STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

02/28/2025

EMERITUS CORPORATION
Brookdale Fishers Landing
17171 SE 22ND DR
VANCOUVER, WA 98683

RE: Brookdale Fishers Landing # 2261

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 55006 (Completion Date 02/28/2025) and 51844 (Completion Date 12/30/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/28/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

The Department staff who did the On Site verification:

Emily Boniface, Community Program Nurse Licensor
Megan Zerby, Community ALF/AFH Licensor

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just

Jody Just, Field Services Administrator
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Fishers Landing
Provider Type: Assisted Living Facility

License/Cert.#: 2261
Intake ID: 157018
Compliance Determination #: 51844
Region/Unit #: RCS Region 3 / Unit I
Investigator: Emily Boniface
Investigation Date(s): 12/20/2024 through 12/30/2024
Complainant Contact Date(s): 12/16/2024

Allegation(s):

Allegation that resident's care plan does not include services resident requires to maintain their health and safety in addition to not receiving care and services as prescribed in the resident's care plan.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions
Interviews:	Business office manager Family members Residents Nursing staff Identified resident Health and Wellness Director Executive Director
Record Reviews:	Staff patterns State reporting log Hospital records Resident Assessments Resident Negotiated Service Agreements Facility Policies Facility Call light log

Investigation Summary:

Based on observation, interview, and record review, it was determined the resident's care plan did not reflect the care and services needed to support their health and safety nor was the resident receiving the services as outlined in their

current care plan. Failed practice identified for not providing quality care and treatment.

Conclusion / Action:

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

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AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 12/20/2024, 12/20/2024 and 12/20/2024 of:

Brookdale Fishers Landing
17171 SE 22ND DR
VANCOUVER, WA 98683

This document references the following complaint number(s): 157018

The following sample was selected for review during the unannounced on-site visit: 3 of 83 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Emily Boniface, Community Program Nurse Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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 — 1.8.2025 (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) 1/14/2025 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide care and services as agreed upon in the personal service plan (the facility's version of the negotiated service agreement [NSA]) for 1 of 3 sampled residents (Resident 1 [R1]). This failure placed R1 at risk for a decreased quality of life by causing an increase in illness and injury by not having their care needs provided.

Findings included...

Record review of the Characteristic Roster, dated 12/20/2024 showed R1 moved into the facility on [redacted]2020, with a diagnosis of [redacted]. utilized mobility devices (wheelchair), and had vision problems.

Record review of R1's CARE assessment, dated 08/01/2024, showed R1 required extensive assistance, and that need was unmet at the time of the assessment. Under the clinical complexity section. the document showed R1 had "one or more of the following problems:
- frequently incontinent (bladder, incontinent all or most of the time (bladder).
-frequently incontinent (bowel).
- or incontinent all or most of the time (bowel).
- AND One of the following applies:
-The status of your individual management of bowel bladder supplies is "Uses, has leakage, needs assistance".
-The status of the individual management of bowel bladder supplies is "Does not use, has leakage"; or
- uses any scheduled toileting plan.

Record review of R1's NSA, dated 05/20/2024, showed R1 required assistance with toileting and assistance with transferring to and from the toilet, to pull their pants up and down, and to complete wiping and changing protective undergarments. The service plan showed staff were to provide the needed assistance to the resident.

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

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Findings included...

Record review of the Characteristic Roster, dated 12/20/2024 showed R1 moved into the facility on [redacted]/2020, with a diagnosis of [redacted], utilized mobility devices (wheelchair), and had vision problems.

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Record review of R1's NSA, dated 05/20/2024, showed R1 required assistance with toileting and assistance with transferring to and from the toilet, to pull their pants up and down, and to complete wiping and changing protective undergarments. The service plan showed staff were to provide the needed assistance to the resident.

Record review of R1's NSA, dated 11/13/2024 showed R1 had a diagnosis of [redacted], and [redacted]. The service plan showed R1 required assistance with toileting and assistance with transferring to and from the toilet, to pull their pants up and down, and to complete wiping and changing protective undergarments. The service plan showed staff were to provide the needed assistance to the resident.

Record review of R1's progress notes, dated 05/01/2024 to 12/24/2024, showed R1 sustained a fall on 08/22/2024 at 2:14 AM. The note showed "Resident is on alert for injury fall. Resident was found lying on the floor in front of [their] bed, resident stated that [they were] trying to use the restroom, but [they] slid down from [their] wheelchair. Resident stated [they] bumped [their] head a little bit on the cabinet door, but not hard."

Record review of the facility's progress note entered on 10/07/2024 at 7:58 AM showed R1 was sent to the hospital on 10/07/2024 for hyponatremia (low sodium level in blood) and a urinary tract infection.

