was dry, their bed was clean and dry. The resident denied being neglected and stated staff were very helpful. The named resident was not able to walk, staff escorted them to meals and gave them their showers as they could not do so alone. The ALF followed the resident's care plan. No failed provider practice identified.
7. Observation and interview showed that the resident was clean well dressed and groomed and in no acute distress. The named resident denied feeling neglected and said they did not need help like other residents did. The resident stated that staff came when they needed help, though sometimes they had to wait to get their call light answered. The ALF followed the resident's care plan. No failed provider practice identified.
8. Observation and interview showed that the resident was clean well dressed and groomed and in no acute distress. The named resident denied feeling neglected and

stated that staff always came whenever they needed help. The named resident's skin was intact. The ALF followed the resident's care plan. No failed provider practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 04/09/2024 and 04/09/2024 of:

Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following complaint number(s): 125901, 125718, 126382

The following sample was selected for review during the unannounced on-site visit: 19 of 85 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator
Robin Rainville, Assisted Living Facility 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.

Gwin Kaercher
Residential Care Services

05/03/2024
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) 5-10-24 Date

WAC 388-112A-0220 What is safety training, who must complete it, and when should it be completed?

(1) Safety training is part of the long-term care worker requirements. It is a three hour training that must meet the requirements of WAC 388-112A-0230 and include basic safety precautions, emergency procedures, and infection control.

(2) The following individuals must complete safety training:

(a) All long-term care workers who are not exempt from certification as described in RCW 18.88B.041 hired after January 7, 2012, must complete three hours of safety training. This safety training must be provided by qualified instructors that meet the requirements in WAC 388-112A-1260

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under chapter 388-112A WAC still apply to these individuals, except for registered nurses and licensed practical nurses.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff completed the orientation and safety trainings before providing care to residents, for 3 of 3 staff (Staff B, C and D) who were hired as long-term care workers. This failure placed residents at risk of being cared for by untrained staff.

Findings included...

Staff records were reviewed with Staff A, Business Office Manager, on 04/09/2024 at 1:21 PM. Staff A stated that they were responsible for maintaining and tracking staff records.

The file for Staff B, Caregiver showed that they were hired on 11/15/2023. Staff B's file did not show that they had a certificate to show they had completed the long-term care worker orientation and safety trainings before starting work with residents. Staff B was not exempt from long-term care worker training requirements when they were hired at the facility.

The file for Staff C, Caregiver showed that they were hired on 12/29/2023. Staff C's file did not show that they had a certificate to show they had completed the long-term care worker orientation and safety trainings. The file showed that Staff C was not exempt from long-term care worker training requirements when they were hired at the facility.

The file for Staff D, Medication Tech (MT), showed that they were hired on 02/22/2024. Staff C's file did not show that they had a certificate to show they had completed the long-term care worker orientation and safety trainings. The file showed that Staff D was not exempt from long-term care worker training requirements when they were hired at the facility.

In an interview with Staff A on 04/09/2024 at 3:18 PM they stated that they and the facility maintenance person held orientation and safety training, but they hadn't been scheduled very regularly.

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) 6-12-24.

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

Administrator (or Representative) 5-10-24 Date

WAC 246-980-030 Can a nonexempt long-term care worker work before obtaining certification as a home care aide?

(1) A nonexempt long-term care worker may provide care before receiving certification as a home care aide if all the following conditions are met:

(b) The long-term care worker must submit an application for home care aide certification

to the department within fourteen calendar days of hire. An application is considered to be submitted on the date it is post-marked or, for applications submitted in person or online, the date it is accepted by the department.

WAC 388-78A-2474 Training and home care aide certification requirements.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a Home Care Aide (HCA) application was sent to the department within 14 days of hire for 2 of 2 current Staff (B and C), who were not certified and had provided care to the residents in the facility. This failure placed residents at risk of being cared for by unqualified staff and precluded the department from the ability to track and monitor home care aide applicants.

Findings included...

Staff records were reviewed with Staff A, Business Office Manager (BOM) on 04/09/2024 at 1:21 PM. Staff A stated that they were responsible for ensuring that long term care workers HCA applications were submitted, and that training was completed as required.

Review of staff records showed that Staff B, Caregiver, was hired on 11/15/2023. Staff B's file did not include documentation of their qualification as a long-term care worker, which included an HCA application.

Review of staff records showed that Staff C, Caregiver, was hired on 12/09/2023. Staff C's file did not include documentation of their qualification as a long-term care worker, which included an HCA application.

On 04/09/2024 at 3:23 PM, Staff A stated that the facility previously used an online HCA course. Staff A Stated that they knew the HCA application had to be done within 14 days of hire and did not get it the applications submitted.

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) 6-12-24.

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

Statement of Deficiencies	License #: 1696	Compliance Determination # 39473
Plan of Correction	Brookdale Richland	Completion Date
Page 5 of 6	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	04/29/2024

Administrator (or Representative) 5-10-24 Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 current staff (Staff B, C, D) received facility orientation training as required. This failure placed residents at risk of being cared for by untrained staff.

Findings included...

Staff records review was conducted on 04/09/2024 at 1:21 PM with Staff B, Business Office Manager.

The file for Staff B, Caregiver, showed that they were hired at the ALF on 11/15/2023. Staff A's file did not contain documentation that they had received facility orientation.

The file for Staff C, Caregiver, showed that they were hired at the ALF on 12/29/2023. Staff D's file did not contain documentation that they had received facility orientation.

