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

04/24/2024

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

RE: Brookdale Richland # 1696

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 38575 (Completion Date 04/24/2024) and 36169 (Completion Date 02/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/24/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

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

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

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

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

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

Statement of Deficiencies	License #: 1696	Compliance Determination # 36169
Plan of Correction	Brookdale Richland	Completion Date
Page 1 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	02/02/2024

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 follow-up on 02/01/2024 and 02/02/2024 of:
Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following SOD dated: 02/02/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 105 current residents and 0 former residents.

The department staff that inspected 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

02/13/2024
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.

Heather Steiling
Administrator (or Representative)

02/15/2024
Date

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.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

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

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

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to maintain a clean, sanitary environment in 3 of 3 floors (1st Floor, 2nd Floor, and 3rd Floor). This failure resulted in residents complaining about the condition and smell of the carpet and contributed to residents living in an unsanitary environment and risk for not living in a dignified manner.

Findings included...

Record review of the "Department of Social and Health Services" document, Completion date 12/07/2023, showed "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. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/19/2023."

Record review of the facility's policy titled, "Cleaning & Disinfection of Environmental Surfaces & Common Areas," dated 07/2019, showed the facility common area spaces shall

be maintained in a clean and sanitary environment for residents. The policy showed high traffic common areas were to be cleaned at least daily, and disinfection of common areas should be performed on a routine basis, at least weekly.

First Floor observations on 02/01/2024 at 11:30 AM, showed outside of resident room 121 had a red stain on the carpet outside the apartment door that an unidentified staff member stated they thought might be cranberry juice. There was a matted area of carpet between room 119 and room 121.

First Floor observations on 02/01/2024 at 11:35 AM, showed outside resident rooms 115, 129 and 130, in the back hall, was an odor of a perfume scented air freshener (in place to mask or remove unpleasant odors) and urine.

Second Floor observation on 02/01/2024 at 11:40 AM, showed outside resident room 208 had spots and marks on the hallway carpet.

Third Floor observations on 02/01/2024 at 11:45 AM, showed the carpet on the third floor had a stain about 12 inches in diameter with drops of black textured stains next to it on the carpet in the hallway outside of the elevator.

During an interview on 02/02/2024 at 8:45 AM Resident 2 (First Floor) stated they had watched the carpets be cleaned. They stated the carpeting looked dirty and stained and smelled like urine after they were cleaned professionally. Resident 2 stated they were concerned about the carpets being unsanitary.

During an interview on 02/02/2024 at 9:05 AM, Collateral Contact 1, (CC1) reported that they visited the facility frequently to see Resident 3 (First Floor). The CC stated Resident 3 complained to them that the carpets in the hallway were still dirty and stained appearing. CC1 stated they had observed the same stains in the carpet after they were cleaned. Resident 3 told CC1 that the air freshener was being used to mask the smell of urine and feces in the carpet. CC1 stated that the smell of the air freshener was so strong that they didn't believe that was healthy to be smelling the chemical smell around the clock.

During an interview on 02/02/2024 at 10:11 AM, Resident 1 reported they lived on the first floor back hall, and it smelled of perfumed air freshener and urine, so they did not leave their room much. Resident 1 reported they had shampooed the carpets recently, but the stains and the smell returned right away.

On 02/01/2024 at 12:20 PM, Staff B, Business Office Manager reported they had been working on cleaning the carpets and spot cleaning as needed.

On 02/01/2024 at 12:30 PM, Staff A, Administrator, stated that the facility had been working on having the carpets cleaned professionally and staff were using the in-house carpet cleaner for spot cleaning. Staff A stated that the urine smell was stronger after the carpets were cleaned and some stains were still present after the cleaning.

This is an uncorrected deficiency previously cited on 12/07/2023 for WAC 388-78A-2660, subsection (2) and RCW 70.129.140, subsection (1).

Statement of Deficiencies	License #: 1696	Compliance Determination # 36169
Plan of Correction	Brookdale Richland	Completion Date
Page 4 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	02/02/2024

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) 3-15-24 .

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

Administrator (or Representative) — Date: 2-15-24

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Richland
Provider Type: Assisted Living Facility
License/Cert.#: 1696
Compliance Determination #: 33023
Intake ID: 109233
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/28/2023 through 12/07/2023
Complainant Contact Date(s):

Allegation(s):

1. The facility kitchen is not clean.
2. The facility is not keeping the warm food warm enough.
3. The facility is understaffed during mealtime on a specified day.

