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

Statement of Deficiencies	License #: 2497	Compliance Determination # 40727
Plan of Correction	Brookdale Olympia West	Completion Date
Page 1 of 12	Licensee: BKD Clare Bridge of Olympia LLC	05/09/2024

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 follow-up on 05/02/2024, 05/03/2024, and 05/09/2024 of:
Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028668

This document references the following SOD dated: 05/09/2024

The following sample was selected for review during the unannounced on-site visit: 41 of 41 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
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.

Cory Cisneros
Residential Care Services

05/20/2024
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.

This document was prepared by Residential Care Services for the Locator website.

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Brookdale Olympia West
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OLYMPIA, WA 985028660

This document references the following SOD dated: 05/09/2024

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Residential Care Services _____ Date _____

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Administrator (or Representative) Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that all fire extinguishers had service tags that showed when they were serviced and checked and failed to ensure that all fire extinguishers were serviced yearly for 1 of 1 facility reviewed. These failures placed all 41 of 41 residents, staff, and visitors at risk of harm during a fire.

Findings included…

State Fire Marshall regulation code IFC 906.2 2015,2018
“Portable fire extinguishers shall be selected, installed, and maintained in accordance with this section and NFPA 10.
Exceptions: 1. The distance of travel to reach an extinguisher shall not apply the travel distance to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2. Thirty-day inspections shall not be required, and maintenance shall be allowed to be once every three years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
2.3. The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
2.4. Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
2.5. A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by NFPA10.
3. In Group 1-3, portable fire extinguishers shall be permitted to be located at staff locations."

Record review of the “Department of Social And Health Services” document, Completion date 03/06/2024, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2040] as stated in the cited deficiencies in the enclosed report. I understand that to

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maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times." The administrator section showed Staff A, Executive Director, signed the document on 03/21/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 04/20/2024.

In an observation on 05/02/2024 at 1:15 PM, by the shower room by "E" court, the fire extinguisher was noted to have the service tag ripped off. There were no other service tags to show when the fire extinguisher was last checked and serviced.

In an observation on 05/02/2024 at 1:56 PM, in between the laundry room and the Bridge side country kitchen dining room, the fire extinguisher service tag was ripped and unreadable. There were no other service tags on the fire extinguisher that showed when it was last serviced or when the last inspection was.

In an observation on 05/02/2024 at 2:03 PM, by the life enrichment office, the fire extinguisher's service tag had been ripped off. There were no other service tags on the fire extinguisher to show when it was last serviced or when the last check was.

In an observation on 05/02/2024 at 3:02 PM, in the kitchen by the handwashing sink, the red fire extinguisher showed it was last serviced with the months April and May punched 2023. The Class K fire extinguisher that was below the red fire extinguisher, the service tag showed it was last serviced February 2023. The service tag showed it had a monthly check completed on 01/31/2024 and then 04/23/2024. There were no monthly checks documented for February 2024 or March 2024 for review.

In an observation on 05/03/2024 at 12:06 PM, in between the Bridge side country kitchen and the small television room, the fire extinguisher had a ripped service tag. The residual service tag had a handwritten date 01/31/2024. There were no other dates document to show when the fire extinguisher was last serviced and checks were completed for review.

In an observation on 05/03/2024 at 12:08 PM, the fire extinguisher by the "E" Court did not have a service tag to show when it was last serviced and check was completed for review.

In an observation on 05/03/2024 at 12:13 PM, in the kitchen by the handwashing sink showed the Class K fire extinguisher was last serviced in February 2023. The red fire extinguisher that was above the Class K fire extinguisher showed it was last serviced on April and May 2023. There were no other documented service dates for review for both fire extinguishers.

In an interview on 05/02/2024 at 2:39 PM, Staff C, Maintenance Director, stated they completed the last monthly check on all the fire extinguishers at the end of each month. Staff C stated they were the only staff member to complete the monthly fire extinguisher checks. Staff C stated on 04/23/2024 they checked the fire extinguishers for the facility. Staff C stated they had gotten new service tags that were left at the front desk on 03/29/2024, by the representative from Johnson and Johnson controls, to replace the ripped or missing service tags on the fire extinguishers.

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In an interview on 05/03/2024 at 1:13 PM, Staff A, Executive Director, stated the residents often tore the service tags. Staff A stated Staff D was responsible to check the fire extinguisher's monthly.

This is an uncorrected and recurring deficiency previously cited on 03/06/2024 and 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observations, interview, and record reviews, the facility failed to ensure food was stored and labeled properly for 3 of 3 kitchen areas reviewed (Bridge Side Kitchenette, Clare Side Kitchenette, and Main kitchen). The facility failed to ensure proper hand hygiene and infection control practices were conducted for 5 of 5 staff (Staff D, Staff E, Staff F, Staff G, and Staff H) reviewed. These failures placed all 41 of 41 residents at risk for exposure to food-borne illnesses and at risk for receiving food that was incorrectly stored and prepared.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 03/06/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2305] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 03/21/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "I hereby certify that I have

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reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, [the facility] is or will be in compliance with this law and/or regulation on 04/20/2024."

WAC 246-215-02310 "Hands and arms—When to wash (FDA Food Code 2-301.14).
food employees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:
(1) After touching bare human body parts other than clean hands and clean, exposed portions of arms;
(2) After using the toilet room;
(3) After caring for or handling service animals or aquatic animals as specified under WAC 246-215-02415(2);
(4) Except as specified under WAC 246-215-02400(2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;
(5) After handling soiled equipment or utensils;
(6) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;
(7) When switching between working with raw food and working with ready-to-eat food;
(8) Before donning gloves for working with ready-to-eat food unless a glove change is not the result of contamination; and
(9) After engaging in other activities that contaminate the hands or gloves."

WAC 246-215-03526
"Temperature and time control—Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).
(1) Except whenpackaging foodusing areduced oxygen packagingmethod as specified under WAC246-215-03540, and except as specified in subsections (5) and (6) of this section, refrigerated,ready-to-eat, time/temperature control for safety foodprepared and held in afood establishmentfor more than twenty-four hours must be clearly marked to indicate the date or day by which thefoodmust be consumed on thepremises, sold, or discarded when held at a temperature of 41ºF (5ºC) or less for a maximum of seven days. The day of preparation must be counted as day one.
(2) Except as specified in subsections (5) through (7) of this section, refrigerated,ready-to-eat, time/temperature control for safety foodprepared andpackagedby afood processing plantmust be clearly marked, at the time the original container is opened in afood establishmentand if thefoodis held for more than twenty-four hours, to indicate the date or day by which thefoodmust be consumed on thepremises, sold, or discarded, based on the temperature and time requirements specified in subsection (1) of this section and:
(a) The day the original container is opened in thefood establishmentis counted as day one; and
(b) The day or date marked by thefood establishmentmay not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based onfoodsafety.
(3) A refrigerated,ready-to-eat, time/temperature control for safety foodingredient or a portion of a refrigerated,ready-to-eat, time/temperature control for safety foodthat is combined with additional ingredients or portions offoodmust retain the date marking of the earliest-prepared or first-prepared ingredient.
(4) A date marking system that meets the criteria stated in subsections (1) and (2) of this section may include:
(a) Using a methodapprovedby theregulatory authorityfor refrigerated,ready-to-eat,

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time/temperature control for safety foodthat is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft-serve mix or milk in a dispensing machine;
(b) Marking the date or day of preparation, with a procedure to discard thefoodon or before the last date or day by which thefoodmust be consumed on the premises, sold, or discarded as specified under subsection (1) of this section;
(c) Marking the date or day the original container is opened in afood establishment, with a procedure to discard thefoodon or before the last date or day by which thefoodmust be consumed on the premises, sold, or discarded as specified under subsection (2) of this section; or
(d) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to theregulatory authorityupon request."

WAC 246-215-03525
"(1)Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be maintained: (a) At 135°F (57°C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400(2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130°F (54°C) or above; or (b) At 41°F (5°C) or less. (2) EGGS that have not been treated to destroy all viable Salmonellae must be stored in refrigerated EQUIPMENT that maintains an ambient air temperature of 45°F (7°C) or less. (3) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD in a homogenous liquid form may be maintained outside the temperature control requirements, as specified under subsection (1) of this section, while contained within specially designed EQUIPMENT that complies with the design and construction requirements as specified under WAC 246-215-04230(5)."

WAC 246-215-03351
"Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).
(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:
(a) In a clean, dry location;
(b) Where it is not exposed to splash, dust, or other contamination; and
(c) At least six inches (15 cm) above the floor."

Record review of the facility's policy titled, "Handwashing/Hand Hygiene", dated 10/2021, showed regular hand washing and hand hygiene was the primary means to prevent the spread of infections. Associates, residents, family members, and visitors should be encouraged to wash their hands or use an alcohol based hand sanitizer solution. The Centers for Disease Control and Prevention (CDC) promotes regular hand washing as one of the best way to remove germs, avoid getting sick, and prevent the spread of germs to others. Associates should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other associates, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) should be readily accessible and convenient for associates to use to encourage compliance with hand hygiene policies. Hands were to be washed with soap and water for specific situations that included but not limited to after conducting personal hygiene, before eating, and when hands were visibly soiled. The CDC recommends use of alcohol based hand sanitizer was preferred over use of soap and water in most clinical situations due to better compliance. Alcohol based hand sanitizer was to be used but not limited to when in contact with intact

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skin and after removing gloves.

Record review of the facility's policy "Labeling - DS-04.028," revised on 5/10 (date as shown), showed "All food items must be labeled and dated before storing."

Record review of the facility's policy, titled, "Storage of Perishable Food-DS-04.014", dated 05/2010, showed perishable food must be refrigerated in a manner that optimizes food safety, nutrient retention, and aesthetic quality. Perishable foods include fruits, vegetables, meats, dairy, etc. Refrigerators would be maintained at a temperature of 32 – 40 degrees Fahrenheit (F) or below. Food storage containers would have a tight fit lid. All refrigerated items shall be covered, labeled, indicating product name, and dated (month/day/year) product was received or prepared. All pre-dished items must be covered, labeled, and dated to prevent off-flavors, drying, or cross-contamination while refrigerated.

Record review of the facility's policy, titled, "Storage of Frozen Food-DS-04.015", dated 05/2010, showed Frozen foods must be stored in a manner that insures food safety, optimal nutrient retention and optimal aesthetic quality. All frozen products must be labeled indicating product name and date (month/day/year) product was received or used.

Record review of the facility document, titled, "Temperature Log- Equipment", dated April (no year) for the kitchen's freezer showed the target temperature was -10 degrees Fahrenheit (F) and 0 degrees F. On top of the temperature log document showed, "food holding equipment temperatures must be monitored and recorded every four hours during operating hours."Review of the documentation dated April 1st through April 24th showed all temperatures recorded were ranged from 29 to 3.0 degrees F. On 04/03/2024 the temperature was documented as 3.0. Under the section titled, "corrective action taken", showed "not at temp [temperature]". On 04/13/2024 the documented temperature showed it was 18.8 degrees F and under the corrective action section showed, "not at temp, flooding".

Bridge Side Kitchenette

In an observation on 05/02/2024 at 1:41 PM, inside the Bridge dining room on a coffee table stand there were two pitchers that contained white liquid. The pitchers were unlabeled with what was inside them and undated to show when they were opened and prepared. Both pitchers were warm to the touch.

In an observation on 05/02/2024 at 1:43 PM, inside the Bridge kitchenette unlocked refrigerator was a gallon jug of milk that was half gone. The gallon jug was undated. There was a clear container with a white top that had white liquid with dark flakes in it. The clear container was unlabeled and undated. There was a drink pitcher that was a quarter full of brown liquid. The pitcher was unlabeled and undated.

Clare Side Kitchenette

In an observation on 05/02/2024 at 2:10 PM, inside the Clare side kitchenette refrigerator showed an open container of milk that was three quarters of the way gone. The container was unlabeled and undated. Inside the refrigerator door there was a clear plastic bottle that contained an unknown white substance. The bottle was unlabeled and undated.

Main Kitchen

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In an observation on 05/02/2024 at 3:08 PM, inside the walk-in refrigerator there were two open one-gallon jugs of milk. Both jugs were undated. There was a zip lock bag with an open package of seven hard unshelled eggs. The zip lock bag with the unshelled eggs inside were unlabeled and undated. There were two bags that had been opened with soft white whipped cream. Both bags of opened whipped cream were undated.

Freezer Temperature checks

In an interview on 05/02/2024 at 3:32 PM, Staff D, Cook, stated they had not been checking the temperature of the freezer as it was broken. Staff D stated they were not instructed to continue to check the temperature of the freezer or any other specific directions for the food inside the freezer.

In an observation on 05/02/2024 at 4:11 PM, Staff D was observed to remove corn that had been thawed out of the freezer that was not holding accurate temperature out and placed into a pan in preparation to cook for the residents for dinner that evening.

In an observation and interview on 05/02/2024 at 4:37 PM, Staff A, Executive Director reviewed the "temperature log- equipment" dated April no year for the kitchen freezer showed there were no documented temperatures for the 25th,26th, 27th, and 30th. There were no available documented temperatures for the freezer for May 1st or 2nd for the Department to review. Staff D told Staff A that they were not checking the temperature of the freezer as it was broken and not keeping accurate temperature.

Hand Hygiene

In an observation on 05/02/2024 at 3:03 PM, the Department entered the kitchen. Staff D, Cook, had a pair of gloves on their hands. Staff D was observed putting clean kitchen dishes away. At 3:13 PM, Staff D was observed to doff (take off) the pair of gloves they wore, they did not perform hand hygiene before they donned (put on) another new pair of gloves. Staff D was observed to turn on the kitchen oven, put clean dishes away, and touched a spoon to stir food that was in a pot on the stove. Staff D started washing dirty dishes. At 3:14 PM, staff D doffed the gloves on their hands and did not perform hand hygiene before they took a pan out of the kitchen's oven. Staff D then started to wash dirty dishes.

In an interview on 05/02/2024 at 3:14 PM, Staff D stated the food in a pot on the stove that they stirred was cream of broccoli soup that they would serve to residents for dinner.

In an observation on 05/03/2024 at 12:15 PM, Staff F, Care Staff, entered the kitchen and did not perform hand hygiene before they touched two circular grey serving trays. At 12:20 PM, Staff F picked up multiple plates of food off the counter and put the plates onto the serving tray. It was observed that Staff F's thumb touched the inner part of the plates rim. Staff F left with the tray of food to serve to the residents for lunch.

In an observation on 05/03/2024 at 12:18 PM, Staff G, Care Staff, entered the kitchen and did not perform hand hygiene before they touched a grey serving tray. Staff G picked up rectangular cards and arranged the cards on top of the serving tray. At 12:20 PM, Staff G picked up a plate of food and placed it on the serving tray. Staff G stated they would be right back and took the food on the serving tray with them.

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In an observation on 05/03/2024 at 12:22 PM, Staff F and Staff G returned into the kitchen while they carried empty grey serving trays. Staff F and Staff G did not perform hand hygiene before they picked up rectangular cards and arranged the cards on top of the serving trays. Staff G picked up a brown container of food and placed it on the grey serving tray.

In an interview on 05/03/2024 at 12:25 PM, Staff F stated they always performed hand hygiene. Staff F stated they were supposed to perform hand hygiene when they entered the kitchen. Staff F said in the employee breakroom outside of the kitchen had a sink where they washed their hands.

In an observation on 05/03/2024 at 12:42 PM, the employee breakroom outside of the kitchen showed there was no sink for staff to be able to perform hand hygiene.

In an observation on 05/03/2024 at 12:31 PM, Staff E had gloves on their hands. Staff E touched serving utensils, rectangular cards that they organized on the grey serving trays, and a white paper bag on the kitchen counter. Without changing gloves or performing hand hygiene Staff E started plating residents' food. At 12:34 PM, with the same gloves on Staff E took a knife and started to chop food for a resident's lunch. Staff E then continued to touch serving utensils and plated residents' food. Staff E with their gloved hand grabbed a handful of chips out of a bag and put it on a resident's plate for lunch.

In an observation on 05/03/2024 at 12:37 PM, Staff H, Cook, entered the kitchen and did not perform hand hygiene before donning on a pair of gloves.

This is an uncorrected and recurring deficiency previously cited on 03/06/2024 and 12/14/2023 for subsection (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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe,

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sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 areas within the building (Bridge side, Clare Side, and the kitchen). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean for 1 of 1 facility reviewed. These failures resulted in 41 of 41 residents receiving care and services in an environment that was unsafe, unsanitary, and with unmaintained living conditions.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 03/06/2024, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3090] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 03/21/2024. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 04/20/2024.

Bridge Side

In an observation on 05/02/2024 at 1:42 PM, on the Bridge side kitchenette counter tops were multiple used dirty plates and cups. There were some plates with food left on them, that were observed to have been eaten off of. The cups had residual colored liquid substance inside that were left out in the open and on the counter. The area was unsecured and accessible to all residents.

Clare Side

In an observation on 05/02/2024 at 2:10 PM, on the Clare side kitchenette behind the standing trash can on the white wall, there were multiple areas of foods and liquids that had been spilled or splattered. There were pink and brown areas that were halfway up the white wall that had dripped down towards the ground. The pink and brown areas covered three quarters of the length of the wall.

In an observation on 05/02/2024 at 2:10 PM, the Clare side kitchenette showed a trash can without a lined bag that had various trash inside of the container. The white wall behind the trashcan had been stained with various sizes of brown splatter.

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In an observation on 05/02/2024 at 2:17 PM, in the shower room that was adjoined to the “C” court, the white shower curtain that hung on the walk-in shower stall halfway up from the ground, was observed to be soiled in a yellow and light brown in color.

In an observation on 05/02/2024 at 2:20 PM, the Clare Side bathroom in between the shower room showed four black rolling racks with hangers on them. The rolling racks impeded access to the bathroom toilet and hand washing sink. There were two blue mats propped up against the trashcan under the paper towel dispenser.

In an interview on 05/03/2024 at 1:13 PM, Staff A, Executive Director, stated the facility purchased the rolling carts to use for lost and found items. Staff A stated the rolling carts were supposed to be in the laundry rooms. Staff B, Clinical Service Specialist, stated all four rolling racks were not supposed to be kept inside the Clare Side bathroom.

Kitchen

In an observation on 05/02/2024 at 3:05 PM, in the kitchen next to the freezer’s doors and in front of the walk-in refrigerator was a large amount of standing water. The standing water submerged the kitchen floor tiles. There was an electric industrial fan that was blowing towards the walk-in freezer on the water that was making ripples in the water. In the area of the standing water there was no sign to show that there was water and to use caution when walking in the area. Staff D, Cook, stated the water was from the freezer not working. Staff D stated the freezer had not been working and was leaking since they were hired on 04/16/2024.

In an observation on 05/02/2024 at 3:06 PM, the caution wet water sign in the kitchen was unopened and leaned up against the wall partially behind the ice machine. The wet water sign was not in the immediate vicinity of the standing water on the floor.

In an observation on 05/02/2024 at 3:11 PM, the kitchen sink next to coffee pots showed a continued stream of water coming out of the faucet. The Department attempted to turn off the sink and the water continued to stream.

In an observation on 05/02/2024 at 3:12 PM, Staff D and Staff I, Care Staff, walked through the standing water.

Record review of the facility’s “Employee Phone List”, undated, showed Staff D, Cook, date of hire at the facility was on 04/16/2024.

In an interview on 05/02/2024 at 3:11 PM, Staff D stated the kitchen sink that leaked was mainly used to serve coffee. Staff D stated they had attempted to turn the faucet off and were unable to. Staff D stated the faucet had been broken since they first started working at the facility a couple of weeks ago. Staff D stated Staff C, Maintenance Director, was aware.

In an interview on 05/02/2024 at 3:19 PM, Staff J, Registered Nurse/District Director of Clinical Services, stated the staff were informed not to be walking through the water.

In an interview on 05/02/2024 at 3:44 PM, Staff C, Maintenance Director, stated the kitchen freezer started not working on 04/15/2024 and on 04/18/2024 it was when the freezer began to leak water and required to be replaced as the cost to repair was more than purchasing a new freezer. Staff C was unsure how often the freezer’s temperature was

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being checked. Staff C stated something similar to this had happened and the facility had to rent a new freezer. Staff C stated the faucet that leaked required a new faucet that he had not purchased to replace and repair.

In an observation on 05/03/2024 at 12:19 PM, the kitchen's sink next to the coffee pots showed a continued stream of water coming out of the faucet.

In an interview on 05/03/2024 at 3:49 PM, Staff C said they knew the faucet sink in the kitchen had been leaking. Staff C stated they had tried everything they could to fix the leak. Staff C stated they had not yet ordered a new kitchen faucet.

This is an uncorrected and recurring deficiency previously cited on 03/06/2024 and 12/14/2023 for subsections (1)(a)(b)(c)(d), and 07/13/2021 for subsection (1)(a).

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

This document was prepared by Residential Care Services for the Locator website.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

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 follow-up on 02/02/2024 and 03/06/2024 of:

Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following SOD dated: 03/06/2024

The following sample was selected for review during the unannounced on-site visit: 8 of 47 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Cory Cisneros, Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
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 _____ 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.

This document was prepared by Residential Care Services for the Locator website.

