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) 42518 (Completion Date 06/07/2024) and 40634 (Completion Date 05/16/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/07/2024 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-2450-1-a, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Anne Sinclair, NCI Community Complaint Investigator

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

Sincerely,

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 #: 40634
Intake ID: 129340
Investigator: Anne Sinclair
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 04/30/2024 through 05/16/2024
Complainant Contact Date(s): 05/10/2024, 05/16/2024

Allegation(s):
Insufficient staff to address resident care needs.

Investigation Methods:

Sample:
Total residents: 47
Resident sample size: 7
Closed records sample size: 1

Observations:
Identified resident
Residents
Staff to resident interactions
Resident to resident interactions
Dining
Activities
Resident rooms

Interviews:
Residents
Health and Wellness Director
Caregiver
Resident representative
Hospice
Regional Nurse manager
Medtech
Executive Director

Record Reviews:
Named resident care plan/face sheet
Sample resident care plan/face sheet
Facility investigation
Facility Abuse/neglect reporting policy
Disclosure of Services
Characteristic roster
Staff roster
Progress notes

Investigation Summary:
1. Facility had no qualified staff scheduled onsite to give resident medications as

needed. Failed facility practice identified for WAC 388-78A-2210(2)(a) Medication Services and WAC 388-78A-2450(1)(a) Staffing.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 1696	Compliance Determination # 40634
Plan of Correction	Brookdale Nine Mile	Completion Date
Page 1 of 5	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	05/16/2024

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 complaint investigation on 04/30/2024, 04/30/2024 and 04/30/2024 of:

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

This document references the following complaint number(s): 127794, 128084, 128482, 129340, 129954

The following sample was selected for review during the unannounced on-site visit: 7 of 47 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Anne Sinclair, NCI Community 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. [illegible]
Residential Care Services

05/23/2024
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.

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

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Brookdale Nine Mile
5329 WEST RIFLE CLUB COURT
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Anne Sinclair, NCI Community 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.

Residential Care Services _____ 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.

Statement of Deficiencies	License #: 1698	Compliance Determination # 40534
Plan of Correction	Brookdale Nine Mile	Completion Date
Page 2 of 6	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	05/16/2024

Administrator (or Representative) 5/20/24 Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a qualified staff member was onsite to administer as needed medications for 1 of 4 sampled residents (Resident 1). This failure resulted in unmet end-of-life symptom management, discomfort, and difficulty breathing for Resident 1, and placed all residents at risk of unmet medication administration.

Findings included...

Review of the facility's undated Disclosure of Services showed the facility must assist residents in taking their medications if needed, and that the facility had qualified staff who would administer and oversee medication administration.

In interview on 05/10/2024 at 10:50 AM, Collateral Contact 1 (CC1), Resident Representative, stated they had arrived at the facility on [redacted]/2024 at around 7:15 PM to check on Resident 1, and discovered Resident 1 in apparent distress, noting mottled cheeks (skin discoloration due to low oxygen), and with labored breathing they described as "breathing through water." CC1 further stated that when they asked a staff member to administer medication for Resident 1's discomfort, they were told there was no staff member onsite at the time that could administer medication for residents. CC1 stated the staff at the facility notified Staff A, Health and Wellness Director, of Resident 1's discomfort and need for medication administration after CC1 requested end-of-life symptom management for Resident 1's symptoms.

In interview on 05/10/2024 at 11:25 AM, Collateral Contact 2 (CC2), Hospice Nurse, stated that on the evening of [redacted]/2024, they had spoken with Staff A on the telephone after normal business hours and Staff A had asked about Resident 1's hospice nursing staff's availability to come to the facility that evening to administer as needed medication for Resident 1, as there were no qualified staff available at the facility who could administer medications to residents.

In interview on 05/09/2024 at 2:50PM, Staff C, Caregiver stated they had arrived at the

Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a qualified staff member was onsite to administer as needed medications for 1 of 4 sampled residents (Resident 1). This failure resulted in unmet end-of-life symptom management, discomfort, and difficulty breathing for Resident 1, and placed all residents at risk of unmet medication administration.

Findings included…

Review of the facility's undated Disclosure of Services showed the facility must assist residents in taking their medications if needed, and that the facility had qualified staff who would administer and oversee medication administration.

