STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

EMERITUS CORPORATION
Brookdale College Place
550 E WHITMAN DRIVE
COLLEGE PLACE, WA 99324

RE: Brookdale College Place License # 2322

Dear Administrator:

This letter addresses Compliance Determination(s) 24898 (Completion Date 06/27/2023) and 22710 (Completion Date 04/20/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/27/2023 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-2240

The Department staff who did the on-site verification:
Krista Connelly, Community Nurse Consultant

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale College Place
Provider Type: Assisted Living Facility
License/Cert.#: 2322
Compliance Determination #: 22710
Intake ID: 78919
Investigator: Melissa Milanez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/19/2023 through 04/20/2023
Complainant Contact Date(s): 04/25/2023

Allegation(s):
A named resident was not given their prescribed medications.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 3 Closed records sample size:
Observations:	Environment, cares, residents, resident rooms, staff to resident interactions, resident to resident interactions, facility common areas, med cart.
Interviews:	Staff Facility, Residents, and others not associated with the facility.
Record Reviews:	Characteristic roster, facility's medication and treatment policy, resident record (face sheet, assessments, care plan, progress notes, physician orders, medication administration records).

Investigation Summary:
Interviews and record review showed that the named resident did not receive their medications as ordered. This failure placed the resident at risk of a decline in health and unmet needs. Failed practice identified WAC 388-78A-2240.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2322	Compliance Determination # 22710
Plan of Correction	Brookdale College Place	Completion Date
Page 1 of 4	Licensee: EMERITUS CORPORATION	04/20/2023

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 04/19/2023 and 04/19/2023 of:

Brookdale College Place
550 E WHITMAN DRIVE
COLLEGE PLACE, WA 99324

This document references the following complaint number(s): 78919, 77642

The following sample was selected for review during the unannounced on-site visit: 3 of 84 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

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.

Gwin Kaercher
Residential Care Services

05/04/2023
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)

05/10/2023
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to obtain medications in a timely manner for 1 of 3 sampled Residents (Resident 1). This failure caused the resident to miss doses of prescribed medications.

Findings included...

Record review of the facility's policy, "Medication Policy" dated 03/31/2022, showed that all currently ordered medications would be available to the resident, and that the ALF was responsible for obtaining newly ordered medications or refills for medications and treatment orders.

Resident 1

Review of the medical record showed that Resident 1 was admitted to the facility on [redacted]/2023 with diagnoses that included [redacted], and [redacted].

Resident 1's Negotiated Service Agreement (NSA) dated [redacted]/2023 showed the facility was to order, assist, and store medications for the resident.

Resident 1 was interviewed in their apartment on 04/19/2023 at 4:18 PM. They reported that staff assisted with their medications and that they were out of some of their medications but did not know which ones. They had gone to Urgent Care on 04/17/2023 to obtain refill prescriptions for their missing medications and only some (medications) were filled.

Resident 1's Medication Administration Record (MARs) for 04/11/2023 through 04/18/2023 showed that the ALF did not provide prescribed medications which included:

- 8 doses of Amlodipine (treats high blood pressure)
- 8 doses of Atorvastatin (treats high cholesterol)
- 8 doses of Cetirizine doses of (treat allergy symptoms)
- 8 doses of Mirtazapine (treats depression)
- 8 doses of Montelukast (treats allergies)
- 8 doses of Sertraline (treats depression)
- 16 doses of Carvedilol (treats high blood pressure)
- 16 doses of Mucinex (relieves coughs)
- 15 doses of Memantine (treats dementia)
- 15 doses of Glyburide (treats type 2 diabetes)
- 15 doses of Potassium
- 8 doses of Eliquis (used to lower the risk of stroke or blood clot)

Review of the 04/01/2023 through 04/19/2023 MARs showed that staff documented reasons for the medication not being available included: pharmacy action required, absent from home, and four doses were blank as if not given and no documentation was listed for why it was not given.

On 04/19/2023 at 2:33 PM, Staff C, Med-Tech, stated that Resident 1 had not received some of their prescribed medications because the facility had run out of them. Staff C stated that Resident 1 moved into the facility on [redacted]/2023, and only came with a short supply of prescribed medications from the previous facility. Staff C stated that Resident 1 went to Urgent Care on 04/17/2023 to get their medication refills but that they were still missing some medications as of 04/19/2023. Staff C stated they had not administered all prescribed medications because they were not available.

On 04/19/2023 at 3:30 PM, Staff B, Registered Nurse (RN)/Health and Wellness Director, stated that Resident 1 went to the Urgent Care on 04/17/2023 to obtain new prescriptions for their medications because the resident had run out. When this investigator informed Staff B that Resident 1 was still missing prescribed medications, which included: two blood pressure medications and one medication to control blood sugars (diabetic). Staff B responded that they were not aware (two days after the Urgent Care visit) that the prescriptions had not been filled. At that time, Staff B went to the medication cart to identify and confirm that Resident 1 was still missing prescribed medications.

On 04/19/2023 at 5:17PM, Staff A, Administrator, stated Resident 1 had recently gone to Urgent Care due to an issue with their medications. Staff A stated that they were aware that it was the facility's responsibility to obtain all prescribed medications for Resident 1.

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 College Place is or will be in compliance with this law and / or regulation on (Date) 05/31/2023 .

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

Administrator (or Representative) — Date: 5/10/2023