Administrator (or Representative) Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff had the required nurse delegation training, supervision, and documentation by the Registered Nurse (RN) Delegator for 4 of 4 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]) receiving nurse delegated services. The facility failed to verify 6 of 6 staff members (Staff A, Staff H, Staff F, Staff G, Staff E, and Staff D) credentials and trainings for qualification prior to administering nurse delegated tasks. The facility failed to ensure that qualified medication technicians administered nurse delegated services and tasks to 4 of 4 sampled residents (R1, R2, R3, and R4). These failures resulted in residents receiving medication services from unqualified, untrained, and unsupervised staff, and placed all residents receiving RN delegated services at risk for harm and injury due to untrained, unqualified, and unsupervised care staff.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2320] as stated in the cited deficiencies in the enclosed report . 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”

Record review of the Washington State (WA) Department of Social and Health Services document titled, “Community Nurse Delegation Orientation 2024”, undated, showed it was mandatory for delegation to a long term care worker that the Registered Nurse (RN) must ensure the long term care worker was currently a registered or certified as a nursing assistant or home care aide in WA state without restrictions, they completed the nurse

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delegation for caregiver's core training, and if they were to administer insulin, the special focus on diabetes training was completed. The RN's evaluations of all residents that required RN delegated tasks were on-going and must be completed at least every 90 days. The residents would have an updated assessment. The resident's goals and outcomes were reviewed if met or not. The delegated long term care workers were supervised and evaluated for each assigned nurse delegated task for each resident. The RN delegator would document the assessment, evaluation, and the competency on the nursing visit form for each resident. For a resident to have medication assistance in place, the resident must functionally be able to get the medication where it needs to go and be cognitively aware they received mediations that does not include the name of the medications or intended side effects.

Record review of the facility policy, titled, "Nurse Delegation Policy", dated 01/2023, showed "Before performing any delegated task, the RN must: a. Verify that the nursing assistant or home care aid is currently registered in Washington state without restriction; b. Verify that the nursing assistant or home care aide has completed both basic caregiver training and core delegation training before performing any delegated task; c. Verify that the nursing assistant or home care aid has evidence as required by the department of social and health services of successful completion of nurse delegation core training; and nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client… Delegation may only be done through written instructions to the nursing assistant or home care aide with a copy maintained in the resident record… Nursing assistants or home care aids: a. must show the certificate of completion of both the basic caregiver training and core delegation training (this can be obtained from any approved trainer) to the registered nurse delegator. b. Who may be completing insulin injections, must give a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator." Delegation may only be done through written instructions to the nursing assistance or home care aide with a copy maintained in the resident's record that included the nursing task (s), rationale for the nursing task, nature of the condition requiring the treatment and the purpose of the delegated nursing task, clear description of the procedure or steps to follow to perform the task, predictable outcomes of the nursing tasks, risks of the treatment, interactions of prescribed medications, and how, what, and when to report possible side effects. The RN delegator must evaluation the resident's responses to the delegated nursing care, supervises and evaluates the performance of the delegated medication technicians, and with any insulin injection supervision shall occur at least every 90 days. Review of the documentation of the delegation process has to be completed at least every 90 days or with a change of condition.

Staff Credentials

Record review on 02/02/2024 of the RN Delegation binder showed there were no credential and training verification, Washington state Department of Health (DOH) credentials, nurse delegation certificate, or diabetes specialty delegation certificate for Staff A, Executive Director; Staff F, Medication Technician; Staff G, Medication Technician; and Staff H, Medication Technician for review. In the binder for Staff E, Medication Technician, there was a credential and training verification form that had only Staff E's name and no other information documented for review. Staff E's WA DOH credential verification, dated 12/04/2023, showed Staff E had a Nursing Assistance Registration credential that expired on 03/26/2019. 4 of 6 staff (Staff H, Staff F, Staff G, and Staff E) listed medication technicians on the facility provided employee list were unqualified and did not have all the required credentials, verifications, and training, and required

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certifications.

Record review of facility provided documents on 02/05/2024 at 1:00 PM, showed Staff D's credentials and training verification was completed on 02/03/2024. Staff D did not have a certification for their WA home care aide core basic training for review. Review of Staff F's credentials and training verification form showed it was completed on 02/02/2024. Staff F's WA DOH credential verification and certificates for nurse delegation core and diabetes were not provided for review.

Record review on 02/22/2024 of the DOH healthcare provider credential website, showed Staff H's Nursing Assistant Registration verification, had expired on 03/08/2022.

Record review of the facility's safety plan sent to the department on 02/02/2024 at 5:50 PM, titled, "Safety Plan – Brookdale Olympia West 02/02/2024 RE: Safety plan re: med tech coverage," dated 02/02/2024, showed "The community execs to maintain safe and appropriate medication distribution by using Med Tech's and Licensed Nurse."

Record review of the facility's safety plan sent to the Department on 02/16/2024 at 5:23 PM, titled, "Clinical Schedule", dated 02/16/2024 through 02/23/2024, showed the facility was coordinating with staffing agency to have caregivers and licensed nurses (in lieu of medication technicians) staff to fill the shifts they did not have staff to work. There were 38 shifts that were either filled by agency staff and were needing to be filled by agency staff on the schedule for day, evening, and night shift.

Resident Records

R1

Record review of R1's Admission Record, dated 09/13/2023, showed R1 moved into the facility on [redacted]/2021 with multiple [redacted] diagnoses that included [redacted] ([redacted]).

Record review of R1's Personal Service Plan (facility's version of negotiated service agreement and nursing assessment together), dated 11/21/2023, showed R1 required a licensed nurse or delegated medication technician was to check R1's blood sugar and administer R1's insulin injection once in the morning and once in the evening. R1 was not always aware of current time.

Record review of R8's Nurse Delegation: Nursing Visit form, dated 10/30/2024, showed R1 required nurse delegation for medication administration, insulin administration and blood sugar checks related to R1's dementia. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff D, Staff E, Staff F, Staff G, and Staff H were not listed to have been reviewed, trained, and observed and approved to administer R1's RN delegated tasks. There were no other nursing visit forms in the RN delegation binder for review that R1 was evaluated at 90 days.

Review of R1's Nurse Delegation: Instructions for Nursing Task form, dated 10/30/2023, showed R1 was delegated for all oral (in the mouth) medication administrations.

Record review of R1's Medication Administration Record (MAR), dated 01/01/2024 through 01/31/2024, showed Staff F had administered R1's oral medications 1 of 4 days from the attestation date of 01/28/2024. Staff E checked R1's blood sugar and administered R1's

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insulin injection and oral medications 1 of four days. Staff G administered R1's oral medications 2 of 4 four days; and Staff D administered R1's oral medications, insulin injection, and checked R1's blood sugar 2 of 4 days after attestation date.

Record review of R1's MAR, dated 02/01/2024 through 02/18/2024, showed Staff D administered R1's insulin and checked R1's blood sugar 8 of 18 days. Staff D administered R1's oral medications 9 of 18 days. Staff E administered R1's oral medications 1 of 2 days their DOH credentials were expired. Staff G administered R1's oral medications, checked R1's blood sugar level, and administered R1's insulin injection 1 of 18 days.

Resident 2 (R2)

Record review of R2's Admission Record, dated 02/18/2024, showed R2 moved into the facility on [redacted]/2013 with multiple [redacted] diagnoses that included [redacted] ([redacted]), [redacted] ([redacted]), and [redacted] ([redacted]).

Record review of R2's Personal Service Plan (facility version of the Negotiated Service Agreement and nurses assessment), dated 10/18/2023, showed R2 had Alzheimer's (a progressive brain disorder that slowly destroys ones memory, thinking skills, and eventually ones ability to carry out simple daily living tasks). R2 was not oriented to place or time. R2 was unable to verbalize their needs and preferences. R2 would talk in word salad (speech that consist of a mix of unintelligible, random words together that often do not correlate with each other).

Record review of R2's Nurse Delegation: Nursing Visit form, dated 10/30/2023, showed R2 was delegated for medication administration. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff D, Staff E, Staff F, Staff G, and Staff H were not listed to have been reviewed, trained, and observed and approved to administer R2's RN delegated tasks.

Record review of R2's MAR, dated 01/01/2024 through 01/31/2024, showed Staff E administered R2's medications 2 of 4 days after the attestation date. Staff H administered R2's medications 3 of 4 days after the attestation date. Both Staff E and Staff H administered R2's medications with their WA DOH credentials expired.

Record review of R2's MAR, dated 02/01/2024 through 02/18/2024, showed Staff D administered R2's medications 2 of 18 days and Staff E administered R1's medications once with their WA DOH credentials expired. Staff H administered R2's medications 8 of 18 days with their WA DOH credentials expired.

Resident 3 (R3)

Record review of R3's Admission Record, dated 10/30/2023, showed R3 moved into the facility on [redacted]/2023 with multiple [redacted] diagnoses that included [redacted], [redacted], and [redacted].

Record review of R3's Personal Service Plan, dated [redacted]/2023, showed R3 had a diagnosis of [redacted] ([redacted]) and [redacted]. R3 had memory loss and required help to participate in

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community activities. R3 was not oriented to person, place, or time. R3 had cognitive and psychosocial concerns.

Record review of R3's Nurse Delegation: Instructions for Nursing Task, dated 10/30/2023, showed R3's delegated task and expected outcome was "oral medication administration". There were no documented outcomes for the nurse delegated task. There were no other nursing task forms for R3 for any other routes of medication administration in the RN delegation binder on 02/02/2024 for review.

Record review of R3's Nurse Delegation Nursing Visit, dated 10/30/2023, showed R3 required nurse delegation for tasks that included medication administration, insulin administration, and blood sugar checks. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff D, Staff E, Staff F, Staff G, and Staff H were not listed to have been reviewed, trained, and observed and approved to administer R3's RN delegated tasks. There were no other nursing visit forms to show R3's nurse delegated tasks were evaluated every 90 days.

Record review of R3's MAR, dated 01/01/2024 through 01/31/2024, showed R3 had multiple medications that were administered by mouth. Review of the administrations showed Staff E administered R3's oral medication 1 of 4 days after attestation date, Staff G administered R3's oral medication 2 of 4 days after attestation date, Staff F administered R3's oral medications 1 of 4 days after attestation date, and Staff D administered R3's oral medications 1 of 4 days after attestation date.

Record review of R3's MAR, dated 02/01/2024 through 02/18/2024, showed R3 had an order for nystatin powder (prescribed medicated powder to help treat a skin rash that causes yeast and odor) as needed for yeast/redness that was administered on 02/05/2024 at 10:32 AM. The MAR showed Staff E administered R3's medication once with their WA DOH credential expired. Staff D administered R3's oral medication 7 of 18 days.

Resident 4 (R4)

Record review of R4's Admission Record, dated 02/29/2024, showed R4 moved into the facility on [redacted]/2021, with multiple [redacted] diagnoses that included [redacted]).

Record review of R4's Personal Service Plan, dated 11/14/2023, showed R4 was required to take their medication crushed with pudding and lots of sugar mixed with it. R4 was provided small bites of their crushed mixed medication to allow R4 to swallow. R4 was to be informed that they were receiving their medication when provided a bite of their crushed medication in pudding and sugar. R4 had cognitive and psychosocial concerns. R4 was not oriented to place or time.

Record review of R4's Nurse Delegation Nursing Visit form, dated 10/30/2023, showed R4's required nurse delegation for tasks "medication administration" related dementia. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff D, Staff E, Staff F, Staff G, and Staff H were not listed to have been reviewed, trained, observed and approved to administer R4's RN delegated tasks. There were no other nursing visit forms to show R4's nurse delegated tasks were evaluated every 90 days.

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Record review of R4's Nurse Delegation: Instructions for Nursing Task, dated 10/30/2023, showed R4's delegated task and expected outcome was "oral medication administration". There was no documented expected outcome for review.

Record review of R4's MAR, dated 01/01/2024 through 01/31/2024, showed Staff E administered R4's oral medication 1 of 4 days after the attestation date, Staff D administered R4's oral medications 1 of 4 days after attestation date, Staff G administered R4's medications 2 of 4 days after attestation date, and Staff F administered R4's oral medications 1 of 4 days after attestation date.

Record review of R4's MAR, dated 02/01/2024 through 02/18/2024, showed Staff E administered R4's medications once with their WA DOH credentials expired. R4's oral medications were administered by Staff H 1 of 18 administration with their WA DOH credentials expired. Staff D administered R4's oral medications 7 of 18 days.

In an interview on 02/05/2024 at 1:45 PM, Staff E stated they were waiting to be delegated by the nurse so they could provide nurse delegated task to the residents.

In an interview on 02/15/2024 at 11:44 AM, Staff J, Care Staff, stated on 02/11/2024 Staff D was the only medication technician on shift from 6 PM until 9 PM to pass medications for all the residents in the facility.

In an interview on 02/15/2024 at 1:03 PM, Staff D stated on 02/11/2024 they did not have a lot of staff that day for evening shift 2 PM until 10 PM. Staff D stated it was just Staff M, Care Staff, and themself on shift. Staff D stated they were the medication technician for Clare side and Staff N, Care Staff, was the medication technician for Bridge side only until 6 PM and then they were the only medication technician for both sides of the building until the night shift medication technician came on. Staff D stated they were to be delegated by the RN today (02/15/2024) for all the residents nurse delegated tasks. Staff D stated if Staff N was not working then they worked alone as the only medication technician for both sides of the buildings.

In an interview on 02/05/2024 at 7:48 AM, Staff O, RN/District Director of Clinical Services, stated they identified and validated the concerns with the RN delegation.

In an interview on 02/05/2024 at 3:33 PM, Staff A stated they were aware Staff D and Staff E were not qualified to administer RN delegated tasks to RN delegated residents.

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

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Administrator (or Representative) Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care and assisted living residents for 2 of 2 locations within the facility (beauty salon, and Clare Country kitchen laundry room). This failure resulted in potentially hazardous supplies being accessible to residents and placed all 47 of 47 residents at risk for ingesting potentially toxic materials.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3100] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”

Record review of the facility’s document titled, “fresh impressions-chemical labeling, containers, storage and SDS [safety data sheets’] requirements”, updated March 2023, showed chemicals were to never be left unattended. All supply closets that store chemicals were to be locked when they were not in use.

In an observation on 02/02/2024 at 10:16 AM, the beauty shop door was unlocked and accessible to residents, visitors, and staff. On the counter inside the beauty shop was a tall glass filled with blue liquid. The jar was labeled “Disinfectant Jar”. Inside the unlocked cabinet above the counter was an unlabeled clear spray bottle with clear liquid inside. A bottle of Biolage “All purpose gel” was in the cabinet. Upon exiting the beauty salon residents were observed wandering outside the door and through the Town square (front

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lobby area of the building) area by the unlocked beauty salon door.

In an observation on 02/02/2024 at 11:08 AM, there were 10 residents that were sitting just outside of the beauty salon participating in an activity. The door to the beauty salon remained unlocked.

In an observation on 02/02/2024 at 11:29 AM and 1:17 PM, the beauty salon door was still unlocked and the blue disinfectant fluid was still on the counter, accessible to residents.

In an observation on 02/05/2024 at 7:29 AM, inside the unlocked laundry room attached to the Clare side country kitchen, on the counter was spray bottle that was a quarter of the way full of yellow liquid that was unlabeled. Inside the laundry room's unlocked cabinet was a large container labeled "ecolab detergent".

In an interview on 03/06/2024 at 12:33 PM, Staff A, Executive Director, stated the activity department staff and the executive director were responsible to ensure the beauty salon and chemicals inside locked and secured.

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 sampled pets (Resident 5's and Resident 6's pets) and all other pets living on the premises had regular examinations and were certified by a veterinarian to be free of disease transmittable to humans. This failure placed 47 of 47 residents, all staff and visitors at risk

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of being exposed to diseases which could impact their health.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/14/2023, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2620] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

Record review of the facility's policy, titled, "Pet Policy", dated 10/2021, showed that "The community shall maintain a health record for all pets documenting the veterinary name, phone number, address, shots, and dates… The resident's pet must have regular examinations and current vaccinations by a licensed veterinarian upon move in to the community and be verified by a veterinarian to free of diseases transmittable to humans."

In an interview on 02/02/2024 at 1:12 PM, Staff A, Executive Director, stated the pet records binder could not be found. In an interview on 02/02/2024 at 1:30 PM, Staff A provided the pet records binder. Staff A stated the pet records were not up to date. Staff A acknowledged that pet records were not in compliance with the WAC (Washington Administrative Code) requirements.

In an observation on 02/05/2024 at 7:35 AM, Resident 5 was observed in bed with her cat.

In an observation on 02/05/2024 at 8:48 AM, Resident 6's (R6) cat was observed in R6's room.

Record review of facility pet records, undated, showed no pet records for R5's cat. There were no current records for R6's cat. There was a note from a veterinarian for R6's cat, dated 11/07/2022, documenting R6's cat could not be vaccinated.

This is an uncorrected deficiency previously cited on 12/14/2023.

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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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

WAC 388-78A-2471 Background check Confidentiality Use restricted Retention. The assisted living facility must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

(4) Retained and available for department review during the individual's employment or association with a facility and for at least two years after termination of the employment or association.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 4 sampled staff's (Staff J, Staff L, Staff K) had a copy of their Washington State (WA) Name and Date of Birth and Finger Print Background Checks at the facility for the department to review and failed to maintain background check forms, results, and authorizations on-site in a confidential and secure manner. These failures to ensure a Washington State Background Check was available and that background check information was maintained in a confidential and secure manner placed 47 of 47 residents at risk for being cared for by a staff member with a potentially disqualifying history and placed all staff at risk to having confidential information exposed.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/14/2023, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A- 2471] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

Record review of the facility's document that was untitled and undated, with a list of employees, showed Staff L was hired at the facility on 12/27/2023.

Record review of the facility's document that was untitled and undated, with a list of employees, showed Staff J was hired at the facility on 01/18/2024.

Record review of the facility's document that was untitled and undated, with a list of employees, showed Staff K was hired at the facility on 01/30/2024.

Record review on 02/05/2024 of Staff L's employee file showed there were no background

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checks in the binder for review.

Record review on 02/05/2024 of Staff J's employee file showed there were no background checks in the binder for review.

Record review on 02/05/2024 of Staff K's employee file showed there were no background checks in the binder for review.

In an interview on 02/05/2024 at 2:00 PM, the Department requested for Staff J, Staff L, and Staff K's background authorization forms for review. Staff A, Executive Director, stated they were unable to find any authorization forms or background checks in the employee files. Staff A stated they had to print off Staff J, Staff L, and Staff K's background check results from the Washington State background check website for the Department to review.

In an interview on 02/05/2024 at 2:11 PM, Staff B, District Director of Operations, stated all employees background checks, background check authorization forms, and background check finger prints were all filed in a separate binder from the employee files. At 3:28 PM, Staff B stated the binder containing background checks, background check authorization forms, and fingerprint check results was missing.

In an interview on 03/06/2024 at 12:30 PM, Staff A, Executive Director, stated the business office manager and the executive director were responsible to ensure that all background checks, background check fingerprints, and background check authorization forms were safe and secured.

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

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Based on interview and record review, the facility failed to complete reference checks for 3 of 3 employees (Staff J, Staff L, and Staff K) reviewed. This failure placed all 47 of 47 residents at risk of receiving care and services from unqualified and/or unsuitable staff.

Findings included…

RCW 18.20.125 "Inspections—Enforcement remedies—Screening— Limitations on unsupervised access to vulnerable adults. (3)(a) To the extent funding is available, the licensee, administrator, and their staff should be screened through background checks in a uniform and timely manner to ensure that they do not have a criminal history that would disqualify them from working with vulnerable adults. Employees may be provisionally hired pending the results of the background check if they have been given three positive references."

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2450] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”

Record review of the facility’s document that was untitled and undated, with a list of employees, showed Staff L, Cook, was hired at the facility on 12/27/2023, Staff J, Care Staff, was hired at the facility on 01/18/2024, and Staff K, Care Staff, was hired at the facility on 01/30/2024.

Record review on 02/05/2024 of Staff L’s employee file showed there were no reference checks in the binder for review.

Record review on 02/05/2024 of Staff J’s employee file showed there were no reference checks in the binder for review.

Record review on 02/05/2024 of Staff K’s employee file showed there were no reference checks in the binder for review.

In an interview on 02/05/2024 at 2:11 PM, Staff B, District Director of Operations, stated all employees references checks were to be filed in the employee’s file for review.

In an interview on 03/06/2024 at 12:29 PM, Staff A, Executive Director, stated the department head was responsible to check a potential new employee's reference checks prior to the potential employee was hired.

This is an uncorrected deficiency previously cited on 12/14/2023.

This document was prepared by Residential Care Services for the Locator website.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 3 sampled staff (Staff J, and Staff K) had the required CPR (cardiopulmonary resuscitation) and First Aid training and failed to ensure 3 of 3 sampled Staff (Staff J, Staff L, and Staff K) had completed their facility orientation training. These failures resulted in residents being cared for by staff without orientation training, and CPR/First Aide training, and placed 47 of 47 residents at risk of harm in the event of an emergency due to staff not being trained on life saving measures and staff being unaware of the facility's expectations.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/14/2023, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2474] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

WAC 388-112A-0200 "What is orientation training, who should complete it, and when

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should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as

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required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor."

Record review of the facility's document titled, Washington Associate Foundations New Hire Orientation Training Plan and Checklist", dated 02/01/2024, showed "the form must be printed and filed in the associate training/personnel file".

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff J, Care Staff, was hired at the facility on 01/18/2024.

Record Review on 02/05/2024 of Staff J's personnel file showed no CPR or First Aid training documentation for review. There was no documentation that Staff J had completed facility orientation training.

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff K, Care Staff, was hired at the facility on 01/30/2024.