Investigation Methods:

Sample:	Total residents: 105 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents Dining Staff to resident interactions Kitchen Food preparation
Interviews:	Identified resident Kitchen staff Residents Family members
Record Reviews:	Temperature logs Facility policies Staff patterns

Investigation Summary:

1. Observations, interviews identified the kitchen areas not kept in safe, clean and sanitary condition, although the facility continued to receive complaints. Residents and collateral contacts reported facility failure in responding to these concerns, failed practice identified. See statement of deficiency dated 12/08/2023, WAC 388-78A-2660, RCW 70.129.140, Quality of Life.
2. The facility temperature logs showed temperatures in the acceptable range at one and two hour checks. Facility staff interviews confirmed the facility was aware and responding to concerns regarding food safety. The facility had instituted changes such as using plate covers and had requested consultation from the local health jurisdiction. Resident interviews confirmed the staff would reheat food upon request. No deficient practice identified.

3. Resident and facility staff interviews confirmed the facility was aware and made staffing adjustments to cover the staff shortage on the specified date. The facility staff stated they were evaluating server assignments to determine if changes were needed to facilitate timely food service. No deficient practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Richland
Provider Type: Assisted Living Facility
License/Cert.#: 1696
Compliance Determination #: 33023
Intake ID: 106505
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/28/2023 through 12/07/2023
Complainant Contact Date(s): 11/27/2023

Allegation(s):

1. Identified resident is affected by odors and lack of cleanliness surrounding their room.

Investigation Methods:

Sample:	Total residents: 105 Resident sample size: 9 Closed records sample size: 0
Observations:	Identified apartment and surrounding hallways, handrails Resident care equipment Resident rooms Carpets Kitchen
Interviews:	Residents Family members Housekeeping staff Nursing staff
Record Reviews:	Medical records Facility policies Maintenance logs

Investigation Summary:

Observations, interviews identified sampled residents' room, facility common areas and kitchen areas not kept in safe, clean and sanitary condition, although the facility continued to receive complaints. Residents and collateral contacts reported facility failure in responding to these concerns, failed practice identified. See statement of deficiency dated 12/08/2023, WAC 388-78A-2660, RCW 70.129.140, Quality of Life.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Richland
Provider Type: Assisted Living Facility
License/Cert.#: 1696
Compliance Determination #: 33023
Intake ID: 106864
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/28/2023 through 12/07/2023
Complainant Contact Date(s): 11/27/2023

Allegation(s):

1. Identified resident did not have their medications as ordered.

Investigation Methods:

Sample:	Total residents: 105 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents Staff to resident interactions Identified resident
Interviews:	Nursing staff Medication technicians Residents Identified resident Family members
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations. Facility policies

Investigation Summary:

1. Identified resident and their representative stated the resident was without medication for four days before it was reordered causing pain and the inability to walk to the dining room. Facility staff interviews confirmed the resident had issues with their pain medication being reordered and had no medication available. The facility investigation showed the resident ran out of pain medications due to staff not reordering the medication in a timely manner. Deficient practice identified, please see the statement of deficiency dated 12/08/2023 WAC 388-78a-2240.

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

Statement of Deficiencies	License #: 1696	Compliance Determination # 33023
Plan of Correction	Brookdale Richland	Completion Date
Page 1 of 8	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	12/07/2023

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 11/28/2023 and 11/28/2023 of:

Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following complaint number(s): 106481, 106864, 106995, 105985, 106505, 106596, 109233

The following sample was selected for review during the unannounced on-site visit: 9 of 105 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator
Krista Connelly, Community Nurse Consultant

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit Z
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.

Michelle Closner
Residential Care Services

12/11/2023
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) 12-21-23
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure ordered medications were available for 1 of 3 residents (Resident 1) reviewed for medication services. This failure resulted in Resident 1 having unnecessary pain from not receiving their prescribed medications and placed other residents at risk for medication errors.

Findings included...

