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) 35241 (Completion Date 01/16/2024) and 33733 (Completion Date 12/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/16/2024 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-2560-5-a, WAC 388-78A-2560-5-b-i, WAC 388-78A-2560-5-b-ii, WAC 388-78A-2560-5-b, WAC 388-78A-2560-5, WAC 388-78A-2350-1

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 #:** 33733
**Intake ID:** 107682
**Investigator:** Sylvia Shauvin
**Region/Unit #:** RCS Region 1 / Unit B
**Investigation Date(s):** 12/11/2023 through 12/22/2023
**Complainant Contact Date(s):** 11/28/2023, 12/26/2023

**Allegation(s):**

1 - Facility Administrator or nurse was not available to allow resident's return from the hospital
2 - No nurse in facility 24/7

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 46<br>Resident sample size: 5<br>Closed records sample size: 2 |
| **Observations:** | Residents' safety and well-being<br>Any unmet residents' needs<br>Availability of staff to respond to residents' needs, and address concerns pertaining to residents |
| **Interviews:** | Five residents, including named resident<br>Three resident representatives<br>Two hospital emergency department staff<br>Eight facility caregivers<br>Facility receptionist<br>Facility nurse<br>Administrator |
| **Record Reviews:** | Sample residents' Face Sheets, assessments, care plans, and Progress Notes<br>Hospital notes pertaining to named resident<br>Admission Agreement<br>Disclosure of Services<br>Staff schedule - Nov and Dec 2023<br>Transfer-Discharge roster |

**Investigation Summary:**

1 - Interviews with facility and hospital emergency department (ED) staff, and review of hospital ED notes pertaining to named resident showed the facility sent the resident to the hospital for evaluation related to a fall and agitation. These sources showed ED staff was unable to reach the Administrator or facility nurse when the ED physician determined the resident was medically cleared to return to the facility. This resulted a

costly and unnecessary stay in the hospital for the resident. Failed facility practices were found and documented in a Statement of Deficiencies (SOD) under Washington Administrative Code (WAC) 388-78a-2560(5)(a),(b)(i-ii) Administrator responsibilities, and WAC 388-78a-2350(1) Coordination of health care services.
2 - Assisted living regulations do not require a nurse to be in the facility 24/7. No failed facility practices were found.

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**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 #: 1698 | Compliance Determination # 33733 |
| Plan of Correction | Brookdale Nine Mile | Completion Date |
| Page 1 of 5 | Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC | 12/22/2023 |

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 12/11/2023, 12/11/2023 and 12/22/2023 of:

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

This document references the following complaint number(s): 107682

The following sample was selected for review during the unannounced on-site visit: 5 of 46 current residents and 2 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

12/28/2023

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)

01/15/2024
Date

**WAC 388-78A-2560 Administrator responsibilities. The licensee must ensure the administrator:**

(5) When the administrator is not available on the premises, either:

(a) Is available by telephone or electronic pager; or

(b) Designates a person approved by the licensee to act in place of the administrator. The designee must be:

(i) Qualified by experience to assume designated duties; and

(ii) Authorized to make necessary decisions and direct operations of the assisted living facility during the administrator's absence.

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to ensure the Administrator or a designee was available to address a resident's timely return to the facility from the hospital for 1 of 7 sampled residents (Resident 4). This failure resulted in the resident's unnecessary stay in the emergency room.

Findings included...

Review of Resident 4's Progress Note, dated [redacted]/2023 at 5:30 PM, showed the resident had two falls and was extremely agitated. The note showed the facility sent the resident to the hospital.

Review of Resident 4's emergency department (ED) physician's note, dated [redacted]/2023 at 11:29 PM, showed the physician spoke with Staff G, Facility Caregiver, who informed the physician that Staff B, Director of Nursing, was not available and they would have Staff B call the physician. The note further showed that Staff G was unable to provide the physician with information about how to reach Staff B.

Review of Resident 4's ED nurse note, dated [redacted]/2023 at 12:38 AM, showed when the hospital called the facility, Staff I, Caregiver told them there was not a facility nurse available to speak with the hospital. Further review of the note showed that when the ED nurse asked for information about how to speak with Staff A, Administrator, Staff I instructed them to leave a message or call the Administrator in the morning.

Review of Resident 4's ED physician's note, dated [redacted]/2023 at 1:23 AM, showed the

facility told the ED case management staff that Resident 4 had to remain in the ED until Monday [redacted]/2023 for clearance by the facility for Resident 4's return to the facility. The physician's note showed the resident was already medically cleared, there was no need for medical admission, and was appropriate for transfer back to the facility. The note stated that Staff B had not returned the call to the physician, and there was no justification as to why the facility was unable to allow Resident 4's return, which resulted in the resident staying in the ED. The physician documented "this is not the best environment for this patient to remain in" while awaiting consultation on Monday.