Record Review of Staff K's personnel file showed no CPR or First Aid training documentation. There was no documentation that Staff K had completed facility orientation training.

Record review of the facility's document that was untitled and undated, with a list of employees, showed Staff L, Cook, was hired at the facility on 12/27/2023.

Record Review of Staff L's personnel filed showed no documentation Staff K had completed the facility orientation training.

In an interview on 02/05/2024 at 2:11 PM, Staff B, District Director of Operations, stated all employee's facility orientation, CPR and First Aid cards were to be filed in the employee's file for review.

In an interview on 02/05/2024 at 3:58 PM, Staff B stated the Washington Associate Foundations New Hire Orientation Training Plan and Checklist was completed on the new employee's first day of orientation.

This is an uncorrected deficiency previously cited on 12/14/2023 for 388-78A-2474 (2)(a)(d).

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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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the Resident Service Plans (Negotiated Service Agreements) for 1 of 4 sampled residents (Resident 6 [R6]) were agreed to and signed at least annually by the resident, resident's representative, and representative of the assisted living facility. This failure placed the residents and their responsible party at risk for not being involved in or agreeing to their care decisions and the services being provided.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/14/2023, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2150] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

Record review of R6's Admission Record, dated 09/13/2023, showed R6 moved into the facility on [redacted]/2023, with multiple [redacted] diagnoses that included [redacted]). Collateral Contact 2 (CC2), R6's representative, was identified as the Power of Attorney for R6.

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Record review of R6's Personal Service Plan, dated 08/24/2023, showed the service plan was not signed by the resident, the resident's legal representative, or the facility's representative.

In an interview on 02/05/2024 at 1:16 PM, Staff A, Executive Director, stated R6's personal service plan dated 08/24/2023 was not signed.

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 2 of 4 sampled staff members (Staff K and Staff A) were screened for tuberculosis (TB, a communicable disease) within three days of employment as required. This failure placed all 47 of 47 residents and staff at risk of TB infection.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/14/2023, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2480] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "I hereby certify that I have

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reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

Record review of the facility's document titled, "Tuberculosis (TB) Associate Requirements by State-Reference", dated 12/2023, showed if a new employee had a TB skin test documented more than 12 months before they were hired, the employee was required to have a two-step TB skin test completed. If the new employee had a TB skin test that was documented less than 12 months upon hire, the new employee only required a one step skin test.

Record review of the ALF's "Tuberculosis Exposure Control Plan Policy - Associates" revised 09/2021, showed that TB testing was to be retained in the associate's confidential medical record file, separate from their general personnel records.

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff K, Care Staff, was hired at the facility on 01/30/2024.

Record Review on 02/05/2024 of Staff K's personnel file showed there were no TB testing results for review.

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff A, Executive Director, was hired at the facility on 11/06/2023.

Record review of Staff A's document titled, "Associate Health Record" dated 06/2019, showed Staff A had a one step TB skin test on 11/06/2023. There was no date documented when the TB test was read or results of the skin test reading.

In an interview on 02/05/2024 at 2:11 PM, Staff B, District Director of Operations, stated that all employee's TB test results were kept in a separate binder than the employee's file.

In an interview on 02/05/2024 at 3:28 PM, Staff B stated they were unable to find the binder with all the employee's TB test results for the Department to review.

This is an uncorrected deficiency previously cited on 12/14/2023.

This document was prepared by Residential Care Services for the Locator website.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to maintain a respiratory protection program to ensure all staff had required annual medical evaluations and were fit tested for an N95 respirator (a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances) for 5 of 5 staff (Staff A, Staff E, Staff J, Staff K, and Staff P) reviewed. The facility failed to ensure that all fire extinguishers had service tags that showed they when they were yearly serviced and checked monthly. These failures placed all 47 of 47 residents, staff, and visitors at risk for spread of infectious disease and at risk of harm during a fire.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2040] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”Review of the document titled "L&I (Labor and Industries) and Department of Health (DOH) Respirator and PPE guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE" dated 03/30/2021, DOH 420-328 showed, “The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 and other airborne hazards. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes.’’

WAC 296-842-14005 “Provide medical evaluations.
Medical Evaluation Process
Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:
(a) Are required to use respirators; or
Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:

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(a) Whether or not the employee is medically able to use the respirator;
(b) Any limitations of respirator use for the employee;
(c) What future medical evaluations, if any, are needed;
(d) A statement that the employee has been provided a copy of the written recommendation"

WAC 296-842-15005
"Conduct fit testing.
(1) Provide, at no cost to the employee, fit tests for ALL tight fitting respirators on the following schedule:
(a) Before employees are assigned duties that may require the use of respirators;
(b) At least every twelve months after initial testing;"

State Fire Marshall regulation code IFC 906.2 2015,2018

"Portable fire extinguishers shall be selected, installed, and maintained in accordance with this section and NFPA 10.
Exceptions: 1. The distance of travel to reach an extinguisher shall not apply the travel distance to reach an extinguisher shall not apply to the spectator seating portions of Group A-5 occupancies.
2. Thirty-day inspections shall not be required, and maintenance shall be allowed to be once every three years for dry-chemical or halogenated agent portable fire extinguishers that are supervised by a listed and approved electronic monitoring device, provided that all of the following conditions are met:
2.1. Electronic monitoring shall confirm that extinguishers are properly positioned, properly charged and unobstructed.
2.2. Loss of power or circuit continuity to the electronic monitoring device shall initiate a trouble signal.
2.3. The extinguishers shall be installed inside of a building or cabinet in a noncorrosive environment.
2.4. Electronic monitoring devices and supervisory circuits shall be tested every 3 years when extinguisher maintenance is performed.
2.5. A written log of required hydrostatic test dates for extinguishers shall be maintained by the owner to verify that hydrostatic tests are conducted at the frequency required by NFPA10.
3. In Group 1-3, portable fire extinguishers shall be permitted to be located at staff locations."

Record review of the facility's Respiratory Protection Program (RPP), dated 01/15/2021 showed the Executive Director was responsible to maintain RPP records and conduct program evaluations annually. Facility supervisors were listed as responsible to ensure associates received initial and annual respirator mask fit tests and medical clearances before authorization to wear a respirator. Records were to be kept based on Occupational Safety and Health Administration guidelines, which would be an associate's period of employment, plus 30 years.

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff A, Executive Director, was hired at the facility on 11/06/2023. Record review of Staff A's, Medical Clearance for Respirator use, dated 12/26/2023, showed Staff A did not have any restriction on respirator use. There was no documented N95 respirator fit testing record for Staff A provided for review.

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Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff E, Medication Technician, was hired at the facility on 04/03/2023. Record review of Staff E's, Medical Clearance for Respirator Use, dated 12/27/2023, showed Staff E was cleared to use a respirator. There was no documented N95 respirator fit testing record for Staff E provided for review.

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff P, Care Staff, was hired at the facility on 05/13/2023.

Record review of Staff P's Medical Clearance for Respirator Use, dated 12/27/2023, showed Staff E was cleared to use a respirator. There was no documented N95 respirator fit testing record for Staff E provided for review.

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff J, Care Staff, was hired at the facility on 01/18/2024.

Record review on 02/05/2024 showed there were no medical clearances or N95 fit testing records for review for Staff J.

Record review on 02/05/2024 of the facility's document that was untitled and undated, with a list of employees, showed Staff K, Care Staff, was hired at the facility on 01/30/2024.

Record review on 02/05/2024 showed there were no medical clearances or N95 fit testing records for review for Staff K.

In an interview on 02/02/2024 at 9:26 AM, Staff E stated they had not been fit tested for an N95 respirator.

In an interview on 02/05/2024 at 2:48 PM, Staff J stated they had not been fit tested for an N95 respirator.

In an interview on 02/05/2023 at 12:00 PM, Staff A stated they were unaware if all employees had been fit tested for N95 respirators. Staff A stated the facility only had all employees complete their medical clearance's but did not get them fit tested for the N95 respirators.

In an interview on 03/06/2024 at 12:29 PM, Staff T, Director Clinical Service Specialist, stated the facilities expectation was that all employee's were fit tested for an N95 respirator prior to the working on the floor at the facility.

Fire Extinguishers

In an observation on 02/02/2024 at 9:29 AM, on the wall by the Bridge side laundry room was a fire extinguisher with no service tag. There was no documentation on the fire extinguisher that showed when it was last serviced, or monthly check had been completed.

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In an observation on 02/02/2024 at 9:48 AM, the fire extinguisher by E court had no service tag. There was no documentation on the fire extinguisher that showed when it was last serviced, or monthly check had been completed.

In an observation on 02/02/2024 at 10:12 AM, on the wall by the Clare country kitchen, the fire extinguisher did not have a tag. There was no documentation on the fire extinguisher that showed when it was last serviced, or monthly check had been completed.

In an observation on 02/02/2024 at 10:22 AM, on the wall by the B court shower room, the fire extinguisher did not have a tag. There was no documentation on the fire extinguisher that showed when it was last serviced, or monthly check had been completed.

This is an uncorrected deficiency previously cited on 12/14/2023.

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

WAC 388-78A-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 2 of 2 laundry rooms (Bridge and Clare unit laundry rooms) implemented infection control practices to keep clean and soiled laundry separated. This failure resulted in 47 of 47 residents not having infection control practices in place for proper handling and prevention of cross contamination for all laundry services.

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Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/14/2023, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3040] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

Record review of the facility's document titled, "Fresh Impressions – Resident and Contaminated Laundry", dated June 2023, under the section titled, "handling contaminated laundry" showed, contaminated linen was anything with blood or other potential infectious material and soiled linen was everyday dirty laundry. Staff were to wash their hands prior to applying gloves to handle soiled or contaminated linens. Staff were to spray and wipe the outside of the machine to disinfect the washing machine. The laundry workloads were to be balanced across seven days. The first shift (day shift) were to collect the dirty laundry, the cart was to be used to collect and return laundry, and remove the clothes from the dryer promptly to avoid wrinkles. The second shift (evening shift) were to put the laundry away, and the third shift (night shift) was to wash, dry, and fold the laundry.

In an observation on 02/02/2024 at 9:26 AM, the Bridge side laundry room was observed to have no soap in the dispenser, the soap inside had curdled and hardened and would not dispense. The handwashing sink was full of mop heads, resident clothing, soiled clothes, a red bucket, and a rubber door seal. The paper towel dispenser did not dispense towels. The door to the laundry room was unlocked and accessible to the memory care residents. In the unlocked cabinet above the washer was solid laundry detergent. There were no staff observed in the area.

In an interview and observation on 02/02/2024 at 9:44 AM, in the Bridge side laundry room, Staff C, Housekeeper, stated they did not normally do laundry but was doing it today. Staff C stated they started at the facility approximately three weeks prior. At 9:47 AM, on top of the lid of one of the washing machines had a brown smeared area that resembled feces. Staff C acknowledged that there was clean and soiled laundry intermixed in the laundry room. At 9:49 AM, Staff C stated no one had told them they had to go in or out a specific door for the laundry rooms. The door that exited to the F court had a sign posted that showed, "no soiled laundry through this door please". Staff C was observed to place clean folded laundry on the counters on both ends of the laundry room. During the entire interview Staff C had on a clear disposable gloves. Staff C was observed to open a large bag that was on the ground that had soiled linens, then grabbed some clothes that were on the counter to the right of the drying machines fold them then walk past the washing and drying machines to put the folded clothes on the countertop. Staff C did not change their gloves the entire time and was walking by the bags of soiled laundry with the folded clean clothes.

In an interview and observation on 02/02/2024 at 10:23 AM, of the laundry room by the B court, Anonymous Staff 1 (AS1) stated they were not working the floor today, and that they were just there to do laundry. The sink was observed to have a giant grey blanket in it,

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blocking access and use of the sink. The floors of the laundry room were covered in plastic bags of linens, resident clothing, and towels, creating a narrow pathway through the center of the narrow room. The bagged items on the floor were stacked from the floor to past the handle on the door (halfway up the wall). The door to the bathroom area from the laundry room was blocked by bags of soiled laundry stacked in front of the door. The trash can was observed to have a full trash bag stacked on top of the overflowing trash can. When asked how AS1 would wash their hands, AS1 stated she could not currently access the sink to wash her hands as it was full of clothing items and blocked from use. There was no hand sanitizer available in the room. AS1 stated the care staff were responsible to complete the resident's laundry during their shift. AS1 stated they would not have enough time to provide the care and services to their residents and complete the resident's laundry before the end of their shift at 2 PM.

In an observation on 02/02/2024 at 10:51 AM, the Clare side laundry room was observed to have a pink laundry basket with clothing with brown matter splattered across it sitting next to the dryer and clean clothing and linen items.

In an interview on 02/02/2024 at 4:01 PM, Staff A, Executive Director, stated all resident's laundry was to be completed on the day the resident received their shower. Staff A stated they walked the facility every day they were there. Staff A was unable to elaborate what the barriers were with the process of resident's laundry being completed and in a clean infection control manner for all laundry rooms.

In an observation on 02/05/2024 at 8:00 AM, the linen closet across from room E6, had multiple linens stored on the ground. On the top shelf of the linen closet were multiple blankets and other linens that were stored above the red taped line. The linens had to be moved to see the red taped line on the wall.

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according

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to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observations, interview, and record reviews, the facility failed to ensure food was stored and labeled properly for 3 of 3 kitchen areas reviewed (Bride Side Kitchenette, Clare Side Kitchenette, and Main kitchen). The facility failed to ensure proper hand hygiene and infection control practices were conducted for 1 of 2 cooks (Staff R) in between tasks in the kitchen. These failures placed all 47 of 47 residents at risk for exposure to food-borne illnesses and at risk for receiving food that was incorrectly stored and prepared.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2305] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”

“246-215-02310
Hands and arms—When to wash (FDA Food Code 2-301.14).
food employees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and:
(1) After touching bare human body parts other than clean hands and clean, exposed portions of arms;
(2) After using the toilet room;
(3) After caring for or handling service animals or aquatic animals as specified under WAC 246-215-02415(2);
(4) Except as specified under WAC 246-215-02400(2), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;
(5) After handling soiled equipment or utensils;
(6) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;
(7) When switching between working with raw food and working with ready-to-eatfood;
(8) Before donning gloves for working with ready-to-eatfood unless a glove change is not the result of contamination; and
(9) After engaging in other activities that contaminate the hands or gloves.”

“WAC 246-215-03610
Labeling—Food labels (FDA Food Code 3-602.11).
(1) food packaged in a food establishment must be labeled as specified in law, including chapters 69.04 and 15.130 RCW; 21 C.F.R. 101 - Food Labeling; and 9 C.F.R. 317 - Labeling, Marking Devices, and Containers.

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(2) Label information must include:
(a) The common name of the food or, absent a common name, an adequately descriptive identity statement;
(b) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the food;
(c) An accurate declaration of the quantity of contents;
(d) The name and place of business of the manufacturer, packer, or distributor;
(e) The name of the food source for each major food allergen contained in the food unless the food source is already part of the common or unusual name of the respective ingredient;
(3) Bulk food that is available for consumer self-dispensing must be prominently labeled with the following information in plain view of the consumer:
(a) The manufacturer's or processor's label that was provided with the food; or
(b) A card, sign, or other method of notification that includes the information specified under subsection (2)(a), (b), and (f) of this section."

WAC 246-215-03525
"(1)Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be maintained: (a) At 135°F (57°C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400(2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130°F (54°C) or above; or (b) At 41°F (5°C) or less. (2) EGGS that have not been treated to destroy all viable Salmonellae must be stored in refrigerated EQUIPMENT that maintains an ambient air temperature of 45°F (7°C) or less. (3) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD in a homogenous liquid form may be maintained outside the temperature control requirements, as specified under subsection (1) of this section, while contained within specially designed EQUIPMENT that complies with the design and construction requirements as specified under WAC 246-215-04230(5)."

"WAC 246-215-03351
Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).
(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:
(a) In a clean, dry location;
(b) Where it is not exposed to splash, dust, or other contamination; and
(c) At least six inches (15 cm) above the floor."

Record review of the facility's policy titled, "Handwashing/Hand Hygiene", dated 10/2021, showed regular hand washing and hand hygiene was the primary means to prevent the spread of infections. Associates, residents, family members, and visitors should be encouraged to wash their hands or use an alcohol based hand sanitizer solution. The Centers for Disease Control and Prevention (CDC) promotes regular hand washing as one of the best way to remove germs, avoid getting sick, and prevent the spread of germs to others. Associates should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other associates, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) should be readily accessible and convenient for associates to use to encourage compliance with hand hygiene policies. Hands were to be washed with soap and water for specific situations that included but not limited to after conducting personal hygiene, before eating, and when

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hands were visibly soiled. The CDC recommends use of alcohol based hand sanitizer was preferred over use of soap and water in most clinical situations due to better compliance. Alcohol based hand sanitizer was to be used but not limited to when in contact with intact skin and after removing gloves.

Record review of the facility's policy "Labeling - DS-04.028," revised on 5/10 (date as shown), showed "All food items must be labeled and dated before storing."

Record review of the facility's policy titled, "Storage of Perishable Food-DS-04.014, dated 05/2010, showed perishable food must be refrigerated in a manner that optimizes food safety, nutrient retention, and aesthetic quality. Perishable foods include fruits, vegetables, meats, dairy, etc. Refrigerators would be maintained at a temperature of 32 – 40 degrees Fahrenheit (F) or below. Foot storage containers would have a tight fit lid. All refrigerated items shall be covered, labeled, indicating product name, and dated (month/day/year) product was received or prepared. All pre-dished items must be covered, labeled, and dated to prevent off-flavors, drying, or cross-contamination while refrigerated.

Record review of the facility's policy titled, "Storage of Frozen Food-DS-04.015", dated 05/2010, showed Frozen foods must be stored in a manner that insures food safety, optimal nutrient retention and optimal aesthetic quality. All frozen products must be labeled indicating product name and date (month/day/year) product was received or used.

Record review on 02/02/2024 of a facility document located on the Bridge side kitchenette refrigerator, titled, "Record of Resident Refrigeration Temperature", dated January 2024, showed no temperatures listed for 01/01/2024 through 01/11/2024, and no temperatures listed for 01/13/2024 through 01/31/2024. There was no documentation for February 2024 refrigeration temperatures for review.

Record review of the main kitchen freezer temperature log, dated February 2024, showed on 02/02/2024 the freezer temperature was documented to be 44 degrees Fahrenheit with a note that read, "some things are melting."

In an observation on 02/02/2024 at 9:20 AM, inside the Bridge side Kitchenette's refrigerator there were two tall squeeze bottles that were half full of red substance inside that were unlabeled and undated. There was one squeeze bottle that was three quarters the way full of white liquid that was undated and unlabeled. There was one squeeze bottle that was quarter full of brown liquid that was undated and unlabeled. Inside the freezer part of the refrigerator there was a bag of five pie shells that were open to air and undated.

In an observation on 02/02/2024 at 10:08 AM, inside the Clare side Kitchenette's refrigerator was a full pitcher with red liquid inside that was unlabeled and undated. There was a second pitcher that was half full of clear liquid that was unlabeled and undated.

In an observation on 02/02/2024 at 11:31 AM, the dry storage room for the kitchen was observed to have white powder, dirt, and debris on the floor. There were two dead insects (appeared to be large flies) noted in one of two overhead lights in the dry storage area.

In an observation on 02/02/2024 at 11:35 AM, the top of the ice machine located in the main kitchen was covered in dirt and debris. When opening the lid to the ice machine, the lid came completely detached from the ice machine as the door had been broken from its secure sliding mechanism. The ice scoop was observed to be sitting on a tray on top of the

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ice machine. The tray holding the ice scoop was observed to have yellow and red food splatters across it. The interior of the ice machine showed red and black matter spots covering the interior paneling. The lid to the ice machine was noted to be covered in splatters of food/liquid debris and was sticky to the touch.

In an observation on 02/02/2024 at 11:36 AM, Staff R, Cook, was observed in the kitchen preparing food. Staff R was observed to touch her watch, her face, then grab trays off a rolling rack and place on the counters with gloved hands. Staff R was then observed to put on oven mitts, poured cooked gravy into a pan, then took off the oven mitts, then proceeded to the dish washing area, placed clean dishes onto a cart, wheeled the cart back into the food preparation area, and began putting the clean dishes away. Staff R then was observed to handle dirty dishes, placing them on a tray, and proceed to then pick up a clean white cutting board to place on a shelf. At 11:45 AM, Staff R continued to wear the same pair of gloves throughout the observation without changing her gloves or performing hand hygiene. Staff R was then observed to push the dish cart into the dishwashing area, then return to the cooking area. Staff R then put on the oven mitts and pulled out a silver pan with cooked carrots and peas and square silver dishes. Staff R then took off their oven mitts, scooped food out of one of the silver dishes, spilling some, picking up the spilled food with their gloved hands, then proceeded to begin plating the food. At 11:48 AM, Staff R continued to touch their apron, face, kitchen utensils, then scoop the ready to eat food onto resident's plates. At 11:49 AM, Staff R was observed to reach into the container of ready to eat corn, grab some with their gloved hand, then continue to plate food. Staff R continued to the dishwashing area, opened the dishwasher, removed the clean dishes, and put them away. Staff R then was observed to touch their face, reach into their pocket, and pulled out their cell phone. Staff R was observed wearing the same gloves, changing tasks, and touching numerous surfaces and items both clean and dirty throughout the observation from 11:36 AM-11:52 AM.