In interview on 05/10/2024 at 10:50 AM, Collateral Contact 1 (CC1), Resident Representative, stated they had arrived at the facility on [redacted]/2024 at around 7:15 PM to check on Resident 1, and discovered Resident 1 in apparent distress, noting mottled cheeks (skin discoloration due to low oxygen), and with labored breathing they described as “breathing through water.” CC1 further stated that when they asked a staff member to administer medication for Resident 1’s discomfort, they were told there was no staff member onsite at the time that could administer medication for residents. CC1 stated the staff at the facility notified Staff A, Health and Wellness Director, of Resident 1’s discomfort and need for medication administration after CC1 requested end-of-life symptom management for Resident 1’s symptoms.

In interview on 05/10/2024 at 11:25 AM, Collateral Contact 2 (CC2), Hospice Nurse, stated that on the evening of [redacted]/2024, they had spoken with Staff A on the telephone after normal business hours and Staff A had asked about Resident 1’s hospice nursing staff’s availability to come to the facility that evening to administer as needed medication for Resident 1, as there were no qualified staff available at the facility who could administer medications to residents.

In interview on 05/09/2024 at 2:50PM, Staff C, Caregiver stated they had arrived at the

facility on [redacted]/2024 at around 9:00 PM to administer Resident 1's as needed medication (medications for acute health symptoms) after being called into the facility that evening by staff A. Staff C stated that when they arrived at the facility there were no qualified staff onsite who could administer resident medications.

Review of a facility incident investigation, dated 05/06/2024, showed that on the night of [redacted]/24, Resident 1, who was terminal (expected and imminent death), required medication for symptom management and there was not a qualified staff person onsite to administer medication to residents for the overnight hours. The investigation showed that Staff A stated that they thought if there were no scheduled medications during the night, then a night medication tech did not have to be on the premises.

In interview on 05/09/2024 at 1:45PM, Staff B, Executive Director, stated that on the night of [redacted]/2024 there was a gap of time where no qualified staff were scheduled in the facility to provide medication administration for residents.

In interview on 05/10/2024 at 10:10am, Staff D, Registered Nurse and Regional Manager, stated that there should never be a time when a qualified staff is not in the facility to give medications for residents, and that it's never okay not to have staff in the facility who can dispense medications. Staff D further stated that Staff A would be terminated related to their responsibility and management of having no qualified staff onsite to give medication to residents on the night of [redacted]/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 Nine Mile is or will be in compliance with this law and / or regulation on (Date) 5/17/24

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

Administrator (or Representative) 5/30/24 Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

facility on [redacted]/2024 at around 9:00 PM to administer Resident 1's as needed medication (medications for acute health symptoms) after being called into the facility that evening by staff A. Staff C stated that when they arrived at the facility there were no qualified staff onsite who could administer resident medications.

Review of a facility Incident Investigation, dated 05/06/2024, showed that on the night of [redacted]/24, Resident 1, who was terminal (expected and imminent death), required medication for symptom management and there was not a qualified staff person onsite to administer medication to residents for the overnight hours. The investigation showed that Staff A stated that they thought if there were no scheduled medications during the night, then a night medication tech did not have to be on the premises.

In interview on 05/09/2024 at 1:45PM, Staff B, Executive Director, stated that on the night of [redacted]/2024 there was a gap of time where no qualified staff were scheduled in the facility to provide medication administration for residents.

In interview on 05/10/2024 at 10:10am, Staff D, Registered Nurse and Regional Manager, stated that there should never be a time when a qualified staff is not in the facility to give medications for residents, and that it's never okay not to have staff in the facility who can dispense medications. Staff D further stated that Staff A would be terminated related to their responsibility and management of having no qualified staff onsite to give medication to residents on the night of [redacted]/2024.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 observation, interview, and record review, the facility failed to ensure a safe delivery system was in place for medication administration and failed to provide medication as ordered for 1 of 4 sampled residents (Resident 1). This failed practice resulted in the resident not receiving their end of life pain and comfort medications which caused distress and difficulty breathing for Resident 1's during the dying process and placed residents at risk of unmet medication administration.

Findings included…

Review of the facility's undated Disclosure of Services showed the facility must assist residents in taking their medications if needed, and that the facility had qualified staff who would administer and oversee medication administration.

