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) 40270 (Completion Date 04/24/2024) and 37432 (Completion Date 03/13/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/24/2024 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-2640-1-b, WAC 388-78A-2640-1-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 #: 37432
Intake ID: 118963
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 02/28/2024 through 03/13/2024
Complainant Contact Date(s): 02/27/2024, 03/19/2024

Allegation(s):

1. The facility sent the named resident to the hospital and did not notify their family.
2. The named resident's apartment was always dirty and laundry on the floor.
3. The named resident would urinate in a bucket and the facility staff would not empty it.
4. The named resident's infected toe's dressing change was not done by facility as the doctor ordered.
5. Facility staff never changed the named resident's sheets.
6. Facility staff would not assist the named resident with showers, toileting, and housekeeping.
7. Facility staff would not pick up and or remove the named resident's garbage.

Investigation Methods:

Sample:	Total residents: 104 Resident sample size: 12 Closed records sample size: 1
Observations:	The facility's common areas, sampled resident apartments, resident to resident and resident to staff interactions were observed.
Interviews:	Sampled residents, current residents, facility staff, and others not associated with the facility.
Record Reviews:	Characteristic roster, resident records (demographics, assessments, care plans, progress notes, shower sheets), incident investigations, and staff roster.

Investigation Summary:

1. Facility staff stated that they did not notify the representative of the need to send the resident to the hospital. Facility records showed the resident went to the Emergency Department and returned to the facility. Failed practice identified, see the Statement of Deficiency for 388-78a-2160 for failure to notify the resident's representative of the change in condition and the need for a hospital visit.
2. Facility staff interviews confirmed the resident did not always accept help with activities of daily living (ADLs) or routine assistance. Other sampled resident and their representative stated that they observed staff asking if they could provide care and

services for the resident and the resident was not willing. The resident's apartment was observed to be empty, the carpet had dark areas and a faint odor. No failed practice identified.
3. Staff interviews confirmed the resident preferred to use the bedside commode bucket instead of a urinal. The facility staff stated the resident was mostly willing to have them empty the bucket. No failed practice identified.
4. The resident representative stated that the dressing was not changed ever by the facility. Facility staff interviews confirmed the resident removed their own dressing and then it would be replaced to reduce the pain from the two toes touching each other. Facility incident report showed the wound was assessed and the dressings checked and reapplied. No failed practice identified.
5. Facility staff interviews confirmed that the resident would not always accept help with ADLs or routine assistance. Other sampled resident and their representative stated that they observed staff asking if they could provide care and services for the resident and the resident was not willing to allow staff assistance. No failed practice identified.
6. Facility staff interviews confirmed that the resident would not always accept assistance with ADLs or routine assistance. No failed practice identified.
7. Facility staff interviews showed that staff would pick up and remove the garbage from the resident's apartment. No failed practice identified.

Conclusion / Action:

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

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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 02/28/2024 and 03/04/2024 of:

Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following complaint number(s): 120152, 120156, 119611, 120147, 118251, 118963, 118936, 121132, 121210

The following sample was selected for review during the unannounced on-site visit: 12 of 104 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator
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.

Gwin Kaercher
Residential Care Services

03/22/2024
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: 2-22-24

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff reported to the resident's representative when a change in resident condition caused an Emergency Department (ED) visit for 1 of 3 residents (Resident 1). This failure resulted in the representative not receiving notice that the resident was transported to the ED for evaluation.

Findings included...

A review of Resident 1's record included a Negotiated Service Agreement, (NSA) dated 01/25/2024. The NSA showed that the resident had a diagnosis of [redacted] and [redacted].

On 02/27/2024 at 9:25 AM, Collateral Contact 1 (CC1) stated that the facility had not called them when Resident 1 was sent to the ED and stated that this was not the first time that they were not notified.

On 02/28/2024 at 11:00 AM interview with Staff A, Registered Nurse/Health Wellness Director, was asked if Resident 1's family were notified when the facility sent the resident to the ER. Staff A stated that the Medication Technician (MT) usually do the notifications to family and was not sure why the family was not notified.

On 02/28/2024 at 11:00 AM, Staff B, Caregiver stated that they had not notified Resident 1's representative and that it was the Medication Technician's (MT) responsibility to notify the resident's representative when residents were sent to the hospital.

Review of an incident report dated 03/05/2024 initiated by Staff A, Registered Nurse (RN), showed that on 02/08/2024, Staff B, had notified them that Resident 1 had possible injuries to their first two toes. The report showed Resident 1 did not know what happened

to their toes and they had awakened with them looking red.

On 03/05/2024 at 12:50 PM, Staff B stated that she had reported the injury to Staff A. Staff B stated that the ambulance transported Resident 1 to the hospital immediately after that.

In an interview with Staff C, MT on 03/13/2024 at 1:43 PM they stated that they were working on the day Resident 1 was sent to the hospital, but they did not know they needed to call the resident's representative to let them know.

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) 3-29-24.

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

FD — Administrator (or Representative)

3-22-24 — Date