STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Nine Mile
5329 WEST RIFLE CLUB COURT
SPOKANE, WA 99208

RE: Brookdale Nine Mile License # 1698

Dear Administrator:

This letter addresses Compliance Determination(s) 30874 (Completion Date 09/29/2023) and 25428 (Completion Date 08/21/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/29/2023 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371, WAC 388-78A-2630-1-a, WAC 388-78A-2660-1, WAC 388-78A-2660-4, RCW 70.129.130, WAC 388-78A-2450-3-d-i, WAC 388-78A-2450-3-d-ii, WAC 388-78A-2450-3-d-iii, WAC 388-78A-2450-3-d

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

S.M

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Nine Mile
Provider Type: Assisted Living Facility
License/Cert.#: 1698
Compliance Determination #: 25428
Intake ID: 88557
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 06/14/2023 through 08/21/2023
Complainant Contact Date(s): 07/14/2023, 08/11/2023

Allegation(s):

1 - Lack of monitoring related to foot swelling/infection
2 - Fall and injury to the head
3 - Lack of timely medication refill, resulting in resident's hospitalization
4 - Missing valuables, including money

Investigation Methods:

Sample:
Total residents: 36
Resident sample size: 14
Closed records sample size: 4

Observations:
Residents' safety and well-being
Any injuries/signs of skin infection
Any signs of lack of care
Medication passes
Residents' access to safe storage for their valuables
Staff's response to residents' concerns

Interviews:
Seven residents
Eight resident representatives
Two facility medication aides
Two caregivers
Health and Wellness Director
Receptionist
Business Office Coordinator
Administrator

Record Reviews:
Sample residents' Face Sheets, assessments, care plans, Progress Notes, and medication administration records (MARS)
Facility injury/incident investigation documents
Staff schedule - June 2023
Policy and procedures - Abuse/neglect and Mandatory Reporting
Disclosure of Services
Residency Agreement

Investigation Summary:

1 - Staff was observed monitoring current sample residents for physical and mental changes in their baselines. Named resident no longer resided in the facility therefore, staff's care of them could not be observed. Per staff interview, and Progress Notes; facility monitored the resident's skin, and their leg infection was found during their hospitalization. Investigation findings did not support failed facility practices related to allegation.
2 - This allegation was investigated in May 2023 at which time no failed facility practices were found.
3 - Observations of medication passes showed medication aides provided medications to current residents, as ordered. Department investigator was unable to observe medication services to named resident, as they no longer resided in the facility. Interview with named resident's representative showed they were responsible for obtaining resident's medication from the pharmacy, and they asked an acquaintance to pick up a refill. The representative stated the facility didn't immediately notify them of the need for a refill, and the representative's and acquaintance's inability to go to the pharmacy right away created an additional delay of several days. The resident, who had existing health issues, was hospitalized for treatment, and investigation findings did not show their hospitalization was the result of the medication delay. Investigation findings did not support failed facility practice/warrant citation.
4 - Per named residents' representative, the residents were missing money while in the facility. The representative stated they reported the missing money to facility Administrator and receptionist. Administrator stated facility did not make reports to the Department hot line or investigate the allegations of residents' missing money. Failed facility practices were found and documented in Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2630 Reporting abuse and neglect and WAC 388-78a-2371 Investigations.

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 Nine Mile
Provider Type: Assisted Living Facility
License/Cert.#: 1698
Compliance Determination #: 25428
Intake ID: 88859
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 06/14/2023 through 08/21/2023
Complainant Contact Date(s):

Allegation(s):

1 - Resident injury
2 - Resident to resident altercation
3 - Resident aggression toward staff
4 - Facility didn't allow resident to return

Investigation Methods:

Sample:
Total residents: 36
Resident sample size: 14
Closed records sample size: 4

Observations:
Residents' safety and well-being
Any injuries, signs of distress
Accessibility of staff, staff's response to residents' needs
Staff's response to residents' problem behaviors e.g. anxiety, agitation, aggression

Interviews:
Seven residents
Eight resident representatives
Two facility medication aides
Two caregivers
Health and Wellness Director
Receptionist
Business Office Coordinator
Police detective
Administrator

Record Reviews:
Sample residents' Face Sheets, assessments, care plans, Progress Notes, and medication administration records (MARS)
Facility injury/incident investigation documents
Staff schedule - June 2023
Policy and procedures - Abuse/neglect and Mandatory Reporting
Disclosure of Services
Residency Agreement
Police Field Case Report