In an interview on 02/02/2024 at 11:52 AM, when Staff R was asked if their clothes were considered clean, Staff R stated no one had told Staff F their clothes were dirty. Staff R stated they "washed their clothes daily". When Staff R was asked when they wash their hands, Staff R stated when they took their gloves off.

In an observation on 02/02/2024 at 11:38 AM, the microwave in the main kitchen was observed with yellow food splatter over the interior roof of the microwave. Rice and brown burn spots were observed at the bottom of the interior of the microwave. The back interior of the microwave was noted with yellow food splatters and food debris stuck to the wall.

In an observation on 02/02/2024 at 11:41 AM, the walk-in refrigerator was observed to have a condiment bottle filled with an unidentified liquid. The liquid inside the bottle had separated, with brown textured matter at the bottom with oily clear fluid over the brown matter at the bottom. The bottle was unlabeled and undated. There was a contained of uncovered raw seasoned chicken sitting on the bottom of a rack in the walk-in refrigerator with no date or label. Observation of the kitchen did not show that the chicken was actively being prepared at that time by any kitchen staff. The walk-in refrigerator had two large bags with pink fluid inside, the bags of pink fluids showed they had expired on 01/09/2024. There was a pitcher of a milk like substance on the shelf in the refrigerator with no label or date. The floor of the walk-in refrigerator was noted to be sticky and made a sticky noise when lifting one's foot off the ground.

In an observation on 02/02/2024 at 11:45 AM, there was an open bag of meat patties opened to air and not labeled or sealed. There was an open to air bag of meatballs with no

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label or date.

This is an uncorrected deficiency previously cited on 12/14/2023.

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

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide housekeeping and resident care needs and services as written on their personal services plan for 4 of 4 sampled residents (Resident 2 [R2], Resident 3 [R3], Resident 5 [R5], and Resident 7 [R7]. This failure placed all 47 residents at risk for unmet care needs and decreased quality of life.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2710] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”

Record review of the facility’s disclosure of services, undated, showed the facility must provide laundry services to keep the residents clothes clean and in good repair, and

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provide them with clean towels, wash cloths, and bed linens at least once per week. The weekly linen service was included in the monthly fees. The facility must maintain the resident's living quarters and other areas the residents may use in a safe, clean, and comfortable condition. The monthly fee included light housekeeping services once per week. Under the section titled, "Bathing", showed if the resident required assistance with showering the facility would provide.

Record review of the facility's document titled, "Fresh Impressions- Resident and Contaminated Laundry", dated 06/2023, showed the laundry workloads were to be balanced across seven days. The first shift were to collect the dirty laundry, the cart was to be used to collect and return laundry, and remove the clothes from the dryer promptly to avoid wrinkles. The second shift was to put the laundry away, and the third shift was to wash, dry, and fold the laundry.

Record review of the facility's policy titled, "Service Plan Process Policy", dated 03/2020, showed "individual resident service plans are developed through the evaluation process or other identified systems and provide information about resident needs to the care associates. Service plans are implemented and maintained for each resident to address these needs."

Record review of the facility's document titled, "Clare Side Showers", undated, showed on day shift there were four resident showers and laundry services scheduled every Sunday through Thursday and on Friday and Saturday there was three residents that were scheduled for showers and laundry services. The Evening shift was scheduled to complete three resident showers and laundry services every Sunday through Wednesday and two resident showers and laundry services daily on Thursday through Saturday. The form showed "beds must be changed and laundry pulled by the RA [resident assistant/care staff] assigned to that resident every shower day!! No bed baths unless directed by Health and Wellness Director".

Record review of the facility's document titled, "Bridge Side Showers", undated, showed for day shift there were four residents scheduled for showers and laundry services on Sunday through Tuesday, Thursday, and Saturday. There were three resident showers and laundry services scheduled every Wednesday and Friday. For evening shift there were three residents scheduled for showers and laundry services every Friday through Tuesday and on Wednesday and Thursday there were two resident showers and laundry services scheduled.

Resident 2 (R2)

Record review of R2's Admission Record, dated 02/18/2024, showed R2 moved into the facility on /2013 with multiple diagnoses that included ( ), (, and ( ).

Record review of R2's Personal Service Plan (facility version of the Negotiated Service Agreement and nurses assessment), dated 10/18/2023, showed R2 had Alzheimer's (a progressive brain disorder that slowly destroys ones memory, thinking skills, and eventually ones ability to carry out simple daily living tasks). R2 was not oriented to place or time. R2 was unable to verbalize their needs and preferences. R2 would talk in word

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salad (speech that consist of a mix of unintelligible, random words together that often do not correlate with each other). R2 required assistance from staff with eating, hands on assistance with dressing, grooming, and two showers per week. R2 required two staff members to assist R1 to stand but had a history of getting tired and frequently required R2 to be transferred with two staff members and a Hoyer lift (a device that cradles the resident's entire body and lifts them up in a secured sling to move them from one area to another). R2 was confined to a wheelchair that they were not able to self-propel or move. R2 was incontinent of urine and bowel and required R1 to wear disposable protective underwear.

Resident 3 (R3)

Record review of R3's Admission Record, dated 10/30/2023, showed R3 moved into the facility on [redacted]/2023 with multiple [redacted] diagnoses that included [redacted], [redacted], and [redacted].

Record review of R3's Personal Service Plan, dated [redacted]/2023, showed R3 required stand by assistance for all showers two times a week. R3 had a diagnosis of [redacted] ([redacted]) and had [redacted]. Staff were to monitor R3's skin with each shower and as needed with care.

In an observation and interview on 02/05/2024 at 10:25 AM, Staff N, Care Staff, went to R3's room to apply R3's medicated powder to their skin. When Staff N opened R3's door to their apartment there was a strong odor that was present in the room. When Staff N was asked what the smell was, Staff N stated it was from R3's yeast rash. Staff N stated R3's room smelled like that every day. R3 was compliant with allowing Staff N to look at their skin and apply the powder. R3 was observed wearing disposable underwear that was soiled with feces and urine. Staff N had lifted up both of R3's breast and the skin was shinny, red, and had white matter. Staff N cleansed the area with a wet rag and dried it off. Staff N then applied the medicated powder. All over R3's stomach and middle body area, where there were multiple tiny red pinpoint areas. Some of the areas were scabbed over and others just red. Staff N stated those areas were a new rash that had developed in the last few weeks and recently saw their doctor. Staff N then assisted R3 to remove their pants. Under R3's stomach fold, the skin was bright red with white matter. The redness continued into R3's groin area between their thigh and lower stomach area. When Staff N was cleansing the areas in the groin and the lower stomach area, a strong foul odor was present. The smell was the same odor that was noted when Staff N entered R3's room.

In an interview on 02/02/2024 at 2:32 PM, Anonymous Staff 1 (AS1), care staff, stated they were unable to provide showers due to not enough staff, and that R3 and another female resident had developed skin issues that had worsened from lack of showers.

Resident 5 (R5)

Record review of R5's Admission Record, dated 09/13/2024, showed R5 moved into the facility on [redacted]/2023, with multiple [redacted] diagnoses that included [redacted] and [redacted] ([redacted]).

Record review of R5's Person Service Plan, dated 10/13/2023, showed R5 had a cat. R5 required assistance with managing the cat's litter box. Staff were to ensure the litter box was cleaned daily and that excess litter was regularly swept off the floor. Staff were to assist and ensure the cat had food and water during all interactions in R5's room.

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In an observation and interview on 02/05/2024 at 7:35 AM, upon opening R5 room door on the ground was multiple white particles that resembled cat litter, that covered the entire floor. There was a strong smell that resembled ammonia (a colorless gas that releases a strong foul odor). Staff E, Medication Technician, walked towards R5 that was lying in bed to check on them. Staff E's shoes made a crunch noise when they walked on the white particles on the floor. The floor in front of the cat box had large amounts of the white particles and an area of brown substance that resembled cat feces on the ground. Under R5's window was a black miniature refrigerator. On top of the black miniature refrigerator was an empty plastic container of wet cat food. There was a second empty plastic container of wet cat food that was on the ground. There were two bowls on the ground to the right of the black miniature refrigerator that were empty. Staff E was observed to open a plastic container of wet cat food and poured it into one of the bowls and filled the other bowl with water. Staff E stated care staff were responsible for feeding and cleaning up after R5's cat.

Resident 7 (R7)

Record review of R7's Admission Record, dated 12/07/2023, showed R7 moved into the facility on [redacted]/2023 with multiple [redacted] diagnoses that included [redacted] ([redacted]).

Record review of R7's Personal Service Plan, dated [redacted]/2023, showed R7 required stand by assistance with their showers every Wednesday and Saturdays in the morning. R7's laundry was to be completed every Wednesday and Sunday. R7 was cooperative with all care and did not exhibit any behaviors.

In an interview on 01/24/2024 at 5:31 PM, Collateral Contact 2 (CC2), Daughter of R7, stated they had to hire an additional personal caregiver to ensure that R7's room was getting cleaned and R2 received showers and shaved as they had come to visit R7 on multiple occasions and found feces in R7's bathroom, bed was unmade, and laundry was soiled. CC2 stated they had to hire the personal caregiver because the facility staff were not shaving or showering R7 per their negotiated service agreement. CC2 stated they had to go to the facility's laundry room and observed multiple large plastic bags of soiled laundry. CC2 stated during their visit it was rare to see a care staff in the building and would wait a long time to talk with them.

In an observation on 02/02/2024 at 2:45 PM, walking through the town square area there were multiple residents engaged in an ice cream social. R7 was observed to be enjoying their ice cream. R7 was noted to have an excessive amount of facial hair and was unshaved.

In an observation and interview on 02/05/2024 at 7:21 AM, R7 was observed to be unshaved with facial hair. R7 stated they were not impressed with the facility and that their toilet needed to be cleaned. Observation of the toilet showed there was brown matter that resembled feces on the inside lip of the toilet bowl. Inside on the bottom of the toilet bowl had a film of brown substance. On the grab bar on the wall to the right of the call light system's pull cord was a large brown smudged area that resembled feces. R7 stated they did not always get their clothes back from the laundry. R7 stated the staff just leave these bags in their room and pointed to a big clear bag that sat on the ground just inside their room. The large clear bag had R7's name written in black marker on the bag. The bag had

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folded linens and clothes inside. R7 stated they were unsure if the clothes were clean or dirty.

In an interview on 02/01/2024 at 10:09 AM, the Department received a public call from an Anonymous Collateral Contact 1 (ACC1) that stated they had concerns for the facility. ACC1 stated multiple residents developed skin rashes from not receiving their showers as scheduled, resident's family members had expressed concerns that resident's laundry was not getting completed, and multiple employees that included the head nurse (Health and Wellness Director), business office manager, and care staff had quit working there, making unsafe staffing levels for the residents.

In an interview on 02/02/2024 at 2:32 PM, Anonymous Staff 2 (AS2), care staff, stated that they were not able to meet all the residents needs due to not enough staff. AS2 stated that the staff were responsible for providing residents with ADL (Activities of Daily Living) care, showers, laundry, and all other care needs. AS2 stated they were unable to provide showers due to not enough staff, and that R3 and another female resident had developed skin issues that had worsened from lack of showers. AS2 stated laundry tasks had fallen to the caregivers and they were not able to keep up. AS2 stated families had been voicing lots of frustrations and complaints.

In an interview on 02/02/2024 at 2:48 PM, Staff J, Care Staff, stated they typically worked evenings, and staffing consisted of one caregiver on each side of the building (Clare and Bridge), and one medication technician shared between the two sides of the building. Staff J stated sometimes there was only herself and a medication technician in the building. Staff J stated that last night she was on shift with just herself and a medication technician. Staff J stated residents did not receive showers due to short staffing, and that they had to prioritize immediate care needs for residents.

In an interview and observation on 02/02/2024 at 10:23 AM, of the laundry room by the B court, Anonymous Staff 1 (AS1) stated they were not working the floor today, and that they were just there to do laundry. The floors of the laundry room were covered in plastic bags of linens, resident clothing, and towels, creating a narrow pathway through the center of the narrow room. The bagged items on the floor were stacked from the floor to past the handle on the door (halfway up the wall). The door to the bathroom area from the laundry room was blocked by bags of soiled laundry stacked in front of the door. AS1 stated she had not been able to provide four residents their showers she was assigned due to other tasks and assignments taking priority. AS1 stated the care staff scheduled on day and evening shift were to provide three to four scheduled resident showers. AS1 stated they would often be asked to complete more resident's showers as they were not provided on their scheduled day. AS1 stated it was often they would not be able to provide the residents their showers. AS1 stated they documented the resident showers that were completed on a skin check shower sheet. AS1 stated the skin check shower sheets were turned into the health and wellness director. AS1 stated they were not able to provide showers for the residents on their scheduled day shift on 01/13/2024 and 02/01/2024. AS1 stated they typically worked the day shift 6 AM until 2 PM. AS1 stated the care staff were responsible to complete the resident's laundry during their shift. AS1 stated they would not have enough time to provide the care and services to their residents and complete the resident's laundry before the end of their shift at 2 PM. AS1 stated they were the only caregiver that worked from 6 am until 2 PM on 01/23/2024. AS1 stated they were unable to complete all the resident's showers that were scheduled. AS1 stated there were four residents that required two-person assistance for care related to transfers and behaviors. AS1 stated they had to provide care to residents that required two-person

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assistance independently due to not enough staff.

In an interview on 02/02/2024 at 2:32 PM, AS2 stated they often worked with one care staff and one medication technician for one side of the facility. AS2 stated it was a lot work for the two staff members. AS2 stated they were responsible to pass medications for all the residents on the side they were scheduled on and for any delegated tasks on the other side of the facility as they were the only nurse delegated medication technician. AS2 stated it was often that they were unable to provide residents their scheduled showers and laundry. AS2 stated R3 had a red rash that had an odor under both of their breasts and groin. AS2 stated the area continued to get worse when care staff were unable to provide R3 their scheduled shower.

In an interview on 02/15/2024 at 12:45 PM, Staff M, Care Staff, stated on 02/11/2024 they were the only care staff during the time period, 2 PM until 10 PM, and was training a new staff member. Staff M stated the trainee and themself were the only care staff scheduled for that shift. Staff M stated the new staff member had gotten overwhelmed and left the facility around 3 PM. Staff M stated they did not have the time to provide any showers or laundry services for any residents that day.

In an interview on 02/02/2024 at 3:47 PM, Staff A, Executive Director, stated when a resident's shower was completed, a care staff would fill out a skin check shower sheet. Staff A stated the shower sheets were turned in to Staff S, Former Health and Wellness Director. Staff A stated since Staff S left employment at the facility on 02/01/2023, Staff A had not received any skin check shower sheets for review. Staff A stated they had not seen the laundry room's conditions. Staff A stated family members had expressed concerns about residents laundry not being completed or long periods of them being not returned to the resident, and was aware of the concerns. Staff A stated they were aware care staff were staying over or coming in on their day off to complete resident laundry.

The Department requested on 02/05/2024 at 3:58 PM, on 02/16/2024 at 6:01 AM, and on 02/20/2024 at 10 AM, for the facility to send all the residents skin check shower sheets for review of the resident's showers that had been completed. As of 02/21/2024 at 5 PM, the Department did not receive any resident skin check shower sheets for review. The facility did not provide documentation that residents received showers per the disclosure of services, or their negotiated service agreements (personal service plans).

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

This document was prepared by Residential Care Services for the Locator website.

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 2 of 2 memory care buildings (Bridge and Clare) for staff and residents to use. Additionally, the facility failed to implement proper infection control hand washing measures when job tasks were changed for 1 of 1 observed kitchen sampled staff (Staff R). These failures resulted in a break in hand hygiene practices, staff not having access to hand hygiene supplies, and placed all 47 of 47 residents, staff, and visitors at risk for spread of infectious disease.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2610] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”

Record review of the facility’s policy titled, “Handwashing/Hand Hygiene”, dated 10/2021, showed regular hand washing and hand hygiene was the primary means to prevent the spread of infections. Associates, residents, family members, and visitors should be encouraged to wash their hands or use an alcohol based hand sanitizer solution. The Centers for Disease Control and Prevention (CDC) promotes regular hand washing as one of the best way to remove germs, avoid getting sick, and prevent the spread of germs to others. Associates should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other associates, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) should be readily accessible and convenient for associates to use to encourage compliance with hand hygiene policies. Hands were to be washed with soap and water for specific situations that included but not limited to after conducting personal hygiene, before eating, and when

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hands were visibly soiled. The CDC recommends use of alcohol based hand sanitizer was preferred over use of soap and water in most clinical situations due to better compliance. Alcohol based hand sanitizer was to be used but not limited to when in contact with intact skin and after removing gloves.

Handwashing supplies

In an observation on 02/02/2024 at 9:35 AM, on the Bridge side of the facility inside the shower room by the F court there was a black trash can with a soiled pull up and used disposed gloves inside without a trash bag. Inside the bathroom connected to the shower room the soap dispenser had curdled white soap, paper towel dispenser was empty, and the trash can did not have a trash bag.

In an observation on 02/02/2024 at 9:44 AM, inside the laundry room by the F court there were two soap dispensers by the sink. One soap dispenser had curdled white soap. Both soap dispensers were pressed without any soap being dispensed. Staff C, Housekeeper, turned the hot and cold-water facet knobs on the sink. There was no water that came out of the faucet. Staff C stated they would have to go to the bathroom to wash their hands. In an observation on 02/02/2024 at 10:05 AM, in the kitchenette on Clare side, soap dispenser by the sink was empty. The soap dispenser was pressed without any soap dispensed.

In an observation on 02/05/2024 at 8:08 AM, inside the laundry room by F court, the sink continued to not have running water. The two soap dispensers remained without soap and when pressed no soap was dispensed.

In an interview and observation on 02/02/2024 at 9:44 AM, Staff C, Housekeeper, stated they were unsure where to wash their hands as the sink in the laundry room they were in had piles of clothes and baskets blocking access to the sink, Staff C turned the hand washing sink hot and cold handles without the water turning on, there was no soap, and no trash bag in the trash can.

In an interview and observation on 02/02/2024 at 10:23 AM, of the laundry room by the B court, the sink was observed to have a giant grey blanket in it, blocking access and use of the sink. When asked how Anonymous Staff 1 would wash their hands, AS1 stated she could not currently access the sink to wash her hands as it was full of clothing items and blocked from use. There was no hand sanitizer available in the room.

In an observation and interview on 02/02/2024 at 10:40 AM, inside the bathroom in between the two shower rooms by the B and C courts, the sink and toilet were unable to be accessed as there were shower benches and chairs stored in front of them. Staff Q, Care Staff, stated if a resident needed to use a bathroom when they were in either shower room, the resident would need to use the bathroom that was in between the shower rooms.

Handwashing

In an observation on 02/02/2024 at 11:36 AM, Staff R, Cook, was observed in the kitchen preparing food. Staff R was observed to touch her watch, her face, then grab trays off a rolling rack and place on the counters with gloved hands. Staff R was then observed to put on oven mitts, poured cooked gravy into a pan, then took off the oven mitts, then proceeded to the dish washing area, placed clean dishes onto a cart, wheeled the cart back into the food preparation area, and began putting the clean dishes away. Staff R then was

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observed to handle dirty dishes, placing them on a tray, and proceed to then pick up a clean white cutting board to place on a shelf. At 11:45 AM, Staff R continued to wear the same pair of gloves throughout the observation without changing her gloves or performing hand hygiene. Staff R was then observed to push the dish cart into the dishwashing area, then return to the cooking area. Staff R then put on the oven mitts and pulled out a silver pan with cooked carrots and peas and square silver dishes. Staff R then took off their oven mitts, scooped food out of one of the silver dishes, spilling some, picking up the spilled food with their gloved hands, then proceeded to begin plating the food. At 11:48 AM, Staff R continued to touch their apron, face, kitchen utensils, then scoop the ready to eat food onto resident's plates. At 11:49 AM, Staff R was observed to reach into the container of ready to eat corn, grab some with their gloved hand, then continue to plate food. Staff R continued to the dishwashing area, opened the dishwasher, removed the clean dishes, and put them away. Staff R then was observed to touch their face, reach into their pocket, and pulled out their cell phone. Staff R was observed wearing the same gloves, changing tasks, and touching numerous surfaces and items both clean and dirty throughout the observation from 11:36 AM-11:52 AM.

In an interview on 02/02/2024 at 11:52 AM, when Staff R was asked if their clothes were considered clean, Staff R stated no one had told Staff F their clothes were dirty. Staff R stated they "washed their clothes daily". When Staff R was asked when they wash their hands, Staff R stated when they took their gloves off.

This is an uncorrected and recurring deficiency previously cited on 12/14/2023, and 08/12/2021 for 388-78A-2610 (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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3060 Storage space. The assisted living facility must:

(3) Maintain storage space to prevent fire or safety hazards.

This requirement was not met as evidenced by:

Based on observation, and record review the facility failed to maintain 5 of 5 linen closets in a safe and sanitary manor. This failure placed 47 of 47 residents and all staff members at risk for fire or safety hazards.

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Findings included…

State Fire Marshall regulation code IFC (International Fire Code) 315.3.1 2018

"ceiling clearance, storage shall be maintained 2 feet or more below the ceiling in nonsprinklered areas of buildings or not les than 18 inches below the sprinkler head deflectors in sprinklered areas of buildings."

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3060] as stated in the cited deficiencies in the enclosed report. 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.” The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024.”

Record review of an untitled, undated sign, posted inside of the facility linen closets read, “DO NOT PUT ANYTHING ON THE BOTTOM SHELF FLOOR.”