Review of the facility's policy titled, "Medication and Treatment -Storage, Handling, Distribution, Disposition and Payment" revised on 03/31/2022, showed that the community is responsible for obtaining refills for medication and treatment orders, unless otherwise agreed upon with the resident, family, or legally responsible party in accordance with the Pharmacy Services Agreement Addendum to the residency agreement.

Resident 1
Review of Resident 1's assessments and care plans dated 04/28/2023 showed that the facility managed and assisted Resident 1 with their medications. Resident 1's diagnoses included [redacted] and [redacted].

Review of the facility's incident report dated 11/15/2023 showed that Resident 1 had an order dated 04/29/2023 for tramadol (pain medication) 50 milligrams (mg) by mouth every eight hours as needed for pain. Thirty tablets were ordered, and seven tablets were dispensed by the pharmacy per the insurance company directions.

Review of the November 2023 Medication Administration Record (MAR) showed Resident 1 had taken the ordered pain medication on 11/01/2023, 11/02/2023, 11/06/2023, 11/07/2023, 11/08/2023 and 11/11/2023. Resident 1 did not get another dose of pain medication until 11/17/2023.

The facility investigation dated 11/15/2023 completed by Staff A, Executive Director/ licensed nurse showed the resident ran out of medication on the evening of

11/11/2023. Staff A and Staff B Resident Care Coordinator (RCC) reordered the medication on 11/15/2023, four days after the medication ran out.

During an interview on 11/27/2023 at 2:12 PM Resident 1's representative Collateral Contact (CC) 1 stated that Resident 1 had run out of pain medication on 11/11/2023. The CC stated that Resident 1 had significant pain, difficulty walking and that prevented them from being able to go the dining room like they enjoy. They stated that Resident 1 had been requesting pain medication every day and was being told by the medication technicians (MT) that the ordering physician was not responding to the refill requests. The CC confirmed that on 11/15/2023 they personally verified the order with the pharmacy and were told the order was available but not requested by the facility. CC1 stated that the delay caused significant harm both physically and emotionally while enduring unnecessary pain and anxiety due to the lack of proper communication and medication management.

During an interview on 11/28/2023 at 3:00 PM, Staff A stated that Resident 1 had pain medication ordered as needed on 10/30/2023 and only seven tablets could be dispensed, and the rest would have to be requested when the supply was gone. The facility staff had not requested a refill until Staff A became aware of concern 11/15/2023.

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) 1-19-23.

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

Administrator (or Representative) — Date: 12-21-23

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.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

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

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

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

This requirement was not met as evidenced by:

Based on observation, interviews and record reviews, the Assisted Living Facility (ALF) failed to maintain a clean, sanitary environment in three of three areas, (common areas, resident rooms, Kitchen & food equipment). This failure had the potential to lessen residents quality of life, and increased the risk of exposure to disease producing bacteria.

Findings included...

Record review of the facility's policy titled, "Cleaning & Disinfection of Environmental Surfaces & Common Areas," dated 07/2019, showed the facility common area spaces and environmental surfaces shall be maintained in a clean and sanitary environment for residents. The policy showed high traffic common areas were to be cleaned at least daily, and disinfection of common areas should be performed on a routine basis, at least weekly.

Record review of policies provided by the facility showed they did not have a facility policy on housekeeping and environmental services.

Facility common areas:

Observation on 11/28/2023 at 10:06 AM, showed the front lobby had two halls that led to resident rooms, a main dining room, kitchen, and small dining room. The facility had three levels with resident rooms on each floor. Once inside the front lobby, there was a smell of urine, without any apparent source of the smell and it became stronger when approaching the back hall.

Observation on 11/28/2023 at 10:20 AM, showed the back hall of the first floor of resident rooms was carpeted. The hall had a strong odor of urine, feces, with brown, black, and red colored stains on the carpet throughout the hallway. There was a bench that had two plates with dried on food debris, sitting on it. Later that day at 12.47 PM, observation showed there were two additional plates added to the bench, both with dried on food debris.

Observation on 11/28/2023 at 10:41 AM, showed the first-floor laundry room had black marks on the flooring that appeared to be from dragging a heavy object. There was a sink that dirt had collected into a brown grime at the faucet and along the sides. There was a hand soap dispenser that was empty, with a layer of dust along the top and sides. The faucets/hosing for two washing machines were dusty, with brown built up grime.