Review of Resident 1's Personal Service Plan (the facility's titled negotiated service agreement), dated 12/08/23, showed they were diagnosed with [redacted] and needed assistance with medication administration.

Review of Resident 1's April 2024 Medication Administration Record (MAR) showed Resident 1 was prescribed morphine sulfate (narcotic pain medication) by mouth every 30 minutes as needed for pain and dyspnea (difficulty breathing).

Observation on [redacted]/2024 at 10:30 AM, showed Resident 1 was near end-of-life transition (dying process) and was unable to verbally alert staff to the need for pain/discomfort symptom management.

In an interview on 05/10/2024 at 10:50 AM, Collateral Contact 1 (CC1), Resident Representative, stated they had left the facility on [redacted]/2024 at around 5:45 PM, at which time Resident 1 snored and appeared comfortable. CC1 stated that when they arrived back at the facility at around 7:15 PM that same evening to check on Resident 1, they found the resident in distress, noted mottled cheeks (skin discoloration due to low oxygen), and with labored breathing they described as "breathing through water." CC1 further stated that there were no facility staff available to administer the resident's comfort medications.

In interview on 05/09/2024 at 2:50 PM, Staff C, Caregiver stated they had arrived at the facility on [redacted]/2024 at around 9:00 PM (one hour and 45 minutes after the resident's symptoms were noted) to administer Resident 1's as needed medication (medications for

acute health symptoms) for symptom management, had assessed Resident 1 after speaking with CC1, and noted Resident 1's rigid fingers, crying, and distressed facial expressions, indicating the need for medication administration for symptom management.

In interview on 05/10/2024 at 10:10AM, Staff B, Executive Director, stated that they came into the facility on [redacted]/2024 "after hours" due to being alerted by Staff A, Health and Wellness Director, of Resident 1's discomfort and that no qualified staff were available onsite to administer Resident 1's medications (which were ordered for every 30 minutes as needed). Staff B stated they met with CC1 who expressed concerns over Resident 1's discomfort and not receiving medication for symptom management in a timely manner.

In an interview on 05/10/2024 at 10:50AM, CC1 stated that when they left the facility late at night on [redacted]/2024 after Staff C gave Resident 1 medication, that the medication appeared effective, and Resident 1 was comfortable and had no noticeable anxiety.

Review of Resident 1's April MAR showed Staff C gave Resident 1 their prescribed as needed morphine sulfate at 9:43pm on [redacted]/24 (two hours and 46 minutes after the resident's symptoms were noted). The MAR showed that Resident 1 was administered multiple as needed doses of medication for end-of-life symptom management throughout that night before they passed on the morning of [redacted]/2024. The MAR further showed that the resident's as-needed medication had been assessed by staff as effective for symptom management.

This is a recurring deficiency previously cited on 03/29/2023 for subsection (2)(a) and 09/01/2022 for (1)(b) and (2)(a).

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Administrator (or Representative) 5/30/24 Date

acute health symptoms) for symptom management, had assessed Resident 1 after speaking with CC1, and noted Resident 1's rigid fingers, crying, and distressed facial expressions, indicating the need for medication administration for symptom management.

In interview on 05/10/2024 at 10:10AM, Staff B, Executive Director, stated that they came into the facility on [redacted]/2024 "after hours" due to being alerted by Staff A, Health and Wellness Director, of Resident 1's discomfort and that no qualified staff were available onsite to administer Resident 1's medications (which were ordered for every 30 minutes as needed). Staff B stated they met with CC1 who expressed concerns over Resident 1's discomfort and not receiving medication for symptom management in a timely manner.

In an interview on 05/10/2024 at 10:50AM, CC1 stated that when they left the facility late at night on [redacted]/2024 after Staff C gave Resident 1 medication, that the medication appeared effective, and Resident 1 was comfortable and had no noticeable anxiety.

Review of Resident 1's April MAR showed Staff C gave Resident 1 their prescribed as needed morphine sulfate at 9:43pm on [redacted]/24 (two hours and 46 minutes after the resident's symptoms were noted). The MAR showed that Resident 1 was administered multiple as needed doses of medication for end-of-life symptom management throughout that night before they passed on the morning of [redacted]/2024. The MAR further showed that the resident's as-needed medication had been assessed by staff as effective for symptom management.

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Administrator (or Representative) Date