In an interview on 11/28/2023 at 12:05 PM, Collateral Contact 1 (CC1), an ED case manager, stated the facility sent Resident 4 to the hospital on [redacted]/2023 at 8:00 PM to be evaluated after a fall with bruising to the forehead and agitation. CC1 stated several hours later on [redacted]/2023, the physician determined Resident 4 was stable and could return to the facility. CC1 stated that when an ED nurse called the facility on [redacted]/2023 at 11:30 PM regarding sending Resident 4 back to the facility, Staff I stated the facility could not allow the resident to return. CC1 further stated that Staff I informed the ED nurse that Staff B needed to evaluate Resident 4 for return to the facility, but Staff B had left for the evening and was not available to see the resident.

In an interview on 12/11/2023 at 12:30 PM, Staff C, Caregiver and Staff D, Caregiver, stated that staff should call the Administrator or Staff B for a resident issue or crisis during evenings, nights, or weekends, but it was not always possible to reach either of them.

In an interview on 12/11/2023 at 1:15 PM, Staff B stated the medication aide on duty was responsible for contacting Staff A, Administrator or Staff B when issues arose requiring Staff A or Staff B to address. Staff B stated Resident 4 returned to the facility on the morning of [redacted]/2023 after Staff B assessed the resident at the hospital (two days after the ED physician determined the resident was medically cleared for return to the facility).

In an interview on 12/12/2023 at 2:45 PM, Staff H, Caregiver, stated Staff A and Staff B were not in the facility at night and on weekends. Staff H stated they were unaware and were not trained about who to contact for issues that needed to be addressed in the absence of Staff A or Staff B, or when issues arose during the night and on weekends, such as residents needing to return from the hospital.

In an interview on 12/13/2023 at 8:20 AM, Staff G stated they worked during the night and weekend shifts. Staff G stated they weren't trained on what to do and who to contact when residents needed to return from the hospital during their shifts. Staff G also stated if an issue came up that needed to be addressed by the Staff A or Staff B, they would try to contact Staff B but there were no guarantees they could reach either of them. Staff G stated the hospital called several times regarding Resident 4's return to the facility the evening of [redacted]/2023 and it was difficult to reach Staff B to address the hospital's requests. Staff G stated that Staff B instructed them to inform the hospital that the resident needed to stay in the hospital overnight for observation (Staff B did not assess the resident until [redacted]/2023).

In an interview on 12/12/2023 at 10:15 AM, Resident 4's representative stated the resident could not return from the hospital to the facility on [redacted]/2023 because the facility didn't have a way to reassess the resident at the hospital. The representative further stated it was difficult to reach facility staff that could answer questions on weekends, and the facility did not return calls.

In an interview on 12/12/2023 at 10:15 AM, a representative of Resident 4 stated someone from the facility should always be available to answer calls.

In an interview on 12/22/2023 at 10:15 AM, Resident 4 stated when they were recently in the hospital, they were eager to return to the facility.

In an interview on 12/22/2023 at 11:10 AM, Staff A stated if issues arose after hours or on the weekends, staff should call Staff A. Staff A further stated if staff was unable to reach Staff A, they should call Staff B.

**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). 01/12/2024 .

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

Administrator (or Representative) 12/29/2023 Date

**WAC 388-78A-2350 Coordination of health care services.**

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to coordinate with the hospital to allow a resident's timely return to the facility from the hospital for 1 of 7 sampled residents (Resident 4). This resulted in the resident's unnecessary stay in the emergency room.

Findings included...

Review of a Progress Note, dated [redacted]/2023 at 5:30 PM, showed the facility sent Resident

4 to the hospital because they had two falls and was extremely agitated.

In an interview on 11/28/2023 at 12:05 PM, Collateral Contact 1 (CC1), a hospital emergency department (ED) case manager, stated the ED physician determined Resident 4 was stable and could return to the facility on the evening of [redacted]/2023, but there was no one from the facility that could coordinate with the ED to facilitate the resident's return to the facility. CC1 stated that when an ED nurse called the facility on [redacted]/2023 at 11:30 PM regarding Resident 4's discharge back to the facility, Staff G, Facility Caregiver, stated that Staff B, Director of Nursing, needed to evaluate Resident 4 for return to the facility, but Staff B had left for the evening and was not available to see the resident.

Review of Resident 4's ED physician's note, dated [redacted]/2023 at 11:29 PM, showed the physician spoke with Staff G who told the physician that Staff B was not available, and Staff G would have Staff B call the physician. The note further showed that Staff G did not provide the physician with information about how to reach Staff B.

Review of Resident 4's ED nurse note, dated [redacted]/2023 at 12:38 AM, showed when the hospital called the facility, there was not a nurse available to speak with the hospital. When the ED nurse asked for information about how to speak with the Administrator, Staff I, Caregiver, instructed them to leave a message or call the Administrator in the morning.

Review of Resident 4's ED physician's note, dated [redacted]/2023 at 1:23 AM, showed the Staff B had not returned a call to the physician.

In an interview on 12/11/2023 at 1:15 PM, Staff B stated Resident 4 returned to the facility on the morning of [redacted]/2023 after Staff B assessed the resident at the hospital (two days after the ED physician determined the resident was medically cleared for return to the facility).

**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) 01/12/2024 .

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

Administrator (or Representative) 12/29/2023 Date