In an observation on 02/02/2024 at 9:50 AM, the linen closet by E court showed blankets and linens on the floor. A sign inside the closet on the door read, “DO NOT PUT ANYTHING ON THE BOTTOM SHELF FLOOR.”

In an observation on 02/02/2024 at 10:07 AM, the linen closet by D court was noted to have clothing in a bucket on the floor, with clothing hanging out of the bucket and touching the floor. There was a clear tote with items inside stored on the floor. A sign inside the closet on the door read, “DO NOT PUT ANYTHING ON THE BOTTOM SHELF FLOOR.”

In an observation on 02/02/2024 at 10:44 AM, the linen closet by C court was noted to have bed linens and blankets on the floor. Above the top shelf was a red line that had writing on it that showed, “do not stack above”. The blankets and linens were stacked above the red line and had to be moved to observed. A sign inside the closet on the door read, “DO NOT PUT ANYTHING ON THE BOTTOM SHELF FLOOR.”

In an observation on 02/02/2024 at 10:52 AM, the linen closet by A court was observed to have linens stored on the floor. There were toilet paper rolls stored on the floor.

In an observation on 02/02/2024 at 10:44 AM, the linen closet by C court was noted to have blankets stored on the floor. A sign inside the closet on the door read, “DO NOT PUT ANYTHING ON THE BOTTOM SHELF FLOOR.”

In an observation on 02/05/2024 at 9:56 AM, the linen closet by D court was noted to have clothing in a bucket on the floor, with clothing hanging out of the bucket and touching the floor.

In an observation on 02/05/2024 at 10:02 AM, the linen closet by F court was observed

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with blankets and pillows stored on the floor. A sign inside the closet on the door read, “DO NOT PUT ANYTHING ON THE BOTTOM SHELF FLOOR.”

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 6 of 6 areas within the building (Bridge side, Clare Side, Town square, Resident 7’s [R7] room, Resident 5’s [R5] room, and the kitchen). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures resulted in an unmaintained environment for residents and staff, and placed 47 of 47 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/14/2023, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [[including WAC 388-78A-3090] as stated in the cited deficiencies in the enclosed report. I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the

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licensing laws and regulations at all times." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

Record review of the facility's disclosure of services, undated, showed the facility must provide laundry services to keep the residents clothes clean and in good repair, and provide them with clean towels, wash cloths, and bed linens at least once per week. The weekly linen service was included in the monthly fees. The facility must maintain the resident's living quarters and other areas the residents may use in a safe, clean, and comfortable condition. The monthly fee included light housekeeping services once per week.

Record review of the facility's document titled, "Fresh Impressions- Resident and Contaminated Laundry", dated 06/2023, showed the laundry workloads were to be balanced across seven days. The first shift were to collect the dirty laundry, the cart was to be used to collect and return laundry, and remove the clothes from the dryer promptly to avoid wrinkles. The second shift was to put the laundry away, and the third shift was to wash, dry, and fold the laundry.

In an observation on 02/02/2024 at 9:20 AM, in the Bridge side kitchenette's refrigerator, there was spilt purple and pink dots of substance on the bottom of the refrigerator. Inside the freezer part of the refrigerator on the bottom were large yellow and pink substance that had been spilled. On the white wall behind the tall trash can across from the refrigerator, there were multiple areas of yellow, red, and brown substance that had been splattered.

In an observation on 02/02/2024 at 9:26 AM, the Bridge side laundry room was observed to have no soap in the dispenser, the soap inside had curdled and hardened and would not dispense. The handwashing sink was full of mop heads, resident clothing, soiled clothes, a red bucket, and a rubber door seal. The paper towel dispenser did not dispense towels. The door to the laundry room was unlocked and accessible to the memory care residents. In the unlocked cabinet above the washer was solid laundry detergent. There were no staff observed in the area.

In an observation on 02/02/2024 at 9:36 AM, the shower room by the F court wing had a shower chair speckled with brown matter. There was an adult incontinent brief and blue disposable gloves sitting inside the bathtub with white disposable wipes that had brown matter on them. There were 2 large bags of linens and residents clothing on the floor by the wall with brown matter splattered across. The door to the toilet room was blocked with bags of soiled clothing and linens sitting on the floor in front of the door. There were items stored in the bathroom sink and in front of the toilet making the toilet room inaccessible.

In an observation on 02/02/2024 at 9:39 AM, inside the bathroom in between the shower rooms, there was a large yellow step stool, thick folded foam pads, and a hoyer lift (a device that lifts area person up to moved them from one place to another) stored in front of the toilet and the bathroom sink.

In an observation on 02/02/2024 at 9:41 AM, the E court shower room was observed to have clothes on the floor blocking the door from opening. Inside the room there were

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towels and residents clothing strewn about on the floor and in bags piled against the wall. At 9:47 AM, one of the washing machines, on top of the lid there was a smeared area of brown substance that resembled feces. There was thick, white, crusted and crumbled white matter that was on the lid of washing machines and down the tubing from the detergent container. There were seven large bags of soiled linens and resident clothes, four large bags untied with soiled linens and resident clothing, and one bag untiled with various items of trash that all lined the entire wall and length of the laundry room.

In an interview and observation on 02/02/2024 at 9:44 AM, Staff K, Housekeeper, stated they did not normally do laundry but was doing it today. Staff K stated they started at the facility approximately three weeks prior. Staff K acknowledged that there was clean and soiled laundry intermixed in the laundry room. When asked where staff could wash their hands, Staff K stated they were unsure as the sink in the laundry room they were in had piles of clothes and baskets blocking access to the sink, the water did not turn on, there was no soap, and no trash bag in the trash can.

In an observation on 02/02/2024 at 10:06 AM, in the kitchenette off of the Clare side dining room, on the wall behind the sink there was a large streaked area of brown substance that was from the ground up to the three quarters of the wall. There was a pitcher that was half full of clear liquid was lifted, the pitcher stuck to the bottom of the refrigerator. When the pitcher lifted up off of the bottom, it made a sticking noise. There was sticky blue, red, and purple substance that was on the bottom of the refrigerator. Inside the freezer of the refrigerator there was red and purple substance on the bottom that had been spilt and was frozen. On the white wall behind the standing trash can were multiple area of brown and orange splatters that were three quarters the way up the wall.

In an interview and observation on 02/02/2024 at 10:23 AM, of the laundry room by the B court, Anonymous Staff 1 (AS1) stated they were not working the floor today, and that they were just there to do laundry. The sink was observed to have a giant grey blanket in it, blocking access and use of the sink. The floors of the laundry room were covered in plastic bags of linens, resident clothing, and towels, creating a narrow pathway through the center of the narrow room. The bagged items on the floor were stacked from the floor to past the handle on the door (halfway up the wall). The door to the bathroom area from the laundry room was blocked by bags of soiled laundry stacked in front of the door. The trash can was observed to have a full trash bag stacked on top of the overflowing trash can. When asked how AS1 would wash their hands, AS1 stated she could not currently access the sink to wash her hands as it was full of clothing items and blocked from use. There was no hand sanitizer available in the room. AS1 stated the care staff were responsible to complete the resident's laundry during their shift. AS1 stated they would not have enough time to provide the care and services to their residents and complete the resident's laundry before the end of their shift at 2 PM. In front of one of the washing machines on the ground was a large area of white substance. On the walls behind both the drying machines, were large amounts of brown fuzz that stuck to the wall and ceiling. On the ground and halfway up the wall in between the drying machines and the wall were large amounts of debris, fuzz substance, and balls of thick fuzzy matter that resembled drying machine lint.

In an observation on 02/02/2024 at 10:15 AM, in the outer courtyard on Clare side, there were 2 of 5 window screens that were ripped halfway down.

In an observation on 02/02/2024 at 10:50 AM, inside the laundry room connected to Clare side country kitchen, there was a pink laundry tall plastic laundry basket that had black handwritten writing that showed "Clare dining laundry". There were multiple brown

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smeared substance on the inside of the laundry basket from top to bottom and on the gray handle.

In an observation on 02/02/2024 at 10:56 AM, inside the town square where the popcorn machine the white cabinet that had glass sides and counter tops, were observed to have brown streaks halfway down the cabinet. On the edges of the glass were multiple crumbed particles.

In an observation on 02/02/2024 at 11:31 AM, inside the dry pantry room, the floor was noted to sticky and when walked on there was a sticky noise made. There were black streaked marks on the ground and white powder. In one of two lights in the dry pantry room there were two dead bugs with wings observed.

In an observation on 02/02/2024 at 11:34 AM, upon entering the kitchen door next to the dish washing area, to the right on the wall there was a large gray ground trash can with not lid. On the ground around the trash can were various wrappers and crumbled paper towels with brown substance. On the wall between the water nozzle to the ecolab water filter there was a used clear disposable glove that sat on top of the filters tubing and canister.

In an observation and interview on 02/05/2024 at 7:21 AM, inside R7's room, R7 stated they were not impressed with the facility and that their toilet needed to be cleaned. Observation of the toilet showed there was brown matter that resembled feces on the inside lip of the toilet bowl. Inside on the bottom of the toilet bowl had a film of brown substance. On the grab bar on the wall to the right of the call light system's pull cord was a large brown smudged area that resembled feces.

In an observation and interview on 02/05/2024 at 7:35 AM, upon opening R5 room door on the ground was multiple white particles that resembled cat litter, that covered the entire floor. There was a strong smell that resembled ammonia (a colorless gas that releases a strong foul odor). Staff E, Medication Technician, walked towards R5 that was lying in bed to check on them. Staff E's shoes made a crunch noise when they walked on the white particles on the floor. The floor in front of the cat box had large amounts of the white particles and an area of brown substance that resembled cat feces on the ground. Under R5's window was a black miniature refrigerator. On top of the black miniature refrigerator was an empty plastic container of wet cat food. There was a second empty plastic container of wet cat food that was on the ground. There were two bowels on the ground to the right of the black miniature refrigerator that were empty. Staff E was observed to open a plastic container of wet cat food and poured it into one of the bowls and filled the other bowl with water. Staff E stated care staff were responsible for feeding and cleaning after R5's cat.

In an interview on 02/02/2024 at 3:47 PM, Staff A, Executive Director, stated they had not seen the laundry room's conditions. Staff A stated family members had expressed concerns about resident's laundry not being completed or long periods of them being not returned to the resident, and was aware of the concerns.

This is an uncorrected and recurring deficiency previously cited on 12/14/2023, and 07/13/2021 for 388-78A-3090 (1)(a).

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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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

RCW 70.129.060 Grievances. A resident has the right to:

(1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to promptly address and resolved grievances for 2 of 2 residents (Resident 8 [R8], and Resident 6 [R6]) and their representatives. This failure resulted in unresolved grievances for residents and their representatives, and placed all 47 of 47 residents at risk decreased quality of life.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 12/14/2023, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including RCW 70.129.060] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/21/2023. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/28/2024."

Record review of the facility's document titled, "Grievance Procedure- Resident", dated 09/2003, showed "[facility] is committed to quality customer service. We believe that good communication fosters our ability to provide quality services. In the event a resident and/or resident's responsible party (on behalf of the resident) has a grievance regarding the community, its services, treatment that has or has not been furnished or the behavior of other residents we request the following steps be taken:
1. The resident and/or resident's responsible party should discuss the complaint with the associate and Executive Director.
2. If unable to resolve grievance with step 1, the grievance should be submitted in writing to the Executive Director. The Executive Director should respond to the

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resident and/or resident's responsible party within fourteen (14) days of receipt of the complaint.
3. If unable to resolve grievance with step 2, the written grievance should be submitted to the Regional Director of Operations. The Regional Director of Operations should respond to the resident and/or resident's responsible party within fourteen (14) days of receipt of the complaint.
4. If the grievance cannot be resolved on a Regional level, the resident and/or resident's responsible party are encouraged to contact the [facility] Family Connection at 1-877-400-5296.
5. A resident and/or resident's responsible party may file a grievance with the local Ombudsman at any time during this process. If requested, a community representative should assist the resident or resident's responsible party in forwarding the written grievance to the appropriate address and contact person.
6. Residents and/or their responsible parties may submit grievances without fear of retaliation."

Record review of R8's Resident Grievance Form, dated 11/30/2023 at 1:22 (no PM or AM documented), showed the nature of the grievance was R8's bedding was not being changed as it was discussed. The only times it was changed was when the family "demanded the bed to be changed". Under the section titled "official use only", showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of another of R8's Resident Grievance Form, dated 11/30/2023 at 1:23 (no PM or AM documented), showed the nature of the concern was about garbage in the living area and bathroom were not being emptied for days that caused the room to have a smell. Under the section titled "official use only", showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R8's Resident Grievance Form, dated 11/30/2023 at 1:27 (no PM or AM documented), showed the nature of the concern was R8's room was not being swept or cleaned that required the family to clean R8's room. Under the section titled "official use only", showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R8's Resident Grievance Form, dated 11/30/2023 at 1:31 (no PM or AM documented), showed the nature of the concern was R8's laundry was taken and had not been returned. All of R8's pants were soiled on the ground in the laundry room that resulted in R8 to wear pajama pants and family to had to buy new pants to take R8 out to lunch. Under the section titled "official use only", showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R8's Resident Grievance Form, dated 11/30/2023 at 1:45 (no PM or AM documented), showed R8 for the last six weeks had three pairs of knee socks, labeled with R8's initials, missing. Under the section titled "official use only", showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R8's Resident Grievance Form, dated 11/30/2023 at 2:02 (no PM or AM documented), showed the nature of the concern was R8 had 10 towels when they moved

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into the facility in March (no year documented). R8 only has 3 to 4 towels of the 10 that have been returned and family is wanting all 10 towels returned. The family had pictures to provide of the towels. Under the section titled “official use only”, showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R8’s Resident Grievance Form, dated 11/30/2023 at 2:14 (no PM or AM documented), showed the nature of the concern was the doorbell was not answered by staff resulting in the family to ring the doorbell multiple times to get the door opened by a staff member. Under the section titled “official use only”, showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R6’s Resident Grievance Form, dated 12/04/2023 at 12:00 PM, showed the nature of the concern was R6 frequently went more than a week without a shower or bath. R6 did not get assistance with getting their hair brushed. R6’s towels were not being laundered. R6’s family was told “didn’t have enough staff to do these things”. R6’s family had never received a call that R6 refused any care and services that were trying to be provided. Under the section titled “official use only”, showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R6’s Resident Grievance Form, dated 12/04/2023 at 12 PM, showed the nature of the concern was R6’s room was not provided housekeeping services. Under the section titled “official use only”, showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R6’s Resident Grievance Form, dated 12/04/2023 at 12 PM, showed the nature of the concern was R6 was not provided on going dress and grooming assistance. R6’s teeth was not brushed, hair not combed or brushed, R6 slept in her clothes at night, and often wore the same clothes for multiple days at a time. Under the section titled “official use only”, showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R6’s Resident Grievance Form, dated 12/04/2023 at 12 PM, showed the nature of the concern was R6’s was missing clothes from laundry. R6 had another female residents clothing returned from the laundry room. R6’s bed sheets not cleaned or changed for several weeks. Under the section titled “official use only”, showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review of R6’s Resident Grievance Form, dated 12/04/2023 at 12 PM, showed the nature of the concern showed it was difficult to find staff working on the floor when R6’s daughter visited the facility. The wait times were excessive to have the front door answered. Under the section titled “official use only”, showed there was nothing documented for who was assigned to the complaint and whether the response was completed in writing or a phone call.

Record review on 02/02/2024, the facility provided grievance file showed there was nothing documented on the grievance log.

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In an observation on 02/05/2024 at 8:50 AM, the Department rang the doorbell to enter the secured memory care building. The doorbell rang a melodic tune multiple times before shutting off. The entry way of the building was observed through the glass door to be empty with no staff visibly present. The Department had to wait five minutes at the door, pressing the alarm multiple times, until another Department staff member opened the door. Upon entering the facility entrance from the secured door, it was noted that Staff A, Executive Director, was sitting in her office with the door open and had been there while the doorbell rang, as Staff A's office was within hearing distance of the front doorbell and visible from the front door. Staff A was not noted to have entered or exited their office during the five-minute wait to enter into the building.

Record review of an email sent to the Department on 02/12/2024 at 12:39 PM, from Collateral Contact 3 (CC3), Daughter of R6, that showed the facility had not addressed their grievance concerns. CC3 recently was at the facility to visit R6, when they had to waited over 15 minutes to have the front door opened. CC3 documented that on multiple occasions there were only two people on the floor for one side of the facility. CC3 was scheduled to have a meeting on February 20th with the facility's corporation team and the local ombudsman, to address CC3's ongoing concerns and grievances.

In an interview on 02/15/2024 at 11:19 AM, CC3 stated they continued to have ongoing and unaddressed grievances and concerns. CC3 stated R6 wore another resident's clothes yesterday (02/14/2024) even though they had addressed this same concern back in December 2023.

In an interview on 02/16/2024 at 12 PM, Staff A stated they had a hard time getting anything done at the facility as they needed to field a lot of complaints and concerns from the resident families and staff.

In an interview on 03/06/2024 at 12:29 PM, Staff A stated all grievances would be turned in to the executive director. The grievances would be discussed during the stand up meeting with all department heads. The grievance would then be given to the department head for the nature of the grievance to follow up and resolve the concern expressed.

This is an uncorrected deficiency previously cited on 12/14/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia West
Provider Type: Assisted Living Facility
License/Cert.#: 2497
Compliance Determination #: 32047
Intake ID: 101582
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 11/01/2023 through 12/14/2023
Complainant Contact Date(s): 12/11/2023

Allegation(s):

1) showers not being provided as agreed on the service plan
2) housekeeping has not been provided for residents rooms
3) residents not groomed as preferred
4) not enough staff for the residents

Investigation Methods:

Sample:
Total residents: 53
Resident sample size: 9
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Medication administration
Kitchen

Interviews:
Business office manager
Maintenance staff
Family members
Residents
Nursing staff
Identified resident

Record Reviews:
Medical records
Grievance log
Facility policies
Staff training records
Staff patterns
Personnel files

Investigation Summary:

This document was prepared by Residential Care Services for the Locator website.

1) after observations, interviews, and record reviews the facility failed to provide services as stated on the disclosures of services and residents service plans.
2) after observations and interviews, the facility failed to have housekeeping services completed to maintain the facility and the residents living quarters clean, sanitary, and well maintained as disclosed in the facilities disclosure of services and residents service plans.
3) after observation and interview the facility failed to provide up most dignity to the resident and assisting then with shaving, bathing, and grooming needs as requested.
4) after record review and interview the facility did maintain adequate nursing staffing to provide the care and services to the residents at the facility. no failed practice identified.

Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

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

12/21/2023

Licensee: BKD Clare Bridge of Olympia LLC
Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

RE: Brookdale Olympia West License # 2497

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 12/14/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

This document was prepared by Residential Care Services for the Locator website.

Cory Cisneros, Field Manager
Residential Care Services
Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (253)254-3190.

Sincerely,

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

This document was prepared by Residential Care Services for the Locator website.

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 the unannounced on-site full inspection and complaint investigation on 11/01/2023 and 12/07/2023 of:
Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following complaint numbers: 101582, 104478.

The following sample was selected for review during the unannounced on-site visit: 9 of 53 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Melissa Brunton, Regulatory QA Program Manager - Community Programs
Cory Cisneros, Field Manager
Shirley Grew, LTC Surveyor
Cory Myers, ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
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 _____ Date _____

This document was prepared by Residential Care Services for the Locator website.

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) 12/21/23 Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff had the required nurse delegation training, supervision, and documentation by the Registered Nurse (RN) Delegator for 3 of 3 sampled residents (Resident 21 [R21], Resident 5 [R5], and Resident 1 [R1],) receiving nurse delegated services. The facility failed to verify 6 of 6 staff members (Staff D, Staff C, Staff Q, Staff N, Staff R, and Staff P) credentials and trainings for qualification prior to administering nurse delegated tasks. The facility failed to ensure that qualified medication technicians administered nurse delegated services and tasks to 2 of 2 sampled residents (Resident 21 [R21], and Resident 5 [R5]) These failures placed all residents receiving RN delegated services at risk for harm and injury due to untrained, unqualified, and unsupervised care staff.

Findings included...

"WAC 246-840-930 Criteria for delegation.
...(8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction; (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task; (c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training; (d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions. (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision. (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The

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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) Date

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rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services. (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent. (16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care. (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems. (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

Record review of the Washington State Department of Social and Health Services training document titled, Community Nurse Delegation Orientation, dated 2023 (no month or date), showed long-term care workers (LTCW) must have active home care aide certified credential, or active nursing assistance certified, or active nursing assistance registered credential with completed basic core training. All LTCW must have nurse delegation core training certificate or transcripts and nurse delegation special focus on diabetes certificate or transcript to administer insulin. LTCW must have active credentials with Department of Health (DOH) to be delegated. Under the section titled "planning" showed clear description of the nursing task with step-by-step instructions, expected outcomes of the delegated nursing tasks, and whom the LTCW were to be documented. Under the section titled "evaluations", showed evaluations occurred ongoing and nursing visits must be completed at least every 90 days within the nursing visit form. The goals were determined if met and if outcomes were achieved. Client assessment was completed and the delegated LTCW were supervised and evaluated on the assigned nursing tasks for each resident and documented on the nursing visit form.

Staff Verification

Record review of the facility's "Associate Roster", undated, showed Staff D, Medication Technician, was hired at the facility on 08/13/2023.