Record review of the facility's progress note entered on 10/08/2024 at 3:43 AM showed R1 began taking a new antibiotic to treat a [redacted] diagnosed during their 10/07/2024 hospitalization.

Record review of the Department's CARE database showed a note from 10/08/2024 at 8:44 AM by Collateral Contact two (CC2). The note showed CC2 "received an email from Collateral Contact three, R1's durable power of attorney's significant other and Collateral Contact One (CC1), R1's durable power of attorney, reporting that the client smelled of urine again on 10/4/2024 when CC3 was taking the client to an appointment. The client reported to CC3 that the staff is not assisting[them] with going to the bathroom and pulling up [their] briefs. CC3 reported that CC1 spoke to Staff C and Staff C stated that [they were] unaware that the client needed assistance with toileting as stated in the service summary for the client. CC3 also reported that a physician at Peace Health Fishers Landing noticed a large bruise under the client's right breast. Client stated that [they were} unsure how [they] got it but stated that [the had] fallen multiple times…CC3 reported that client was sent to ER on 10/7/2024 due to a genitourinary infection and low sodium."

Record review of the facility's progress notes showed that alert charting due to soreness, redness, bleeding, and discharge in the peri area began on 12/14/2024 at 9:31 AM. The resident remained on alert for this issue until 12/23/2024 when it was discontinued by Staff C, Health and Wellness Director.

In an interview on 12/16/2024 at 5:15 PM collateral contact one (CC1), R1's durable power of attorney, stated there were multiple occasions when R1 was picked up from the facility and R1 was found completely soiled and soaked through their entire clothing

and brief from urine. CC1 showed they were concerned because they thought R1 was on a toileting schedule which would prevent finding R1 soiled.

In an observation on 12/20/2024 at 2:46 PM, R1 was observed in their wheelchair outside the dining room. R1 was malodorous of urine.

In an interview on 12/20/2024 at 3:32 PM, Staff C stated R1 does not refuse care services, but that the facility does not document care services provided to residents so there was no way to confirm care services provided to any resident, including R1. Staff C stated there was no documentation available to review regarding when and by whom toileting assistance occurred for R1.

In an interview on 12/20/2024 at 3:40 PM Staff C stated they had a conversation with CC1 about four or five months ago. Staff C stated that in that conversation CC1 indicated they thought R1 was on a toileting schedule and received staff assistance with toileting on a consistent schedule. When asked what the facility did with the information from CC1, Staff C stated nothing. Staff C stated the phone call was disconnected and there was never follow up that occurred thereafter.

In an interview on 12/20/2024 at 3:43 PM, Staff C stated the facility's only process to monitor whether a resident is receiving the service plan toileting assistance is to track whether there had been increases in call light usage, incontinent laundry, or urinary tract infections.

In an interview on 12/20/2024 at 4:15 PM, R1 stated they hated the fact that they are incontinent and tried to not call staff for assistance with toileting. R1 stated they usually transfer and toilet themselves. Staff C was present during the interview.

In an interview and observation that began on 12/20/2024 at 4:35 PM, Staff C was asked what they thought about R1's statements about toileting as the statements contradicted Staff C's assessment and service plan details. Staff C stated that they were not surprised to hear R1 toileted themselves and did not call for help and that they were not concerned by those statements. Staff C stated that R1 required at least one person staff assistance for all bathroom transfers but showed there was no way to really track how often R1 sought help outside of the call light report. Staff C pulled up the call light report on their computer. The call light report showed the only time R1 had called for help that day was at 3 AM.

In an interview on 12/20/2024 at 4:38 PM, Staff C stated they acknowledged the discrepancy between the facility's service plans dated, 05/20/2024 and 11/13/2024, that showed R1 required at least one person staff assistance in contrast to R1's report that they were toileting themselves without assistance consistently.

In an interview and observation on 12/20/2024 at 4:45 PM, two fully urine saturated

briefs were observed in R1's bathroom trash can. Staff C stated that when staff help a resident with toileting the waste and waste products were removed from the resident's room at that time. Staff C stated the presence of two soiled briefs indicated that R1 toileted themselves and changed their own brief at least twice since the only documented call light alert that occurred was at 3:00 AM.

During an interview on 12/27/2024 at 3:00PM, both Staff A and Staff C stated they acknowledged R1's NSA was not followed by facility 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 Fishers Landing is or will be in compliance with this law and / or regulation on (Date) 1/19/2025.

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

Administrator (or Representative) 1/13/2025 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

briefs were observed in R1's bathroom trash can. Staff C stated that when staff help a resident with toileting the waste and waste products were removed from the resident's room at that time. Staff C stated the presence of two soiled briefs indicated that R1 toileted themselves and changed their own brief at least twice since the only documented call light alert that occurred was at 3:00 AM.