The file for Staff D, Caregiver, showed that they were hired at the ALF on 02/22/2024. Staff B's file did not contain documentation that they had received facility orientation.

In an interview with Staff A on 04/09/2024 at 3:18 PM they stated that they were not sure why the staff did not have facility orientation completed. Staff A stated that they and the facility maintenance person were the staff that held the facility orientation training.

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) 6-12-24

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

Administrator (or Representative) 5-10-24 Date

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

The following is the Plan of Correction for Brookdale Richland regarding the Statement of Deficiencies dated 04/29/2024. 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.

Deficiency #1: WAC 112A-0220 What is Safety Training, who must complete it and when should it be completed

(Staff B,C,D 3 of 3)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice: Identified Staff members have been assigned to ORSA training 5/10/2024 and 5/14/2024 to be completed by a qualified instructor. Other classes will then be completed weekly on an ongoing basis.

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 of all staff files was completed and those found to be deficient have been assigned to ORSA trainings. Community will have weekly trainings conducted by a qualified ORSA trainer that meet the requirements in WAC 388-112A-0220

Element 3. Who is responsible for the corrective action; Business Office Coordinator (BOC) Executive Director or Designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance): ORSA training will be validated for all new hires before resident contact and within 7 days of hire. Monitoring will be completed during morning stand-up meeting. BOC or designee to bring daily stand-up form to morning stand-up to review trainings with all managers to include, but not limited to, the new hire checklist for each new associate. Validation of ORSA training will be conducted prior to resident contact. Orientation and Safety Trainings will be conducted weekly by BOC or designee that meets the requirements in WAC 388-112A-0220

Element 5. Date by which the correction will be made. ***06/12/24***

Deficiency #2: WAC 388-78A-2474 Training and home care aide certification requirements

(Staff B, C, D, 3 of 3)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice: Identified Staff members have been assigned to Home Care Aide (HCA) safety and ORSA training 5/10/2024 and 5/14/2024

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 of all staff files was completed and those found to be deficient have been assigned to HCA courses and ORSA trainings and/or have completed the HCA Application.

Element 3. Who is responsible for the corrective action; Business Office Coordinator (BOC), Executive Director or Designee.

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance). HCA training will be validated for all new hires before resident contact and within 7 days of hire. Monitoring will be completed during morning stand-up meeting. BOC or designee to bring daily stand-up form to morning stand-up to review trainings with all managers to include, but not limited to, the new hire checklist for each new associate. Orientation and Safety Trainings will be conducted weekly by BOC or designee. HCA trainings conducted monthly by a qualified instructor.

Element 5. Date by which the correction will be made. ***06/12/24***

Deficiency #3: WAC 246-980-030 Can a nonexempt long-term care worker work before obtaining certification as a home care aide ***(Staff B and C, 2 of 2)***

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice: Identified Staff members have submitted an HCA application.

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 of all staff files was completed and those found to be deficient have submitted an HCA application and have been assigned to HCA courses.

Element 3. Who is responsible for the corrective action; Business Office Coordinator (BOC), Executive Director or Designee.

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance). HCA application submission training will be validated for all required associates within 14 days of hire. Monitoring will be completed during morning stand-up meeting. BOC or designee to bring daily stand-up form to morning stand-up to review trainings with all managers to include, but not limited to, the new hire checklist for each new associate.

Element 5. Date by which the correction will be made. ***06/12/24***

Deficiency #4: WAC 388-78A-2474 Training and home care aide certification requirements

(Staff B and C, 2 of 2)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice: Identified Staff members have been assigned to HCA safety and training ORSA training 5/10/2024 and 5/14/2024

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 of all staff files was completed and those found to be deficient have been assigned to HCA courses and ORSA trainings and/or have completed the HCA Application.

Element 3. Who is responsible for the corrective action; Business Office Coordinator (BOC), Executive Director or Designee.

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance). HCA training will be validated for all new hires before resident contact and within 7 days of hire. Monitoring will be completed during morning stand-up meeting. BOC or designee to bring daily stand-up form to morning stand-up to review trainings with all managers to include, but not limited to, the new hire checklist for each new associate. HCA trainings will be conducted monthly by a qualified instructor.

Element 5. Date by which the correction will be made. ***06/12/24***

Deficiency #4: WAC 388-78A-2450 Staff ***(Staff B, C, D 3 of 3)***

(Staff B, C, D 3 of 3)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice: Identified Staff members have completed the facility orientation to include: Organization of the assisted living facility, the physical assisted living layout, specific duties and responsibilities, how to report resident abuse and neglect consistent with chapter74.34 RCW and assisted living facilities policies and procedures, policies, procedures and equipment necessary to perform duties, needs and service preferences identified in the negotiated service agreements of residents with whom the staff person will be working and residents rights, including without limitation, those specified in chapter70.129 RCW. This has been documented in their personnel file as of 5/10/2024.

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 of all staff files was completed and those found to be deficient have been assigned to facility orientation trainings. Community will have weekly orientation conducted by BOC or designee.

Element 3. Who is responsible for the corrective action; Business Office Coordinator (BOC) Executive Director or Designee?

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance): Orientation will be validated for all new hires before resident contact by BOC or designee. Monitoring will be completed during morning stand-up meeting. BOC or designee to bring daily stand-up form to morning stand-up to review necessary trainings with all managers to include, but not limited to, the new hire checklist for each new associate. Validation of facility orientation by BOC or Designee will be conducted prior to resident contact.

Element 5. Date by which the correction will be made. ***06/12/24***