Record review of Staff D's Nurse Delegation: Credentials and Training Verification form, undated, in the nurse delegation form showed there was no certificate for review of

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completion for the 40 hour basic training. There was a handwritten note documented by Staff S, Registered Nurse/District Director of Clinical Services, dated 10/20/2023 that showed Staff D completed the 40 hour class at the local college but had not completed the skills lab. The college would not release the certificate until the skills lab was complete. There was no certificate of completion to show that Staff D completed the nurse delegation diabetes training. The Department was unable to verify from the form that Staff D was verified prior to administering nurse delegated tasks for nurse delegated residents.

On 11/01/2023 at 4:01 PM, the Department requested the certificate for Staff D's nurse delegation diabetes completion.

In an interview and record review on 11/01/2023 at 5:00 PM, Staff S stated Staff D's college would not release the certificate of completion for Staff D's 40 hour class. Staff S stated the college will not provide the certificate until Staff D completes their skills lab. Staff S provide another copy of Staff D's Nurse Delegation Core certificate for review.
The Department requested a copy of Staff D's certification of completion for the nurse delegation diabetes.

As of 11/01/2023 at 6 PM, the department did not receive the certificate of completion for nurse delegation diabetes for Staff D for review.

Record review of the facility's "Associate Roster", undated, showed Staff C, Medication Technician, was hired at the facility on 10/09/2023.

Record review of Staff C's Nurse Delegation: Credentials and Training Verification form, dated 10/30/2023, showed it was completed by Staff S. There was no other staff credential or training verification form for Staff C to show their credentials were verified prior to 10/30/2023.

Record review of the facility's "Associate Roster", undated, showed Staff N, Medication Technician, was hired at the facility on 09/19/2023.

Record review of Staff N's Nurse Delegation: Credentials and Training Verification form, undated, showed the form was completed by Staff S. The Department was unable to verify when the document was completed, and Staff N's credentials and trainings were verified.

Record review of the facility's nurse delegation binder showed there was no nurse delegation credential and training verification form for Staff R, Staff Q, and Staff P for review.

Unqualified Medication Technicians

Record review of the facility's "Associate Roster", undated, showed Staff Q, Medication Technician, was hired at the facility on 04/03/2023.

Record review of the facility's nurse delegation binder showed there was no nurse delegation credential and training verification form for Staff Q for review.

Record review on 11/02/2023 at 12:11 PM, of Staff Q's employee file, showed there were no credentials or license for review. Staff Q did not have nurse delegation core and nurse delegation diabetes certificates for review.

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Record review of the Washington State (WA) Department of Health (DOH) credential verification website on 11/29/2023 showed Staff Q's nursing assistant registration license had expired on 03/26/2023. Record review of the facility's "Associate Roster", undated, showed Staff R, Medication Technician, was hired at the facility on 07/31/2023.

Record review of the facility's nurse delegation binder showed there was no nurse delegation credential and training verification form for review for Staff R.

Record review of the Washington State (WA) Department of Health (DOH) credential verification website on 11/29/2023 showed Staff R's, Medication Technician, nursing assistant registration license expired on 10/24/2023.

Record review on 11/02/2023 at 12:11 PM, of Staff R's employee file, showed there were no credentials or license for review. Staff R did not have nurse delegation core and nurse delegation diabetes certificates for review.

Record review of an email sent to the Department on 12/06/2023 at 7:46 AM, showed Staff P was employed at the facility for dates 09/10/2021 through 10/17/2023.

Record review of the facility's nurse delegation binder showed there was no nurse delegation credential and training verification form for review for Staff P.

Record review of the Washington State (WA) Department of Health (DOH) credential verification website on 11/03/2023 and 11/29/2023 showed Staff P's, Former Executive Director, did not have record of any credentials or license for review.

Record review on 11/02/2023 at 12:11 PM, of Staff P's employee file showed there were no credentials or license for review. Staff P did not have nurse delegation core and nurse delegation diabetes certificates for review.

In an interview on 11/02/2023 at 12:04 PM, Staff B, Registered Nurse/Health and Wellness Director, stated they assumed responsibility for nurse delegation services for the facility on 10/30/2023.

Medication Administration & Nurse Delegation Forms

R21

Record review of R21's, "admission record", dated 11/20/2023, showed R21 moved into the facility on [redacted]/2021 with multiple [redacted] diagnoses that included [redacted] ([redacted]).

Record review of R21's Nurse Delegation: Nursing Visit form, dated 10/30/2023, showed R21 required nurse delegation for tasks "medication administration, insulin administration, and CBG's" (checking someone's blood to test how much sugar is in the blood). The form was completed by Staff B, Registered Nurse/Health and Wellness Director. Under the section titled "long term care worker training/competency, showed five of six caregivers evaluated had dates documented for observation of insulin administration dated 10/01/2023 through 10/25/2023.

Record review of R21's Nurse Delegation: instructions for Nursing Task, dated 10/30/2023, showed R21's delegated task and expected outcome was "oral medications

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administration". There was no documented expected outcome for review. Under the section health care provider name showed "on file- face sheet" was documented. There was no health care provider name or telephone number for review.

Record review of R21's Nurse Delegation: Instructions for Nursing Task, dated 02/02/2023, showed R21's delegated task and expected outcome was "insulin pen administration; delegated staff will administer insulin with pen rotating injections sites". The form showed last date of verification of delegated medication was documented as 03/27/2023.

Record review of the nurse delegation binder on 11/03/2023 showed there were no other nurse delegation: instruction for nursing tasks forms or nurse delegation nursing visit forms for review for R21's oral medications, medication topical powder, eye drop medications for review. There was no documentation to show the qualified medication technicians were observed weekly for four week of insulin administration prior to October 2023 by the previous RN delegator.

Record review of R21's Medication Administration Record (MAR), dated 10/01/2023 through 10/31/2023, showed R21 had the current prescribed physician orders for Humulin N insulin (long-acting insulin that helps maintain blood sugar levels and reduce high spikes), and blood sugar checks two times daily. The MAR showed Staff R checked R21's blood sugar five times in 29 days. Staff R administered R21's Humulin insulin six times in 29 days. Staff R administered R21's prescribed topical nystatin powder (a medicated powder to treat a fungal rash on the skin) 14 times in 28 days and administered R21's physician prescribed oral medications 13 days of 28 days. The MAR showed Staff Q checked R21's blood sugar nine times in 29 days. Staff Q administered R21's Humulin insulin 8 times in 29 days. Staff Q administered R21's prescribed topical nystatin powder seven times in 28 days. Staff Q administered R21's oral delegated medications eight of 29 days.

Record review of R21's MAR, dated 09/01/2023 through 09/30/2023, showed R21's Humulin insulin injection was administered by Staff Q 2 of 30 days. Staff R administered R21's Humulin insulin injection 5 of 30 days. Staff P administered R21's Humulin insulin 1 of 30 days. R21's oral medications were administered by non-delegated staff members for 22 of 30 days.

R5

Record review of R5's "Admission Record", showed R5 moved into the facility on [redacted]/2019 with multiple [redacted] diagnoses that included [redacted] and [redacted] ([redacted]).

Record review of R5's Personal Service Plan, dated 07/09/2023, showed staff prepared and administered R5's medications. R5 required the medication technicians to check R5's blood sugar level every morning per physician orders. R5 was very withdrawn and reserved to self. R5 did not speak much.

Record review of R5's Nurse Delegation: Assumption of Delegation, dated 02/02/2023, showed there was a change in RN delegator.

Record review of R5's Nurse Delegation: nurse visit form dated 02/02/2023, showed R5 required nurse delegated tasks for administration of oral medications, topicals, eye drops,

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suppository's (medications that are administered in the rectum) and as needed medications. There was no nurse delegation task form for R5's blood sugar check for review.

Record review of the nurse delegation binder showed there were no quarterly nurse delegation: nurse visit forms for review for dates 02/02/2023 through 10/30/2023 for review.

Record review of R5's Nurse Delegation: Assumption of Delegation, dated 10/30/2023, showed Staff B, Registered Nurse/Health and Wellness Director, had assumed responsibility for R5's nurse delegation oversight.

Record review of R5's Nurse Delegation: Instruction for Nursing Task, dated 10/30/2023, showed R5's delegated task and expected outcome was "oral medication administration". There was no documented expected outcome for R5 for review. There were no listed medications for review that were delegated for R5. Under the box 6 it showed "see medical record" for a list of specific medications, dosages, and frequency of the delegated medications. There was no healthcare provider name or phone number listed for review. Under the section healthcare provider name showed "on file- face sheet". There were no other nurse delegation instruction for nursing tasks dated 02/02/2023 through 10/30/2023 for review.

Record review of R5's MAR, dated 09/01/2023 through 09/30/2023, showed R5 current delegated medications included nystatin (prescribed medication powder to treat a fungal rash infection) topical powder, alphagan (prescribed medicated eye drops to treat eye disorder that forms a film over the eye) eye drop, allopurinol (prescribed medication to treat a disorder that cause joint pain and high levels of uric acid in the blood), aspirin (medication to help with heart and thinning blood), carvedilol (prescribed medication to treat high blood pressure, and dozol/timol eye drops (prescribed medication to help treat eye disorder that causes a film over the eye).

Record review of R5's MAR, dated 09/01/2023 through 09/30/2023, showed Staff R administered R5's oral, topical, and eye delegated medication tasks for 17 of 30 days.

Record review of R5's MAR, dated 09/01/2023 through 09/30/2023, showed Staff Q administered R5's oral, topical, and eye delegated medication tasks for 5 of 30 days. Staff Q checked R5's blood sugar 5 of 27 documented blood sugar checks. Staff R administered R5's oral, topical, and eye delegated medication tasks for 17 of 30 days. Staff R checked R5's blood sugar 4 of 27 documented blood sugar checks. Staff P checked R5's blood sugar check 1 of 27 documented blood sugar check.

Record review of R5's MAR, dated 10/01/2023 through 10/31/2023, showed Staff Q administered R5's oral, topical, and eye drop delegated medication tasks for 7 of 31 days. Staff Q checked R5's blood sugar 9 of 31 documented blood sugar checks. Staff R administered R5's oral, topical, and eye delegated medication tasks for 13 of 31 days. Staff R checked R5's blood sugar 1 of 31 documented blood sugar checks.

In an interview on 11/03/2023 at 11:03 AM, Staff X, Medication Technician, stated all of R5's medications, eye drops, topical medications, and their blood sugar check was nurse delegated tasks.

R1

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Record review of R1's "Admission Record", showed R1 admitted to the facility on [redacted] 2021.

Record review of R1's Personal Service Plan, dated 07/19/2023, showed R1's assessment was related to Alzheimer's (a progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out simplest tasks and daily living care needs). R1 had cognitive and memory loss concerns. R1 was not always oriented to time and experienced change in orientation that may impact R1's decision-making.

Record review of R1's nurse delegation: instructions for nursing task, dated 10/30/2023, showed R1's delegated task and expected outcome was "oral medication administration". There was no outcome listed. R1's medications were not listed and in box showed "list specific medication (s), dosages and frequency of medications delegated on this date (check here if additional form attached). There was no check that indicated an additional form was attached. There was "See Medical Records" was documented in box six. Under the section "healthcare provider name" showed "on file-face sheet". There was no healthcare provider name or phone number for review.

Record review of the nurse delegation binder on 11/01/2023 showed there were no nurse delegation: nurse visit forms for review for R1. There was a nurse delegation: nurse visit form that was filed with R1's task sheet that was dated 10/30/2023. The nurse delegation: nurse visit form did not have a "client name" at the top of the form. There was no nurse visit quarterly review forms for R1 for dates 01/01/2023 through 11/02/2023 for review.

In an interview on 11/03/2023 at 11:58 AM, Staff B, Registered Nurse/ Health and Wellness Director, stated all the nurse delegation forms they had from the prior nurse delegator were located in the nurse delegation binder that the Department had reviewed. Staff B stated Staff R and Staff Q were not nurse delegated and were not to administered nurse delegated tasks for the residents.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date) 01/28/24

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

Administrator (or Representative) — Date 12/21/23

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This document was prepared by Residential Care Services for the Locator website.

Record review of R1's "Admission Record", showed R1 admitted to the facility on [redacted]/2021.

Record review of R1's Personal Service Plan, dated 07/19/2023, showed R1's assessment was related to Alzheimer's (a progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out simplest tasks and daily living care needs). R1 had cognitive and memory loss concerns. R1 was not always oriented to time and experienced change in orientation that may impact R1's decision-making.

Record review of R1's nurse delegation: instructions for nursing task, dated 10/30/2023, showed R1's delegated task and expected outcome was "oral medication administration". There was no outcome listed. R1's medications were not listed and in box showed "list specific medication (s), dosages and frequency of medications delegated on this date (check here if additional form attached). There was no check that indicated an additional form was attached. There was "See Medical Records" was documented in box six. Under the section "healthcare provider name" showed "on file-face sheet". There was no healthcare provider name or phone number for review.

Record review of the nurse delegation binder on 11/01/2023 showed there were no nurse delegation: nurse visit forms for review for R1. There was a nurse delegation: nurse visit form that was filed with R1's task sheet that was dated 10/30/2023. The nurse delegation: nurse visit form did not have a "client name" at the top of the form. There was no nurse visit quarterly review forms for R1 for dates 01/01/2023 through 11/02/2023 for review.

In an interview on 11/03/2023 at 11:58 AM, Staff B, Registered Nurse/ Health and Wellness Director, stated all the nurse delegation forms they had from the prior nurse delegator were located in the nurse delegation binder that the Department had reviewed. Staff B stated Staff R and Staff Q were not nurse delegated and were not to administered nurse delegated tasks for the residents.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This document was prepared by Residential Care Services for the Locator website.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure medications were stored properly and secured for 1 of 1 resident (Resident 2 [R2]) rooms. This failure placed 53 of 53 assisted living residents at risk to ingest non prescribed medications in error.

Findings included…

Record review of the facility's document titled, "Medication and Treatment storage policy", dated 10/2018, showed medications were to be stored in an organized manner in accordance with the manufacturer's instructions and State regulations were to be followed. Medications and treatments stored by the community were to be stored in designated locations that must be locked when not in use or when unattended. Residents that self-administer their own medications may store and secure their non-controlled medication in their apartment by locking the apartment door each time upon departure.

Record review of R2's admission record sheet, dated 09/13/2023, showed R2 moved into the facility on [redacted]/2023 with multiple [redacted] diagnoses that included [redacted] .

Record review of R2's Personal Service Plan, dated [redacted]/2023, showed R2's medications were stored in the facility's medication storage area (facility's medication carts or room). Staff at the facility were to prepare and administer all medications for R2.

In an observation on 11/03/2023 at 10:10 AM, inside R2's apartment on the top of the dresser next to the R2's television was a clear bottle with red liquid inside. The bottle's label showed "Chloraseptic [over the counter medication to help relieve pain to throat and mouth] sore throat spray, fast relief for sore throat". The bottle was not secured and had dried red substance on the spray area. R2 stated the facility stores and administers their medications.

In an interview on 11/03/2023 at 02:04 PM Staff B, Registered Nurse/Health and Wellness Director, stated they acknowledged the R2 should not have medication unsecured in their room and believed their family may bring in medications when they visited. Staff B stated the facility staff would need to check R2's room after family visits to ensure
no medication was present.

This is a recurring deficiency previously cited 04/21/2022.

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care and assisted living residents for 3 of 3 locations within the facility (beauty salon, town square public bathroom, and Bridge side Kitchenette). This failure placed 53 of 53 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's document titled, "fresh impressions-chemical labeling, containers, storage and SDS [safety data sheets'] requirements', updated March 2023, showed chemicals were to never be left unattended. All supply closets that store chemicals were to be locked when they were not in use.

In an observation and interview on 11/01/2023 at 9:25 AM, in the kitchenette on the Bridge side of the facility, inside the unlocked cabinets above the refrigerator, was a clear spray bottle that was half full of clear liquid inside. There was no label on the spray bottle that showed what the liquid inside was. There was a box of individual packets of cocoa that were sitting on top of a spray bottle that was half full of green liquid inside. The label on the bottle showed "heavy duty alkaline cleaner and bathroom cleaner".

In an interview on 11/01/2023 at 9:32 AM, Staff B, Registered Nurse/ Health and Wellness Director, stated all chemicals were to be locked up and inaccessible to residents at the facility.

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care and assisted living residents for 3 of 3 locations within the facility (beauty salon, town square public bathroom, and Bridge side Kitchenette). This failure placed 53 of 53 residents at risk for ingesting potentially toxic materials.

Findings included…

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In an interview on 11/01/2023 at 9:32 AM, Staff B, Registered Nurse/ Health and Wellness Director, stated all chemicals were to be locked up and inaccessible to residents at the facility.

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In an observation and interview on 11/01/2023 at 10:44 AM, Staff B stated the beauty salon was not being used and the door was to be locked. Staff B turned the handle to the beauty salon and the door opened without the use of the key. Inside the beauty salons unlocked cabinet next to the window was a clear bottle with brown liquid inside that was three quarters full. The label on the bottle showed "barbicide" (a disinfectant solution used for grooming tools such as hair cutting shears and combs).

In an observation on 11/01/2023 at 12:36 PM, inside the unlocked public bathroom of the townhall area of the facility was a little table to the right of the bathroom. The little table had an unlocked top drawer that had a clear spray bottle with a green label that showed multi-surface everyday cleaner lemon verbena scent

In an interview on 11/03/2023 at 02:04 PM, Staff A, District Director of Operations/Executive Director, stated all chemicals were to be properly labeled and locked in a cabinet or housekeeping closet.

Plan/Attestation Statement

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Administrator (or ~~Representative~~) — Date 12/21/23

RCW 70.129.070 Examination of survey or inspection results -- Contact with client advocates. A resident has the right to:

(1) Examine the results of the most recent survey or inspection of the facility conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the facility. A notice that the results are available must be publicly posted with the facility's state license, and the results must be made available for examination by the facility in a place readily accessible to residents; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to have the most recent survey or inspection results publicly posted and easily available for 1 of 1 inspection binders. This failure resulted in all residents and visitors being without access to and being uninformed of the facility's inspections results.

This document was prepared by Residential Care Services for the Locator website.

In an observation and interview on 11/01/2023 at 10:44 AM, Staff B stated the beauty salon was not being used and the door was to be locked. Staff B turned the handle to the beauty salon and the door opened without the use of the key. Inside the beauty salons unlocked cabinet next to the window was a clear bottle with brown liquid inside that was three quarters full. The label on the bottle showed “barbicide” (a disinfectant solution used for grooming tools such as hair cutting shears and combs).

In an observation on 11/01/2023 at 12:36 PM, inside the unlocked public bathroom of the townhall area of the facility was a little table to the right of the bathroom. The little table had an unlocked top drawer that had a clear spray bottle with a green label that showed multi-surface everyday cleaner lemon verbena scent.

In an interview on 11/03/2023 at 02:04 PM, Staff A, District Director of Operations/Executive Director, stated all chemicals were to be properly labeled and locked in a cabinet or housekeeping closet.

Plan/Attestation Statement

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Administrator (or Representative) Date

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Findings included...

In an observation on 11/01/2023 at 9:14 PM, the survey binder (inspection results) was located by the front receptionist desk in a hanging wall folder to review. The binder had the last facility annual inspection that was dated 03/20/2019 for review. The binder did not have any complaint inspections that resulted in citations available to review.

Record review of the Department records showed the facility had received numerous citations and inspection reports since the last annual full inspection on 03/20/2019.

In an interview on 11/03/2023 at 02:04 PM, Staff A, District Director of Operations/Executive Director, stated they were told they only needed to have the annual inspections in the binder for the residents, visitors, and all public to review

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facilty premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans,

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 sampled pets (Resident 8's [R8] pet and Resident 9's [R9] pet) and all other pets living on the premises had regular examinations and were certified by a veterinarian to be free of disease transmittable to humans. This failure placed 55 of 55 residents and 42 staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility's, "Pet Policy", revised date 10/2021, showed that "The community shall maintain a health record for all pets documenting the veterinary name,

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Findings included…

In an observation on 11/01/2023 at 9:14 PM, the survey binder (inspection results) was located by the front receptionist desk in a hanging wall folder to review. The binder had the last facility annual inspection that was dated 03/20/2019 for review. The binder did not have any complaint inspections that resulted in citations available to review.

Record review of the Department records showed the facility had received numerous citations and inspection reports since the last annual full inspection on 03/20/2019.

In an interview on 11/03/2023 at 02:04 PM, Staff A, District Director of Operations/Executive Director, stated they were told they only needed to have the annual inspections in the binder for the residents, visitors, and all public to review.

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Administrator (or Representative) Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 sampled pets (Resident 8's [R8] pet and Resident 9's [R9] pet) and all other pets living on the premises had regular examinations and were certified by a veterinarian to be free of disease transmittable to humans. This failure placed 55 of 55 residents and 42 staff at risk of being exposed to diseases which could impact their health.

Findings included…

Record review of the facility's, "Pet Policy", revised date 10/2021, showed that "The community shall maintain a health record for all pets documenting the veterinary name,

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phone number, address, shots, and dates," and, "The resident's pet must have regular examinations and current vaccinations by a licensed veterinarian upon move in to the community and be certified by a veterinarian to be free of diseases transmitiable to humans."

Record review of R8's financial file showed there was a veterinary hospital letter, dated 11/07/2022, that showed R8's cat's last veterinary examination was on 01/22/2022.
There was no record as to when R8's cat last vaccinations were completed for review.