Investigation Summary:

1 - Staff interviews and facility investigation documents showed staff found named resident with facial injuries i.e. bruising and swelling to the eyes, bruising of the neck, and bloodied face. Per these sources, named resident's roommate told staff they hit the named resident, and the roommate assaulted a staff person the day before. Named resident was observed in the hospital with bruising to the face and neck, but was unable to say how the injuries happened. Staff and representatives of named resident stated they were concerned facility allowed roommate to share apartment with named resident, given the roommate's prior assault of staff member. Failed facility practice was found and documented in Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2660 Resident rights; with reference to Revised Code of Washington (RCW) 70.129.130 Abuse, punishment, seclusion-Background checks.

2 - Refer to summary under Issue 1, above. Failed facility practice was found, and and documented in Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2660 Resident rights; with reference to Revised Code of Washington (RCW) 70.129.130 Abuse, punishment, seclusion-Background checks.

3 - Refer to summary under Issue 1, above. Failed facility practice was found, and and documented in Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2660 Resident rights; with reference to Revised Code of Washington (RCW) 70.129.130 Abuse, punishment, seclusion-Background checks.

4 - Per staff interviews and review of named resident's Progress Notes, the facility sent resident to the hospital for evaluation of assaultive behavior, and did not allow the resident to return because of concern for the safety of residents. Assisted living requirements allow facilities to discharge residents for this reason. No failed facility practices were found.

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 Nine Mile
Provider Type: Assisted Living Facility
License/Cert.#: 1698
Compliance Determination #: 25428
Intake ID: 92403
Investigator: Sylvia Shauvin
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 06/14/2023 through 08/21/2023
Complainant Contact Date(s):

Allegation(s):

1 - Staff drinks and uses drugs while on duty
2 - Facility is understaffed
3 - Facility doesn't make required reports
4 - Resident hit another resident

Investigation Methods:

Sample:
Total residents: 36
Resident sample size: 14
Closed records sample size: 4

Observations:
Residents' safety and well-being
Any signs of lack of care
Staff's care of residents and response to residents' concerns
Staff's response to residents' behavior problems, such as agitation/aggression

Interviews:
Seven residents
Eight resident representatives
Two facility medication aides
Two caregivers
Health and Wellness Director
Receptionist
Business Office Coordinator
Police detective
Administrator

Record Reviews:
Sample residents' Face Sheets, assessments, care plans, and Progress Notes
Facility injury/incident investigation documents
Police narrative
Staff schedule - June, July, August 2023
Policy and procedures - Management of Aggression
Sample staff's credentials

Investigation Summary:

1 - No observations were made of staff under the influence of drugs or alcohol while on duty. Residents and representatives interviewed had no concerns about staff being under the influence of drugs or alcohol while on duty. Reviews of sample staff's credentials showed the facility did not have records of two staff's personnel records in the facility, as required. Failed facility practice was found. The deficiency was documented in a Statement of Deficiencies (SOD) under Washington Administrative Code (WAC) 388-78a-2450 Staff.
2 - Facility was observed conducting caregiving applicant interviews. Staff was observed responding to residents' needs in a prompt manner. No signs of lack of care were observed. Although several representatives stated the facility was under-staffed, they did not identify specific adverse outcomes related to it. The investigation findings did not support failed facility practices and warrant citations.
3 - Representative and staff interviews, and review of facility's investigations and department reporting data base showed facility failed to report and investigate allegations of two sample residents' missing money. Failed facility practices were found. The deficiencies were documented in the SOD under WAC 388-78a-2371(1-4) Investigations, and WAC 388-78a-2630(1)(a) Reporting abuse and neglect.
4 - Staff interviews and facility investigation documents showed staff found named resident with facial injuries i.e. bruising and swelling to the eyes, bruising of the neck, and bloodied face. Per these sources, named resident's roommate told staff they hit the named resident, and the roommate assaulted a staff person the day before. Named resident was observed in the hospital with bruising to the face and neck, but was unable to say how the injuries happened. Staff and representatives of named resident stated they were concerned facility allowed roommate to share apartment with named resident, given the roommate's prior assault of staff member. Failed facility practice was found and documented in Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2660 (1)(4) Resident rights; with reference to Revised Code of Washington (RCW) 70.129.130 Abuse, punishment, seclusion-Background checks.