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During an interview on 11/28/2023 at 12:42 PM, Resident 2 reported they lived on the first floor back hall, and it always smelled of urine and/or feces. Resident 2 reported they had gone to the second and third floors and neither one smelled the way the "Medicaid Hall," did. They alleged the lack of housekeeping was restricted to the back hall because that's where all the state clients lived. Additionally, they reported they recently had to stop another resident from eating food from a dirty plate while sitting on the bench in their hall.

Observation on 11/28/2023 at 1:00 PM, showed the second-floor laundry room had a sink with a hand soap dispenser that was empty and had what appeared to be dried brown fluid down one side of it. An unidentified resident came into the room and reported one of the washing machines always got plugged up and didn't finish a full load. They reported the maintenance director was aware of it but hadn't fixed it yet.

Observation on 11/28/2023 at 1:30 PM, showed the front elevator on the second floor had a piece of metal protruding from an emblem near the up/down buttons used when getting on the elevator. The protruding piece was only held in place by a small piece still intact at the top and would not stay down when pressed.

Resident rooms:

Observation on 11/28/2023 at 10:30 AM, showed resident room 128 had large red stain on the carpet outside the apartment door, and there were drops of red colored substances on the wall next to the door. An unidentified staff member coming down the hall was asked what the stains were, they stated they did not know, and they had been there for a while.

Observation on 11/28/2023 at 10:36 AM, showed outside resident room 130, in the back hall, was a strong odor of urine and feces. Inside the apartment, there was a bag with soiled attends lying outside the bathroom door on the floor. The bedrooms and bathroom did not have any residents present. The bathroom floor was dirty, with black debris and there was a puddle of a dark colored fluid next to the toilet. The toilet had a rust-colored ring inside the bowl. Both bedrooms had dark colored stained carpets from each door, into the rooms and stopped next to the beds.

Observation on 11/28/2023 at 10:50 AM, showed resident room 119, had a smell of urine that became stronger upon entering the apartment. Inside the apartment door, there were 11 plates of food wrapped in cellophane and stacked up on a chair that was up against the wall. The plates were not dated, and the food appeared jellied on some of the plates near the bottom of the stack. One of the bedroom doors was opened and it appeared to be the source of the urine smell. The carpet was stained black with what appeared to be tire marks from a scooter in a traffic pattern from the door to the bed. The carpet had other areas of dark colored stains and garbage was strewn out on the floor as well.

On 11/28/2023 at 1:32 PM, Resident 3 entered resident room [redacted] on a scooter. Resident 3 reported they lived in the apartment, and this was their bedroom. They stated the carpet

was easily stained from the scooter tires and the facility did not have enough housekeepers working, so the room did not always get cleaned. They stated the staff delivered meals to the room while they were not present, and then did not pick the plates back up, so they started stacking the uneaten food to get it out of their bedroom.

The record review for Resident 3 included an assessment and care plan dated 01/08/2023 showed the resident required staff assistance for meals, and required assistance with cleaning (vacuuming, mopping, sweeping, make their bed, laundry their bedding, empty their trash and cleaning their bathroom regularly).

Observation and interview on 11/28/2023 at 12:42 PM, showed Resident 2 shared an apartment with another resident. Resident 2 stated they had recently moved into the facility and expressed not being happy with the move, that the facility did not provide the services promised when they moved in. There was a sign posted on the apartment door that showed that Resident 2's housekeeping and laundry days were Saturday and Sunday. Resident 2 stated they washed their own bedding after being in the facility for two weeks, because no one had done it.

Observation and interview on 11/28/2023 at 12:53 PM, showed Resident 2's shower floor was dirty, had a big clump of hair on the shower wall, the shower head had a dirty washcloth that was dry and stiff. The shower mat had red stains on it and rust colored stains underneath it. Resident 2 stated their apartment had only been cleaned one time since they moved in several weeks prior. They were told the facility only had two housekeepers, one was assigned the second floor and another one was assigned the third hall.

Record review for Resident 2 included an assessment and care plan dated 11/01/2023 that showed the resident required staff assistance to vacuum, mop, sweep, make their bed, laundry their bedding, empty their trash and clean their bathroom regularly.