On 11/01/2023 at 1:47 PM, the facility's pet record binder was requested for review. The Department was not provided with a binder or documentation for review.

In an interview on 11/01/2023 at 2:54 PM, Staff H, Business Office Coordinator, stated they were trying to locate the pet record binder. Staff H stated activities had the binder.

In an interview on 11/01/2023 at 4:23 PM, Staff A, District Director of Operations/Executive Director, stated the pet record binder was to be stored in the business office. Staff A stated they were unable to locate the binder for review.

In an interview on 11/01/2023 at 4:35 PM, Staff B stated there were two residents (R8 and R9) that had cats that lived at the facility.

In an interview on 11/02/2023 at 11:35 AM, Staff A stated Staff M, Claire Bridge Program Coordinator, had the pet binder for the Department to review.

In an observation and interview on 11/02/2023 at 1:59 PM, there was a large [redacted] cat with [redacted] chest in R8's room on their bed. R8 stated that was their cat that lived with them in their room.

In an interview on 11/02/2023 at 3 PM, Staff A stated they were unable to locate the pet binder records for the Department to review.

The facility was unable to provide pet record information for R8's and R9's pets.

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

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phone number, address, shots, and dates," and, "The resident's pet must have regular examinations and current vaccinations by a licensed veterinarian upon move in to the community and be certified by a veterinarian to be free of diseases transmittable to humans."

Record review of R8's financial file showed there was a veterinary hospital letter, dated 11/07/2022, that showed R8's cat's last veterinary examination was on 01/22/2022.
There was no record as to when R8's cat last vaccinations were completed for review.

On 11/01/2023 at 1:47 PM, the facility's pet record binder was requested for review. The Department was not provided with a binder or documentation for review.

In an interview on 11/01/2023 at 2:54 PM, Staff H, Business Office Coordinator, stated they were trying to locate the pet record binder. Staff H stated activities had the binder.

In an interview on 11/01/2023 at 4:23 PM, Staff A, District Director of Operations/Executive Director, stated the pet record binder was to be stored in the business office. Staff A stated they were unable to locate the binder for review.

In an interview on 11/01/2023 at 4:35 PM, Staff B stated there were two residents (R8 and R9) that had cats that lived at the facility.

In an interview on 11/02/2023 at 11:35 AM, Staff A stated Staff M, Claire Bridge Program Coordinator, had the pet binder for the Department to review.

In an observation and interview on 11/02/2023 at 1:59 PM, there was a large [redacted] cat with [redacted] chest in R8's room on their bed. R8 stated that was their cat that lived with them in their room.

In an interview on 11/02/2023 at 3 PM, Staff A stated they were unable to locate the pet binder records for the Department to review.

The facility was unable to provide pet record information for R8's and R9's pets.

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Administrator (or Representative) Date

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WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 3 of 3 sampled staff (Staff A, Staff F, Staff G) had submitted a new Washington State (WA) name and background check every two years. This failure placed 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included…

Record review of an email sent to the Department on 11/15/2023 at 4:55 PM, showed Staff A, District Director of Operations/Executive Director, was hired on 10/01/2000.

Record review on 11/02/2023 of Staff A's personal documents from the corporation's office showed there was no WA state name and date of birth background check for review.

Record review of the facility's employee roster, undated, showed Staff F, Maintenance Technician, was hired at the facility on 10/11/2017.

Record review of Staff F's Washington state name and background check showed it was completed on 03/27/2021 and was valid through 03/27/2023.

Record review of the facility's employee roster, undated, showed Staff G, Caregiver, was hired at the facility on 07/04/2021.

Record review of Staff G's Washington state name and background check showed it was completed on 06/14/2021 and was valid through 06/14/2023.

In an interview on 11/02/2023 at 3:53 PM, Staff A stated they did not have a current background check for review. Staff A stated the last background check they had completed was in the year 2002 or 2004. Staff A stated they came into the facility often to cover and assist. Staff A stated they had unsupervised access to residents. Staff A stated they were to have an updated WA name and date of birth background check updated every two years.

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

Administrator (or Representative) — Date: 12/21/23

WAC 388-78A-2471 Background check Confidentiality Use restricted Retention. The assisted living facility must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

(4) Retained and available for department review during the individual's employment or association with a facility and for at least two years after termination of the employment or association.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 5 of 5 sampled staff's (Staff C, Staff D, Staff E, Staff F, and Staff G) had a copy of their Washington State (WA) Name and Date of Birth and Finger Print Background Checks at the facility for the department to review. This failure to ensure a Washington State Background Check was available placed 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

On 11/01/2023, an on-site review of staff records showed Staff C, Medication Technician, Staff D, Medication Technician, Staff E, Cook, Staff F, Maintenance Technician, and Staff G, Caregiver, did not have a Washington State Name and Date of Birth and Finger Print background check available at the facility for review.

On 11/01/2023 at 1:47 PM, the Department requested Staff C, Staff D, Staff E, Staff F, and Staff G's employee files for review.

On 11/01/2023, review of the sampled staff files showed there were no WA Name and Date of Birth background checks for review.

In an interview on 11/02/2023 at 11:15 AM, Staff H, stated they needed to fill out one more form to give them access to complete and print staff's WA name and date of birth background checks for review. Staff H stated they were hired at the facility on 10/09/2023 as the business office coordinator. Staff H stated they were provided access to the WA stated background check system since they were hired. Staff H stated Staff P, Former Executive Director, was the only person that had access to staff's WA name and date of birth background checks. Staff H stated Staff P quit employment at the facility on

This document was prepared by Residential Care Services for the Locator website.

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Administrator (or Representative) Date

WAC 388-78A-2471 Background check Confidentiality Use restricted Retention. The assisted living facility must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

(4) Retained and available for department review during the individual's employment or association with a facility and for at least two years after termination of the employment or association.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 5 of 5 sampled staff's (Staff C, Staff D, Staff E, Staff F, and Staff G) had a copy of their Washington State (WA) Name and Date of Birth and Finger Print Background Checks at the facility for the department to review. This failure to ensure a Washington State Background Check was available placed 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included…

On 11/01/2023, an on-site review of staff records showed Staff C, Medication Technician, Staff D, Medication Technician, Staff E, Cook, Staff F, Maintenance Technician, and Staff G, Caregiver, did not have a Washington State Name and Date of Birth and Finger Print background check available at the facility for review.

On 11/01/2023 at 1:47 PM, the Department requested Staff C, Staff D, Staff E, Staff F, and Staff G's employee files for review.

On 11/01/2023, review of the sampled staff files showed there were no WA Name and Date of Birth background checks for review.

In an interview on 11/02/2023 at 11:15 AM, Staff H, stated they needed to fill out one more form to give them access to complete and print staff's WA name and date of birth background checks for review. Staff H stated they were hired at the facility on 10/09/2023 as the business office coordinator. Staff H stated they were provided access to the WA stated background check system since they were hired. Staff H stated Staff P, Former Executive Director, was the only person that had access to staff's WA name and date of birth background checks. Staff H stated Staff P quit employment at the facility on

This document was prepared by Residential Care Services for the Locator website.

10/16/2023.

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have a Washington State name and Date of Birth background check and finger prints completed for 2 of 2 contracted agency caregivers (Collateral Contact 1 [CC1]and Collateral Contact 2 [CC2]) prior to them working at the facility. This failure placed all 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Record review of the facility's provided employee schedule, dated 10/15/2023 through 10/21/2023, showed CC1, Agency Caregiver, worked at the facility on 10/18/2023 from 2 PM until 10 PM. The schedule showed CC2, Agency Caregiver, worked at the facility on 10/20/2023 from 6 AM until 2 PM.

Record review of the facility's provided employee schedule, dated 10/22/2023 through 10/28/2023, showed CC1 worked at the facility on 10/23/2023, 10/24/2023, 10/25/2023, and 10/27/2023 from 2 PM until 10 PM. CC2 worked daily at the facility on 10/22/2023 through 10/27/2023 from 6 AM until 2 PM.

Record review of the facility's provided employee schedule, dated 10/29/2023 through

This document was prepared by Residential Care Services for the Locator website.

10/16/2023.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to have a Washington State name and Date of Birth background check and finger prints completed for 2 of 2 contracted agency caregivers (Collateral Contact 1 [CC1]and Collateral Contact 2 [CC2]) prior to them working at the facility. This failure placed all 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included…

Record review of the facility's provided employee schedule, dated 10/15/2023 through 10/21/2023, showed CC1, Agency Caregiver, worked at the facility on 10/18/2023 from 2 PM until 10 PM. The schedule showed CC2, Agency Caregiver, worked at the facility on 10/20/2023 from 6 AM until 2 PM.

Record review of the facility's provided employee schedule, dated 10/22/2023 through 10/28/2023, showed CC1 worked at the facility on 10/23/2023, 10/24/2023, 10/25/2023, and 10/27/2023 from 2 PM until 10 PM. CC2 worked daily at the facility on 10/22/2023 through 10/27/2023 from 6 AM until 2 PM.

Record review of the facility's provided employee schedule, dated 10/29/2023 through

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11/04/2023, showed CC1 worked at the facility on 10/29/2023 and 10/31/2023 from 2 PM until 10 PM. CC2 worked at the facility on 10/29/2023 and 10/30/2023 from 6 AM until 2 PM.

Record review of CC1's document titled, Washington State Patrol (WSP) WATCH web search, dated 02/22/2023, under the section titled "criminal history", showed there was no record found. The facility did not provide a WA state name and date of birth background check for review for CC1.

Record review of CC2's document titled, Washington State Patrol (WSP) WATCH web search, dated 11/17/2022, under the section titled "criminal history", showed there was no record found. The facility did not provide a WA state name and date of birth background check for review for CC1.

In an interview on 11/03/2023 at 2:04 PM, Staff A, District Director of Operations/Executive Director, stated they didn't complete a name and date of birth background check on the agency staff and caregivers. Staff A stated they trusted the agency company they contract with to complete that specific background check.

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete reference checks for 5 of 5 employees (Staff C, Staff D, Staff E, Staff F, and Staff G) reviewed. This failure placed all 53 residents at risk of receiving care and services from unqualified and/or unsuitable staff.

Findings included…

RCW 18.20.125 Inspections—Enforcement remedies—Screening— Limitations on unsupervised access to vulnerable adults. (3)(a) To the extent funding is available, the licensee, administrator, and their staff should be screened through background checks in a uniform and timely manner to ensure that they do not have a criminal history that would disqualify them from working with vulnerable adults. Employees may be provisionally hired pending the results of the background check if they have been given three positive references.

Record review of the facility provided employee list, undated, showed Staff C, Medication Technician, was hired at the facility on 10/09/2023.

Record review on 11/01/2023 of Staff C's personnel file showed there was one work

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reference that was dated 10/10/2023 for review. There were no other reference checks in Staff C's file for review.

Record review of the facility provided employee list, undated, showed Staff D, Medication Technician, was hired at the facility on 08/13/2023.

Record review on 11/01/2023 of Staff D's personnel file showed there were no reference checks in Staff D's file for review.

Record review of the facility provided employee list, undated, showed Staff E, Cook, was hired at the facility on 10/09/2023.

Record review on 11/01/2023 of Staff E's personnel file showed there were no reference checks in Staff E's file for review.

Record review of the facility provided employee list, undated, showed Staff F, Maintenance Technician, was hired at the facility on 10/11/2017.

Record review on 11/01/2023 of Staff F's personnel file showed there were three work references in Staff F's file for review. All three references did not have a date to show when the references were completed.

Record review of the facility provided employee list, undated, showed Staff G, Caregiver, was hired at the facility on 07/04/2021.

Record review on 11/01/2023 of Staff G's personnel file showed there were no reference checks in Staff G's file for review.

In an interview on 11/15/2023 at 11:30 AM, Staff B, Registered Nurse/Health and Wellness Director, stated the facilities Business Office Coordinator was responsible to ensure employees work references were completed. Staff B stated the work references would be filed in the employee's personal file that was stored in the business office.

In an interview on 11/02/2023 at 11:15 AM, Staff H, Business Office Coordinator, stated all employee reference checks once completed would be filed in the employee file if they were completed.

Plan/Attestation Statement

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

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reference that was dated 10/10/2023 for review. There were no other reference checks in Staff C's file for review.

Record review of the facility provided employee list, undated, showed Staff D, Medication Technician, was hired at the facility on 08/13/2023.

Record review on 11/01/2023 of Staff D's personnel file showed there were no reference checks in Staff D's file for review.

Record review of the facility provided employee list, undated, showed Staff E, Cook, was hired at the facility on 10/09/2023.

Record review on 11/01/2023 of Staff E's personnel file showed there were no reference checks in Staff E's file for review.

Record review of the facility provided employee list, undated, showed Staff F, Maintenance Technician, was hired at the facility on 10/11/2017.

Record review on 11/01/2023 of Staff F's personnel file showed there were three work references in Staff F's file for review. All three references did not have a date to show when the references were completed.

Record review of the facility provided employee list, undated, showed Staff G, Caregiver, was hired at the facility on 07/04/2021.

Record review on 11/01/2023 of Staff G's personnel file showed there were no reference checks in Staff G's file for review.

In an interview on 11/15/2023 at 11:30 AM, Staff B, Registered Nurse/Health and Wellness Director, stated the facilities Business Office Coordinator was responsible to ensure employees work references were completed. Staff B stated the work references would be filed in the employee's personal file that was stored in the business office.

In an interview on 11/02/2023 at 11:15 AM, Staff H, Business Office Coordinator, stated all employee reference checks once completed would be filed in the employee file if they were completed.

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Administrator (or Representative) 12/21/23 Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 4 of 5 sampled staff (Staff C, Staff D, Staff E, and Staff G) had the required CPR (cardiopulmonary resuscitation) and/or First Aid training and failed to ensure 2 of 5 sampled Staff (Staff C and Staff G) had completed their facility orientation training. These failures placed 53 of 53 residents at risk for staff not being trained on life saving measures and staff being unaware of the facility's expectations.

Findings included...

WAC 388-112A-0200 "What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the

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Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 4 of 5 sampled staff (Staff C, Staff D, Staff E, and Staff G) had the required CPR (cardiopulmonary resuscitation) and/or First Aid training and failed to ensure 2 of 5 sampled Staff (Staff C and Staff G) had completed their facility orientation training. These failures placed 53 of 53 residents at risk for staff not being trained on life saving measures and staff being unaware of the facility's expectations.

Findings included…

WAC 388-112A-0200 "What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation."

WAC 388-112A-0210 "What content must be included in facility and long-term care worker orientation? (1) For those individuals identified in WAC 388-112A-0200(1) who must complete facility orientation training: (a) Orientation training may include the use of videos, audio recordings, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Facility orientation must include introductory information in the following areas: (i) The care setting; (ii) The characteristics and special needs of the population served; (iii) Fire and life safety, including: (A) Emergency communication (including phone system if one exists); (B) Evacuation planning (including fire alarms and fire extinguishers where they exist); (C) Ways to handle resident injuries and falls or other accidents; (D) Potential risks to residents or staff (for instance, challenging resident behaviors and how to handle them); and (E) The location of home policies and procedures; (iv) Communication skills and information, including: (A) Methods for supporting effective communication among the

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resident/guardian, staff, and family members; (B) Use of verbal and nonverbal communication; (C) Review of written communications and documentation required for the job, including the resident's service plan; (D) Expectations about communication with other home staff; and (E) Who to contact about problems and concerns; (v) Standard precautions and infection control, including: (A) Proper hand washing techniques; (B) Protection from exposure to blood and other body fluids; (C) Appropriate disposal of contaminated/hazardous articles; (D) Reporting exposure to contaminated articles, blood, or other body fluids; and (E) What staff should do if they are ill; (vi) Resident rights, including: (A) The resident's right to confidentiality of information about the resident; (B) The resident's right to participate in making decisions about the resident's care and to refuse care; (C) Staff's duty to protect and promote the rights of each resident and assist the resident to exercise these rights; (D) How staff should report concerns they may have about a resident's decision pertaining to their care and who they should report these concerns to; (E) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident; (F) Advocates that are available to help residents (such as long-term care ombudsmen and organizations); and (G) Complaint lines, hot lines, and resident grievance procedures such as, but not limited to: (I) The DSHS complaint hotline at 1-800-562-6078; (II) The Washington state long-term care ombudsman program; (III) The Washington state department of health and local public health departments; Certified on 2/20/2023 WAC 388-112A-0210 Page 1 (IV) The local police; (V) Facility grievance procedure; and (b) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents. (2) For long-term care worker orientation required of those individuals identified in WAC 388-112A-0200(2), long-term care worker orientation is a two hour training that must include introductory information in the following areas: (a) The care setting and the characteristics and special needs of the population served; (b) Basic job responsibilities and performance expectations; (c) The care plan or negotiated service agreement, including what it is and how to use it; (d) The care team; (e) Process, policies, and procedures for observation, documentation, and reporting; (f) Resident rights protected by law, including the right to confidentiality and the right to participate in care decisions or to refuse care and how the long-term care worker will protect and promote these rights; (g) Mandatory reporter law and worker responsibilities as required under chapter 74.34 RCW; and (h) Communication methods and techniques that may be used while working with a resident or guardian and other care team members. (3) One hour of completed classroom instruction or other form of training (such as a video or online course) in long-term care orientation training equals one hour of training. The training entity must establish a way for the long-term care worker to receive feedback from an approved instructor or a proctor trained by an approved instructor."

Facility Orientation

Record review of the facility provided employee list, undated, showed Staff C, Medication Technician, was hired at the facility on 10/09/2023.

Record review on 11/01/2023 of Staff C's personnel file showed there was no facility orientation training for review.

Record review of the facility provided employee list, undated, showed Staff D, Medication Technician, was hired at the facility on 08/13/2023.

Record review on 11/01/2023 of Staff D's personnel file showed there was no facility orientation training for review.

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Record review of the facility provided employee list, undated, showed Staff E, Cook, was hired at the facility on 10/09/2023.

Record review on 11/01/2023 of Staff E's personnel file showed there was no facility orientation training for review.

Record review of the facility provided employee list, undated, showed Staff G, Caregiver, was hired at the facility on 07/04/2021.

Record review on 11/01/2023 of Staff G's personnel file showed there was no facility orientation training for review.

Record review of the facility provided employee list, undated, showed Staff J, Caregiver, was hired at the facility on 05/24/2021 with a last start date on 05/13/2023.

Record review of the facility provided employee list, undated, showed Staff N, Medication Technician, was hired at the facility on 09/19/2023.

Record review of the facility provided employee list, undated, showed Staff O, Caregiver, was hired at the facility on 11/08/2022.

In an interview on 11/02/2023 at 3:46 PM, Staff N, stated they did not have a facility orientation. Staff N stated they walked independently around the facility to know where different items and exits were located.

In an interview on 11/03/2023 at 10:40 AM, Staff J and Staff O stated they had not been through a facility orientation when they were hired at the facility. Staff O stated they learned the layout and areas of the facility from other coworkers and just walking around.

In an interview on 11/02/2023 at 5:13 PM Staff A, District Director of Operations/Executive Director, stated the facility did not use or follow the facility's document titled "Washington Associate Foundations New Hire Orientation Training Plan and Checklist" that included all the requirements that needed to be reviewed with new employees. Staff A stated the document was to be reviewed with the employee on their first day of employment before they worked on the floor and filed in their employee file in the business office.

CPR/1st Aid

Record review of the facility's document titled "Associates Roster", undated showed Staff C, Medication Technician, was hired at the facility on 10/09/2023.

Record review on 11/01/2023 of Staff C's employee file showed there was no CPR or 1st Aid card for review.

Record review of the facility's document titled "Associates Roster", undated showed Staff G, Medication Technician/Caregiver, was hired at the facility on 07/04/2021.

Record review on 11/01/2023 of Staff G's employee file showed there was no CPR or 1st Aid card for review.

On 11/01/2023 at 1:47 PM, Staff G and Staff C's employee files that contained staff's certificates were requested by the Department for review.

This document was prepared by Residential Care Services for the Locator website.

On 11/01/2023 at 4:07 PM, Staff G and Staff C's CPR/1st Aid card was requested for the second time.

As of 11/01/2023 at 6:00 PM, the Department had not received Staff G or Staff C's CPR/1st Aid card for review.

In an interview on 11/02/2023 at 11:15 AM, Staff H, Business Office Coordinator, stated they were unable to provide Staff G or Staff C's CPR/1st Aid card for review.

Dementia Training

Record review of the facility provided employee list, undated, showed Staff G, Caregiver, was hired at the facility on 07/04/2021.

Record review on 11/01/2023 of Staff G's personnel file showed there was no specialty dementia certificate of training for review.

In an interview on 11/02/2023 at 11:15 AM, Staff H, Business Office Coordinator, stated they were unable to provide Staff G specialty dementia training certificate for review.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date) 01/28/24

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

Administrator (or Representative) — Date 12/21/23

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the Resident Service Plans

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On 11/01/2023 at 4:07 PM, Staff G and Staff C's CPR/1st Aid card was requested for the second time.

As of 11/01/2023 at 6:00 PM, the Department had not received Staff G or Staff C's CPR/1st Aid card for review.

In an interview on 11/02/2023 at 11:15 AM, Staff H, Business Office Coordinator, stated they were unable to provide Staff G or Staff C's CPR/1st Aid card for review.

Dementia Training

Record review of the facility provided employee list, undated, showed Staff G, Caregiver, was hired at the facility on 07/04/2021.