During an interview on 12/27/2024 at 3:00PM, both Staff A and Staff C stated they acknowledged R1's NSA was not followed by facility staff.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

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(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to include the resident's representative and department case manager in the development of the personal service plan (facility's negotiated service agreement [NSA]) for 1 of 2 sampled residents (Resident 1 [R1]). This failure resulted in Resident 1 not having a representative and Department case manager involved in the development of the NSA.

Findings included...

Record review of facility record, titled "Characteristic Roster", dated 12/20/2024, showed R1 moved into the facility on [redacted]/2020 with a diagnosis of [redacted], utilized mobility devices (wheelchair), and had vision problems.

Record review of Department Comprehensive Assessment Reporting Evaluation (CARE) assessment, dated 08/01/2024, conducted by Collateral Contact 2 (CC2), Department case manager (CM), documented that R1 was incontinent of urine at all times and required caregivers to "follow toileting schedule, change pads at least every two hours" and "assist with clothing adjustment, provide perineal care, transfer client on/off toilet."

Record review of R1's NSA, dated 11/13/2024 showed R1 had a diagnosis of [redacted], and [redacted]. The NSA showed R1 required assistance with toileting and assistance with transferring to and from the toilet, to pull their pants up and down, and to complete wiping and changing protective undergarments. The service plan showed staff were to provide the needed assistance to the resident.

Record review of the 6-month service plan review notice for R1, sent to CC1, R1's durable power of attorney (DPOA) on 11/21/2024, said "We are writing you today to invite you to a care conference. The purpose of this conference is to promote open communication about your care and services and to answer questions, personalize your service plan, as well as address any issues or concerns."

On 12/10/2024 at 1:53 PM, CC1 replied to the invitation and stated they were confused by the intent of the meeting because they understood the HCS CM had already evaluated R1's level of care and " [the facility] failed to provide a response recognizing [that information]." CC1 further elaborated stating concern the facility planned "to renegotiate (or ignore) the instructions regarding level of care," that had been provided to the facility by the HCS CM.

On 12/16/2024 at 5:15 PM, Collateral Contact 1 (CC1), stated that there were multiple occasions when R1 was picked up from the facility and found completely soiled and soaked through their entire clothing and brief from urine. CC1 stated that they were concerned because they thought R1 was on a toileting schedule which would prevent finding R1 soiled.

On 12/20/2024 at 2:46 PM, R1 was observed in a wheelchair, outside the dining room, and R1 had an ammonia odor surrounding them.

On 12/20/2024 at 4:15 PM, R1 stated that they hated the fact that they are incontinent and tried to not call staff for assistance with toileting.

On 12/20/2024 at 3:40 PM, Staff C, Health and Wellness Director, stated that they had a conversation with CC1, four to five months prior where CC1 indicated they understood R1 was on a toileting schedule and received staff assistance with toileting on a consistent schedule. When asked what the facility did with the information from CC1, Staff C stated "nothing", and that the phone call was disconnected and there was no follow up done with CC1.

On 12/20/2024 at 5:28 PM, CC1 stated he has not received any follow up from the facility after his phone call to them on 12/12/2024 was disconnected when he reported his concerns that R1 was not on a toileting schedule. CC1 stated the facility sent him an email asking if he was available for a care conference during the day, in which he replied and asked for another date and time. CC1 stated he has not heard from the facility to set up a care conference.

On 12/27/2024 at 3:00 PM, Staff A, Executive Director, and Staff C, acknowledged that the care and services R1 had received was different than the care and services described in R1's NSA. Staff A and Staff C acknowledged CC1 had communicated their frustration about their observations to the facility without resolve nor follow-up. Staff C stated that they did not know what a Home and Community Services (HCS) or CARE assessment and care plan was. Staff C stated that the information from the CM was not incorporated into R1's NSA, however, acknowledged it should have been. Both Staff C and Staff A, stated that they were not aware the CM was supposed to be involved in the NSA planning process. Staff C stated that they pull up the previous NSA and update it as needed and at least every six months. Staff C confirmed that neither a toileting schedule nor every two-hour peri pad changes have ever been incorporated into one of R1's NSAs, both as prescribed in the CARE assessment and as requested by CC1.

Statement of Deficiencies	License #: 2261	Compliance Determination # 51844
Plan of Correction	Brookdale Fishers Landing	Completion Date
Page 8 of 8	Licensee: EMERITUS CORPORATION	12/30/2024

This is a recurring deficiency previously cited on 10/28/2024, 01/31/2023 for subsections 5(b,d) and 6(a,i,ii 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 Fishers Landing is or will be in compliance with this law and / or regulation on (Date) 1/13/2025 .

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

Administrator (or Representative) 1/13/2025 Date

This is a recurring deficiency previously cited on 10/28/2024, 01/31/2023 for subsections 5(b,d) and 6(a,i,ii b).

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Administrator (or Representative) Date