Observation of Resident 4's room [redacted] on 11/28/2023 at 12:56 PM, showed the carpet was stained black near the kitchenette, there was a slight smell of urine and there was a dried bath towel lying on the floor of the shower. The apartment had two garbage cans, and both were overflowing with garbage. The bathroom floor had a used washcloth lying on the floor. The toilet was stained with a rust-colored ring, it was wet on the on the floor around the toilet there wasn't any toilet paper.

During an interview on 11/27/2023 at 3:30 PM, Collateral Contact 2, (CC,) reported they visited the facility frequently to see Resident 4. The CC stated Resident 4 complained to them that they had not had housekeeping services for at least two weeks. CC2 reported the trash was not getting emptied and their dirty attends were often left sitting out in the hall.

CC2 reported Resident 4's carpet had not been vacuumed for at least two weeks, and there

was a stain on the hardwood floor for several days before it was cleaned up. CC2 stated Resident 4 was considering moving to another facility because their frequent complaints to the administration regarding the cleaning did not help.

The record review for Resident 4 included an assessment and care plan dated 06/15/2023 that showed the resident required staff assistance to vacuum, mop, sweep, make their bed, laundry their bedding, empty their trash and clean their bathroom regularly.

On 11/28/2023 at 1:08 PM, Staff G, housekeeper, reported the facility common areas that were to be cleaned every day included the laundry rooms, the conference rooms, the elevators, and the resident rooms following a rotational schedule. They stated they were not responsible for cleaning in the kitchen, and fully staffed in housekeeping meant there were three housekeepers, one for each floor. They reported during the last several weeks, they often only had two on duty because of illness, and that was not enough to do all the daily cleaning.

On 11/28/2023 at 3:00 PM, Staff A, Administrator, reported there were several residents that lived in the back hall with scooters that stained the carpets inside and out of their apartments. They reported some of the residents could also display behavioral traits that effected how their apartments were maintained. Staff A reported they were spending thousands of dollars for carpet cleaning that was only a temporary solution. Staff A stated they had requested to have the carpet replaced with flooring had thus far had been declined by the licensee.

Kitchen and food equipment:

During an interview on 11/27/2023 at 2:12 PM, Collateral Contact 1, said they visited the facility frequently during mealtimes. They expressed concern that the facility did not keep their kitchen clean, and there were times some of the dishes or utensils served out to the residents were dirty.

On 11/28/2023 at 12:16 PM, observation of the facility's kitchen showed there were five staff members working to serve the residents their noon meal. None of the staff members were wearing hairnets. Staff F, dishwasher, was observed doing the dishes, putting them in the dishwasher and taking them out after the clean cycle was completed. Staff F had a beard hanging from his chin and long hair only partially pulled back from their face.

Observation and interview on 11/28/2023 at 12:29 PM, showed the dishwasher had food spills and hard water on the outside. Staff F was taking clean dishes out from the dishwasher as the cycles completed. Observation of a clean load just out of the dishwasher, showed there were bowls that still had dried food debris on it. Staff F stated that happened sometimes and the debris was dried oatmeal from breakfast served that morning. They stated they were not sure why that happened.

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Observation on 11/28/2023 at 12:31 PM, there were three plates under the warming lights, waiting to be served out to the residents. The top of the light had a build-up of dust that hung over the edge in places that were above the plates below. There was a cart used to pass beverages that had clean cups, glasses, coffee pots and pitchers. The cart had food spills, areas that were grey and brown that were on the handle used to push the cart, the tires were dirty with a hair/lint buildup. The cold food preparation area showed a shelf above the area with bottles of food seasoning. The shelf had a buildup of dust, food debris and spills directly above the cold food below.

Observation on 11/28/2023 at 12:35 PM, showed there was a mixer that was not in use, with food spills, dust on it and some bowls stored with it. The exterior of the ice machine and vent was dusty, with food spills and hard water stains. The wall next to the ice machine and the water filtration system had different colored spills and dust. There was a counter area that had opened packages of bread products, an open plastic container of peanut butter that was not dated, with food spills on the sides. There were two ovens, both with grills on top. Both ovens had blackened build up of grease, food residue, on the insides and the handles. There was a broiler oven that had baked on food spills on the inside and the exterior.

interview on 11/28/2023 at 12:40 PM, Staff E, Cook, reported the ovens were scheduled to be cleaned monthly and they did not recall when they were done last.

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) 1-19-23 .

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

Administrator (or Representative) 12-21-23 Date