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
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 1698	Compliance Determination # 25428
Plan of Correction	Brookdale Nine Mile	Completion Date
Page 1 of 8	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	08/21/2023

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 06/14/2023, 06/14/2023, 07/17/2023 and 08/10/2023 of:

Brookdale Nine Mile
5329 WEST RIFLE CLUB COURT
SPOKANE, WA 99208

This document references the following complaint number(s): 84693, 85090, 85074, 85686, 86275, 86714, 87008, 87253, 87288, 87190, 87717, 88557, 88859, 91667, 91684, 92235, 92403

The following sample was selected for review during the unannounced on-site visit: 14 of 36 current residents and 4 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

S.M

Residential Care Services

09/01/2023

Date

Statement of Deficiencies	License #: 1698	Compliance Determination # 25428
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Page 2 of 8	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	08/21/2023

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) 09/10/2023 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document their investigations of missing money for 2 of 4 sample residents (Residents 3 and 4). This failure resulted in a lack of interventions to prevent residents from experiencing further losses.

Findings included...

In an interview on 07/14/2023 at 8:15 AM Collateral Contact 1 (CC1), Resident Representative, stated that Resident 3 was missing 400 dollars from the wallet that CC1 asked the facility to safeguard for the resident. CC1 stated they reported the missing money to Staff A, Administrator, and Staff G, Receptionist, sometime in June or July 2023.

In the 07/14/2023 interview at 8:15 AM, CC1 further stated Resident 4's family noticed 20 dollars was missing from the purse that Resident 4 kept in their apartment. CC1 stated they reported Resident 4's missing money to Staff A.

In an interview on 07/17/2023 at 1:45 PM, Staff A stated CC1 reported 400 dollars was missing from Resident 3's wallet that was stored by the facility. Staff A stated the facility did not investigate the reports of Resident 3 and 4's missing money.

On 07/17/2023 at 1:45 PM, Staff A checked the facility's record of investigations and stated they found no record of investigations of financial exploitation of Resident 3 and Resident 4.

In an interview on 08/10/2023 at 9:45 AM, Staff G stated they informed Staff A about Resident 3 and Resident 4's missing money. Staff G added that Staff A and Staff B, Health and Wellness Director, were responsible for investigating reports of missing money and valuables.

This is a recurring deficiency previously cited on 09/01/2022.

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 Nine Mile is or will be in compliance with this law and / or regulation on (Date) 09/10/2023 .

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

Administrator (or Representative) 09/10/2023 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report allegations of financial exploitation to the Complaint Resolution Unit for 2 of 4 sample residents (Residents 3 and 4). This failure precluded the department from having immediate knowledge to conduct an investigation and placed residents at risk of further loss.

Findings included...

Statement of Deficiencies	License #: 1698	Compliance Determination # 25428
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In an interview on 07/14/2023 at 8:15 AM, Collateral Contact 1 (CC1), Residents 3's and 4's representative, stated they notified Staff A, Administrator, and Staff G, Receptionist, about money missing for Resident 3 and 4. CC1 stated 400 dollars was missing from Resident 3's wallet that they gave to Staff A to store for Resident 3. CC1 stated 20 dollars was missing from Resident 4's purse that the resident kept in their apartment.

In the interview on 07/14/2023 at 8:15 AM, CC1 stated they reported Resident 3's missing money to Staff A and Staff G sometime in June 2023 or July 2023. CC1 also stated they reported Resident 4's missing money to the facility but could not recall the date.

In an interview on 07/17/2023 at 1:45 PM, Staff A stated CC1 reported Resident 3 was missing 400 dollars from their wallet that the facility stored for them. Staff A stated they didn't make a report the allegations of financial exploitation to the department's reporting hotline.

In an interview on 08/10/2023 at 9:45 AM, Staff G stated CC1 reported Residents 3 and 4 were missing money, and Staff G informed Staff A about it.

Review of the department's reporting database showed the facility did not report allegations of financial exploitation for Residents 3 and 4.

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 Nine Mile is or will be in compliance with this law and / or regulation on (Date) 09/10/2023 .

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

Administrator (or Representative) 09/10/2023 Date

RCW 70.129.130 Abuse, punishment, seclusion -- Background checks. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents were free from physical abuse for 1 of 4 sampled residents (Resident 1). This failure resulted in the resident being physically assaulted and sustaining a severe head injury requiring hospitalization.

Findings included...

