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) 59974 (Completion Date 05/22/2025) and 54546 (Completion Date 04/03/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/22/2025 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,

Laura Williams-Davis

Laura Williams-Davis, ALF 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 #: 54546
Intake ID: 166426
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 02/11/2025 through 04/03/2025
Complainant Contact Date(s):

Allegation(s):

1. Identified Resident did not get their medications as prescribed.

Investigation Methods:

Sample:
Total residents: 71
Resident sample size: 12
Closed records sample size: 2

Observations:
Identified resident
Residents
Resident rooms
Staff to resident interactions

Interviews:
Identified resident
Nursing staff
Residents

Record Reviews:
Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations and hospital records.

Investigation Summary:

1. The Identified Resident stated the facility had medication errors that caused them to have to be admitted to the hospital for a few days. The facility staff interview confirmed the resident's medication was inadvertently discontinued. The facility investigation showed the resident was sent to the hospital for treatment after notifying the staff they felt ill. The resident was evaluated and returned to the community when stable. Notifications were made to the Primary Care Provider, the representative and the department hotline. Updates were made to the Negotiated Service agreement. Failed practice identified, please see the Statement of Deficiency dated 03/12/2025 for WAC 388-78a-2210 (1)(b)(2)(a) for medication services.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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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 02/11/2025 and 03/11/2025 of:

Brookdale Richland
1629 George Washington Way
Richland, WA 99354

This document references the following complaint number(s): 165688, 166426, 165686, 166280, 166422, 164715, 170174, 166814

The following sample was selected for review during the unannounced on-site visit: 12 of 71 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator
Melissa Milanez, 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.

Laura Williams-Davis
Residential Care Services

04/15/2025
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)

4-15-25
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 medication was administered as prescribed for 1 of 3 residents (Resident 1). This failure resulted in the resident not receiving medications as ordered and needing hospitalization.

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 "Medication and Treatment-Storage, Handling, Disposition and Payment," dated 11/15/2015 showed that new physician/healthcare provider orders would be obtained by the facility and accepted into the community using a consistent procedure.

Review of Resident 1's Negotiated Service Agreement (NSA) dated 09/24/2024 and 02/16/2025, showed that the facility managed and assisted Resident 1 with their medications. Resident 1's diagnoses included [redacted] and [redacted]

Review of a Physician's Order dated 01/21/2025, showed that Resident 1 was to be given Torsemide (medication to reduce fluid in the body through urination) 10 mg tablet PO (by mouth) every evening to start 01/25/2025. The order had initials of Staff C, Medication Technician (MT) at the bottom of the page.

Review of Resident 1's January 2025, Medication Administration Record (MAR) showed an order of Torsemide entered to start 01/24/2025 at 6:00 PM, one day prior to the ordered start date. The MAR showed the medication was documented as given. The MAR also showed Resident 1's existing order for Torsemide 40 mg by mouth every morning had been discontinued effective after the dose given on 01/25/2025. There was no corresponding Physician's Order to discontinue the 40 mg Torsemide every morning medication. Resident 1 missed eight doses of the Torsemide 40 mg between 01/25/2025 and [redacted]/2025 when they were sent to the hospital for treatment of shortness of breath.

In an interview on 03/12/2025 at 9:55 AM, Collateral Contact 1 (CC1), Advanced Registered Nurse Practitioner, stated that they notified Staff A, Administrator that they believed a medication error had occurred causing the need for hospitalization for three days. CC1 stated that they had written the new order for Torsemide 10 mg (every evening) after seeing Resident 1 on 01/21/2025. CC1 stated that Resident 1 had been doing very well with the morning dose of Torsemide and needed only a small amount of medication to support them in the evening. CC1 stated they had told Staff B the order was in addition to the existing morning dose when handing them the new order.

During an interview on 02/11/2025 at 12/30 AM, Resident 1 stated "I kept telling the staff that I wasn't feeling right. I ended up in the hospital for CHF because I missed the big doses of the diuretic that was ordered. Resident 1 stated "I worked in the medical field for many years, and I was doing well until this unnecessary medication error happened."

In an interview on 02/11/2025 at 2:23 PM, Staff B, Facility Licensed Nurse stated the normal process for when a new order arrives is to enter the order on the MAR and have a second person check the order. Staff B stated that they had entered the order for the evening dose of Torsemide 10 mg on the MAR. Staff B stated that Staff C reviewed the MAR when they returned to work on 01/25/2025 and saw the new evening medication order entered by Staff C. Staff C believed that the new evening order superseded the

morning Torsemide order, and they discontinued the morning order from the MAR. The resident ended up needing to be transported to the hospital later from not receiving the Torsemide medication.

This is a recurring deficiency previously cited on 04/04/2023, 09/05/2023, and 06/19/2024.

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) 5-16-25.

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

Administrator (or Representative) — Date: 4-15-25