Review of a facility Incident Report, dated [redacted]/2023 at 8:15 AM, showed Staff E, Caregiver, found Resident 1 on [redacted]/2023 at 8:15 AM, with facial bleeding and swelling. The report also showed Resident 1 stated they were hit and was transported to the emergency room where they were diagnosed with [redacted], and had to be admitted to the intensive care unit.

The police narrative, dated 07/12/2023, showed a detective responded to the facility on the morning of [redacted]/2023 because Resident 1 was a victim of assault, had bruising and swelling to the face, and might not survive. Per the narrative, Resident 1 pulled their alarm and told Staff E that someone hit them, and Resident 2, had blood and bruising to the hand, and stated they struck Resident 1 six times. The narrative showed Resident 2's dresser had glass from a broken picture frame, Resident 1's pillow had blood on it, and the sink in the bathroom that the two residents shared had blood in it. The narrative showed the hospital informed the detective that Resident 1 had a brain bleed and dislocated shoulder. It also showed Resident 2 assaulted a staff member on [redacted]/2023, the day before Staff E found Resident 1 with the facial injuries.

In an interview on 07/17/2023 at 11:50 AM, Staff D, Caregiver, stated on the morning of [redacted]/2023, Resident 1 didn't show up for breakfast, so Staff E checked on the resident whose eyes were swollen, and nose and lips were bleeding. Staff D stated Resident 1 stated they were hit. Staff D stated that Resident 2 admitted to hitting Resident 1. Staff D stated Resident 2 punched Staff F, Dietary server, the day before hitting Resident 1, causing swelling to Staff F's forehead. Staff D voiced concern that the facility let Resident 2 share an apartment with Resident 1 after hitting Staff F.

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On [redacted]/2023 at 3:45 PM, the department investigator observed Resident 1 and interviewed the resident and Collateral Contacts CC2, CC3, and CC4/resident representatives, in the hospital. Resident 1 was observed with dark purple, crescent-shaped bruising below both eyes, and two rows of dark purple bruising around the neck. As observed and described by CC3, Resident 1's appetite was very poor. CC2 stated the ongoing hospital scans of Resident 1 showed worsening of brain bleeding, and they were concerned the resident's poor appetite might be the result of swallowing problems related to the neck injuries. CC2, CC3, and CC4 voiced concern the facility allowed Resident 2 to reside in the same apartment with Resident 1, given Resident 2's prior physical aggression toward staff.

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 Nine Mile is or will be in compliance with this law and / or regulation on (Date) 09/10/2023 .

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

Administrator (or Representative) 09/10/2023 Date

WAC 388-78A-2450 Staff.

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471 ; and

(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

This requirement was not met as evidenced by:

Statement of Deficiencies	License #: 1698	Compliance Determination # 25428
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Based on interview and record review, the facility failed to maintain documentation in the facility of background check results, reference checks, and staff orientation for 2 of 3 sampled staff (Staff A and B). This failure precluded the department's review of the staffs' credentials to ensure they were qualified to provide care to residents.

Findings included...

On 08/10/2023 at 11:25 AM, the department investigator asked Staff H, Business Office Coordinator, for records of background check results, reference checks, and staff orientation for Staff A, Administrator, and Staff B, Health and Wellness Director.

Review of sample staff's credentials on 08/10/2023 at 11:25 AM showed Staff A's and B's personnel records were not kept in the facility.

In an interview on 08/10/2023 at 11:25 AM Staff H stated that Staff A's and Staff B's personnel files were kept in the facility's corporate office in Milwaukee, Wisconsin, and not in the facility. Staff H stated they would obtain records of background check results, reference checks, and staff orientation for Staff A and B from the corporate office for the investigator's review. Staff H stated they would send the records electronically to the investigator by the end of the day on 08/11/2023.

In an interview on 08/14/2023 at 7:50 AM, the department investigator contacted Staff A by phone to follow up on the record request as the personnel files had not been received. Staff A stated they would check with Staff H and have the requested information sent to the investigator on 08/14/2023.

In an interview on 08/16/2023 at 9:00 AM, Staff H stated they would check with the facility's Human Resources staff regarding investigator's request to review Staff A and B's credentials.

As of 08/21/2023 at 12:00 PM, the department investigator had not received Staff A's and B's background check results, reference checks, and orientation information from the facility.

Plan/Attestation Statement

Statement of Deficiencies	License #: 1698	Compliance Determination # 25428
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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 Nine Mile is or will be in compliance with this law and / or regulation on (Date) 09/10/2023.

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

Administrator (or Representative) — Date: 09/10/2023