Record review on 11/01/2023 of Staff G's personnel file showed there was no specialty dementia certificate of training for review.

In an interview on 11/02/2023 at 11:15 AM, Staff H, Business Office Coordinator, stated they were unable to provide Staff G specialty dementia training certificate for review.

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

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the Resident Service Plans

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(Negotiated Service Agreements) for 2 of 7 sampled residents (Resident 3 [R3], and Resident 5 [R5]) were agreed to and signed at least annually by the resident, resident's representative, and representative of the assisted living facility. This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings included…

Record review of the facility's "Service Plan Process Policy", dated 03/2020, showed upon initial review and subsequent changes, members of the community care team that contributed to the service plan, including the executive director or designee, or nurse and the resident/legally responsible party should sign the service plan.

R3

Record review of R3's Admission Record showed R3 moved into the facility on [redacted]/2023.

Record review of R3's Personal Service Plan, dated [redacted]/2023, showed no signatures from the resident, resident responsible party, and a representative of the facility.

R5

Record review of R5's Admission Record showed R5 moved into the facility on [redacted]/2019.

Record review of R5's Personal Service Plan, dated 06/23/2022, showed no signatures from the resident, resident responsible party, and a representative of the facility.

Record review of R5's Personal Service Plan, dated 12/23/2022, showed no signatures from the resident, resident responsible party, and a representative of the facility.

Record review of R5's Personal Service Plan, dated 07/09/2023, showed no signatures from the resident, resident responsible party, and a representative of the facility.

In an interview on 11/02/2023 at 12:10 PM, Staff B, Registered Nurse/Health and Wellness Director, stated they did not have a signed Personal Service Plan for R3.

In an interview on 11/15/2023 at 11:31 AM, Staff B stated anytime a resident has a new personal service plan completed, the responsible party would be called or come into the facility to discuss, review, and sign the new personal service plan.

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Administrator (or Representative) — Date 12/21/23

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 2 of 3 sampled new staff members (Staff C and Staff D) were screened for tuberculosis (TB, a communicable disease) within three days of employment as required. This failure placed all 53 of 53 residents and staff at risk of TB infection.

Findings included...

Record review of the ALF's "Tuberculosis Exposure Control Plan Policy - Associates" revised 09/2021, showed that TB testing was to be retained in the associate's confidential medical record file, separate from their general personnel records.

Record review on 11/01/2023 of the TB test documents provided by the ALF showed Staff C's and Staff D's TB testing was not presented for review.

Record review of the facility's employee roster, undated, showed Staff C, Medication Technician, was hired on 10/09/2023. Review of Staff C's record failed to show results from a TB test done within three days of employment.

Record review of the facility's employee roster, undated, showed Staff D, Medication Technician, was hired on 08/13/2023. Review of Staff D's record failed to show results from a TB skin test done within three days of employment.

During an interview on 11/01/2023 at 4:20 PM, Staff A, District Director of Operations/Executive Director, said that many of the staff did not have the required TB testing completed. Staff A stated that the employee's TB testing was filed in the employee's file if it had been completed.

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to develop and implement a system to ensure 2 of 3 sampled new staff members (Staff C and Staff D) were screened for tuberculosis (TB, a communicable disease) within three days of employment as required. This failure placed all 53 of 53 residents and staff at risk of TB infection.

Findings included…

Record review of the ALF's "Tuberculosis Exposure Control Plan Policy - Associates" revised 09/2021, showed that TB testing was to be retained in the associate's confidential medical record file, separate from their general personnel records.

Record review on 11/01/2023 of the TB test documents provided by the ALF showed Staff C's and Staff D's TB testing was not presented for review.

Record review of the facility's employee roster, undated, showed Staff C, Medication Technician, was hired on 10/09/2023. Review of Staff C's record failed to show results from a TB test done within three days of employment.

Record review of the facility's employee roster, undated, showed Staff D, Medication Technician, was hired on 08/13/2023. Review of Staff D's record failed to show results from a TB skin test done within three days of employment.

During an interview on 11/01/2023 at 4:20 PM, Staff A, District Director of Operations/Executive Director, said that many of the staff did not have the required TB testing completed. Staff A stated that the employee's TB testing was filed in the employee's file if it had been completed.

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Plan/Attestation Statement

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Administrator (or Representative) 12/21/23 Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to maintain a respiratory protection program to ensure all staff had required annual medical evaluations and were fit tested for an N95 respirator (a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances) for 3 of 5 staff (Staff D, Staff E, Staff G) reviewed. These failures placed all 53 of 53 residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

Review of the document titled "L&I (Labor and Industries) and Department of Health (DOH) Respirator and PPE guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE" dated 03/30/2021, DOH 420-328 showed, "The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 and other airborne hazards. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCWs face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes."

WAC 296-842-14005 "Provide medical evaluations.
Medical Evaluation Process
Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:
(a) Are required to use respirators; or
Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:

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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

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to maintain a respiratory protection program to ensure all staff had required annual medical evaluations and were fit tested for an N95 respirator (a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances) for 3 of 5 staff (Staff D, Staff E, Staff G) reviewed. These failures placed all 53 of 53 residents, staff, and visitors at risk for spread of infectious disease.

Findings included…

Review of the document titled "L&I (Labor and Industries) and Department of Health (DOH) Respirator and PPE guidance for Long Term Care: Employer responsibilities for respiratory protection program and provision of PPE" dated 03/30/2021, DOH 420-328 showed,
“The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 and other airborne hazards. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes.’’

WAC 296-842-14005 “Provide medical evaluations.
Medical Evaluation Process
Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:
(a) Are required to use respirators; or
Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:

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(a) Whether or not the employee is medically able to use the respirator;
(b) Any limitations of respirator use for the employee;
(c) What future medical evaluations, if any, are needed;
(d) A statement that the employee has been provided a copy of the written recommendation"

WAC 296-842-15005
"Conduct fit testing.
(1) Provide, at no cost to the employee, fit tests for ALL tight fitting respirators on the following schedule:
(a) Before employees are assigned duties that may require the use of respirators;
(b) At least every twelve months after initial testing;"
Record review of the facility's Respiratory Protection Program (RPP) dated 01/15/2021 showed the Executive Director was responsible to maintain RPP records and conduct program evaluations annually. Facility supervisors were listed as responsible to ensure associates received initial and annual respirator mask fit tests and medical clearances before authorization to wear a respirator. Records were to be kept based on Occupational Safety and Health Administration guidelines, which would be an associate's period of employment, plus 30 years.

Record review of the facility's provided documents for staff respirator mask fitting and medical clearance to use a respirator showed:
• Staff G's fit testing and clearance documents were dated 08/09/2022, exceeding the annual requirement.
• Staff D's fit testing was conducted 08/09/2023 but had no medical clearance documents.
• Staff E did not have fit testing or medical clearance documentation.

In an interview on 11/03/2023 at 11:58 AM, Staff B, Health and Wellness Director/Registered Nurse stated the N95 respirator fit testing binder was a work in progress. Staff B stated all the employees N95 respirator fit testing results and medical clearance results were located in the binder for review

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 Olympia West is or will be in compliance with this law and / or regulation on (Date) 01/28/24

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

Administrator (or Representative) — Date: 12/21/23

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(a) Whether or not the employee is medically able to use the respirator;
(b) Any limitations of respirator use for the employee;
(c) What future medical evaluations, if any, are needed;
(d) A statement that the employee has been provided a copy of the written recommendation"

WAC 296-842-15005
"Conduct fit testing.
(1) Provide, at no cost to the employee, fit tests for ALL tight fitting respirators on the following schedule:
(a) Before employees are assigned duties that may require the use of respirators;
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Record review of the facility's provided documents for staff respirator mask fitting and medical clearance to use a respirator showed:
• Staff G's fit testing and clearance documents were dated 08/09/2022, exceeding the annual requirement.
• Staff D's fit testing was conducted 08/09/2023 but had no medical clearance documents.
• Staff E did not have fit testing or medical clearance documentation.

In an interview on 11/03/2023 at 11:58 AM, Staff B, Health and Wellness Director/Registered Nurse stated the N95 respirator fit testing binder was a work in progress. Staff B stated all the employees N95 respirator fit testing results and medical clearance results were located in the binder for review.

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_____ _____
Administrator (or Representative) Date

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WAC 388-78A-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 3 of 3 laundry rooms (Bridge, Clare, and "A" court laundry room's) implemented infection control practices to keep clean and soiled laundry separated. This failure resulted in 53 of 53 residents not having infection control practices in place for proper handling and prevention of cross contamination for all laundry services.

Findings included…

Record review of the facility's document titled, "Fresh Impressions – Resident and Contaminated Laundry", dated June 2023, under the section titled, "handling contaminated laundry" showed, contaminated linen was anything with blood or other potential infectious material and soiled linen was everyday dirty laundry. Staff were to wash their hands prior to applying gloves to handle soiled or contaminated linens. Staff were to spray and wipe the outside of the machine to disinfect the washing machine.

In an observation on 11/01/2023 at 9:44 AM, the Bridge laundry room door showed there was no indication if the door was the clean or dirty side. The laundry door was opened and noted the dryers were just inside the door to the left and the area appeared to be the clean side. There was a laundry basket in front of one of the dryers with an overflowing pile of clean clothes that were not bagged or covered sitting on the ground. On the other side of the laundry room near the other entry/exit door in front of a washer was a large clear bag full of soiled linens. There was a large blue blanket that was partially inside the clear bag and outside of the bag that lied on the ground.

In an interview on 11/01/2023 at 9:45 AM, Staff B, Registered Nurse/Health and Wellness Director, stated staff performing laundry services took soiled laundry in through the laundry room doors in each hallway area, then clean laundry was removed through attached shower rooms, and out another door into the hallway.

In an interview on 11/01/2023 at 10:56 AM, Staff B stated there was no process to identify what door to enter for soiled linen and what door to exit clean side for the laundry rooms. Staff B stated they needed to write up and identify the laundry room process. Staff B stated for the laundry rooms there was no process in place to prevent cross contamination. There was no specific door to enter with soiled linens and clothing, and no specific door to exit with clean linens and clothing. Staff B stated there is not written process for the laundry room procedure for review.

In an observation on 11/01/2023 at 11:09 AM, Clare side laundry room's door showed there was no identifiers to show what door to enter with soiled linen or clothes or exit with

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clean clothing and linen. Inside the laundry room showed there was no identifiers or indication what side of the laundry room was clean and or soiled.

In an observation and interview on 11/03/2023 at 10:30 AM, Staff J, Caregiver, stated the door to the left was the only one door to enter and exit the laundry room. Staff J walked into the "A" court laundry room door. Staff J loaded and started the washing machine of soiled linens, opened the left side laundry room door, and exited the room out the same door as they entered. There was another door observed by the drying machines for use.

In an interview on 11/03/2023 at 11:08 AM, Staff T, Caregiver, stated it did not matter what door to enter or exit with soiled or clean linen and clothes for the laundry rooms.

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(ii) Indicate the date, day of week, month and year;

(iii) Include all food and snacks served that contribute to nutritional requirements;

(iv) Are kept at least six months;

(v) Provide a variety of foods; and

(vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(i) Age, gender and activities, unless medically contraindicated; and

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clean clothing and linen. Inside the laundry room showed there was no identifiers or indication what side of the laundry room was clean and or soiled.

In an observation and interview on 11/03/2023 at 10:30 AM, Staff J, Caregiver, stated the door to the left was the only one door to enter and exit the laundry room. Staff J walked into the “A” court laundry room door. Staff J loaded and started the washing machine of soiled linens, opened the left side laundry room door, and exited the room out the same door as they entered. There was another door observed by the drying machines for use.

In an interview on 11/03/2023 at 11:06 AM, Staff T, Caregiver, stated it did not matter what door to enter or exit with soiled or clean linen and clothes for the laundry rooms.

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Administrator (or Representative) Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(ii) Indicate the date, day of week, month and year;

(iii) Include all food and snacks served that contribute to nutritional requirements;

(iv) Are kept at least six months;

(v) Provide a variety of foods; and

(vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(i) Age, gender and activities, unless medically contraindicated; and

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(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to create written menus that reflected the actual food service at least one week in advance or make them available for residents' view for 2 of 2 dining areas reviewed, and alternative meals available to residents were not of similar nutritional value. The facility failed to ensure palliative and attractive meals were served for 5 of 5 sampled residents (Resident 14 [R14], Resident 15 [R15], Resident 13 [R13], and Resident 16 [R16], Resident 8 [R8]). These failures resulted in 53 of 53 residents unable to review upcoming meals provided and placed them at risk of not having their nutritional needs met.

Findings included…

Record review of the facility's document titled, "Menu Archives policy", dated 05/2013, showed a planned "master menu" record and an additional menu showing any changes made to the planned menu should be kept on file in the community for a minimum of two years. Responsibility for implementing this policy was assigned to Dining Services management.

Record review of the facility's document titled, "Menu Posting policy", dated 05/2007, showed menus were to be posted before a meal in an area available to all residents, as well as posted in the kitchen and food service pantries. Changes to the menu were to be re-posted to the same areas.

Record review of the facility's document titled, "Menu Changes policy", dated 05/2007, showed planned menus served to residents should be approved by a Corporate Dietician for nutritional adequacy and changes to the menu should be approved by a dietitian and be of equal nutritional value. The policy required the changes, date, meal, substituted item, and reason for the substitution was to be documented on a Menu Substitution Log and kept on file for a minimum of two years.

Record review of the facility's document titled, "Menu Substitutions policy", dated effective on 05/2013, showed when meal substitutions were needed, the Dining Services management were responsible for providing meals of equal nutrient value to the original menu. The facility's Diet Manual was to be used when determining nutrition value and portion size.

In an observation in 11/01/23 at 9:24 AM, in the Bridge side dining room, a wall mounted signboard titled "featured selections" contained no menu information.

In an observation on 11/01/2023 at 12:44 PM, in the Clare side dining room, residents were served spaghetti noodles with red meat sauce on top of the noodles, with green brussel sprouts, and a bread roll. On the wall next to the entry way of the kitchenette was a sign that was titled "feature selections" with two white areas underneath. There was nothing posted on the sign to show what the meal was to be served for any meal that day.

In an interview on 11/01/2023 at 12:47 AM, Staff I, Caregiver, stated the menus were not posted on the wall by the dining rooms. Staff I stated the facility was working on getting

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the scheduled meals posted for review.

In an interview on 11/01/2023 at 2:00 PM, Resident 15 stated food served at meals was sometimes too cold. Resident 14 stated the kitchen only prepared grilled cheese sandwiches if they wanted an alternative to the offered meal.

In an interview on 11/02/2023 at 12:45 PM, Staff A, District Director of Operations/Executive Director, stated the facility had not been storing the previously used menus. Staff A stated the staff were throwing the menus away and were not aware they were required to keep on file. Staff A stated they registered dietician plans the menu's out and every Sunday they are available to print for the following week. Staff A stated they were to make the meal that is listed on the menu.

In an interview on 11/14/2023 at 9:29 AM, Collateral Contact 4 ([CC4] daughter of R8) stated they have not seen a menu posted since Resident 8 (R8) moved into that facility on [redacted] 2023.

In an observations and interviews on 11/01/2023 at 12:50 PM, in the Clare dining room, multiple residents had not eaten their Brussel sprouts and only a small portion of their meal that were served for lunch. R14 stated the Brussel sprouts were "mushy and gross". R15 stated the Brussel sprouts were gross. R15's lunch plate had a large amount of Brussel sprouts and half of their noodles with meat and red sauce remaining on their plate. R15 stated they were done with lunch. R15 stated there was too much food served on their plate for meals. R13's lunch plate had Brussel sprouts on it and nothing else. R13 stated the Brussel sprouts were "gross".

In an interview on 11/01/2023 at 1:15 PM, R16 stated the food was only lukewarm. R16 stated the Brussel sprouts were slimy and green. It was observed that R16's place had a large amount of Brussel sprouts. R16's plate was pushed to the side. R16 stated they were not going to eat the Brussel sprouts. R16 stated it depended on when you were served your food if it came out hot or not.

In an interview on 11/14/2023 at 9:29 AM, Collateral Contact 4 (CC4) stated R8 had complained about the food that was served and the facility was unable to provide an alternative meal.

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In an interview on 11/02/2023 at 12:45 PM, Staff A, District Director of Operations/Executive Director, stated the facility had not been storing the previously used menus. Staff A stated the staff were throwing the menus away and were not aware they were required to keep on file. Staff A stated they registered dietician plans the menu's out and every Sunday they are available to print for the following week. Staff A stated they were to make the meal that is listed on the menu.

In an interview on 11/14/2023 at 9:29 AM, Collateral Contact 4 ([CC4] daughter of R8) stated they have not seen a menu posted since Resident 8 (R8) moved into that facility on [redacted]/2023.

In an observations and interviews on 11/01/2023 at 12:50 PM, in the Clare dining room, multiple residents had not eaten their Brussel sprouts and only a small portion of their meal that were served for lunch. R14 stated the Brussel sprouts were "mushy and gross". R15 stated the Brussel sprouts were gross. R15's lunch plate had a large amount of Brussel sprouts and half of their noodles with meat and red sauce remaining on their plate. R15 stated they were done with lunch. R15 stated there was too much food served on their plate for meals. R13's lunch plate had Brussel sprouts on it and nothing else. R13 stated the Brussel sprouts were "gross".

In an interview on 11/01/2023 at 1:15 PM, R16 stated the food was only lukewarm. R16 stated the Brussel sprouts were slimy and green. It was observed that R16's place had a large amount of Brussel sprouts. R16's plate was pushed to the side. R16 stated they were not going to eat the Brussel sprouts. R16 stated it depended on when you were served your food if it came out hot or not.

In an interview on 11/14/2023 at 9:29 AM, Collateral Contact 4 (CC4) stated R8 had complained about the food that was served and the facility was unable to provide an alternative meal.

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Administrator (or Representative) Date 12/14/23

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the Assisted Living Facility (ALF) failed to ensure food was stored and labeled properly for 3 of 3 kitchen areas reviewed (Bride Side Kitchenette, Clare Side Kitchenette, and Main kitchen) The ALF also failed to ensure 1 of 6 sampled staff (Staff E) had a current food worker card. These failures placed all 53 residents at risk for exposure to food-borne illnesses and at risk for receiving food that was incorrectly prepared by unqualified staff.

Findings included...

"WAC 246-215-03610
Labeling—Food labels (FDA Food Code 3-602.11).
(1) food packaged in a food establishment must be labeled as specified in law, including chapters 69.04 and 15.130 RCW, 21 C.F.R. 101 - Food Labeling, and 9 C.F.R. 317 - Labeling, Marking Devices, and Containers.
(2) Label information must include:
(a) The common name of the food or, absent a common name, an adequately descriptive identity statement;
(b) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the food;
(c) An accurate declaration of the quantity of contents;
(d) The name and place of business of the manufacturer, packer, or distributor;
(e) The name of the food source for each major food allergen contained in the food unless the food source is already part of the common or unusual name of the respective ingredient;
(3) Bulk food that is available for consumer self-dispensing must be prominently labeled with the following information in plain view of the consumer:
(a) The manufacturer's or processor's label that was provided with the food; or
(b) A card, sign, or other method of notification that includes the information specified under subsection (2)(a), (b), and (f) of this section."

"WAC 246-215-03351
Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).
(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:
(a) In a clean, dry location,

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Administrator (or Representative) Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the Assisted Living Facility (ALF) failed to ensure food was stored and labeled properly for 3 of 3 kitchen areas reviewed (Bride Side Kitchenette, Clare Side Kitchenette, and Main kitchen) The ALF also failed to ensure 1 of 5 sampled staff (Staff E) had a current food worker card. These failures placed all 53 residents at risk for exposure to food-borne illnesses and at risk for receiving food that was incorrectly prepared by unqualified staff.

Findings included…

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(a) The common name of the food or, absent a common name, an adequately descriptive identity statement;
(b) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the food;
(c) An accurate declaration of the quantity of contents;
(d) The name and place of business of the manufacturer, packer, or distributor;
(e) The name of the food source for each major food allergen contained in the food unless the food source is already part of the common or unusual name of the respective ingredient;
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(a) The manufacturer's or processor's label that was provided with the food; or
(b) A card, sign, or other method of notification that includes the information specified under subsection (2)(a), (b), and (f) of this section.”

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Preventing contamination from the premises—Food storage (FDA Food Code 3-305.11).
(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:
(a) In a clean, dry location;

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(b) Where it is not exposed to splash, dust, or other contamination; and
(c) At least six inches (15 cm) above the floor."

"WAC 246-217-015
(1), "All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."
WAC 246-215-03525 "Temperature and time control—Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16). (3) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be maintained: (a) At 135°F (57°C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400(2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130°F (54°C) or above."
WAC 246-215-03400 Cooking—"Raw animal foods (FDA Food Code 3-401.11). (1) Except as specified under subsections (2), (3), and (4) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, must be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked: (a) 145°F (63°C) or above for fifteen seconds for: (ii) Except as specified under (b) and (c) of this subsection and subsections (2) and (3) of this section, FISH and INTACT MEAT, including GAME ANIMALS commercially raised for FOOD as specified under WAC 246-215-03230 (1)(a) and GAME ANIMALS under a voluntary inspection program as specified under WAC 246-215-03230 (1)(b) (b) 158°F (70°C) or above for < 1 second (instantaneous) or a temperature and time combination specified in Table 3-1, provided that FOOD EMPLOYEES monitor both temperature and time under an APPROVED plan, for RATITES; MECHANICALLY TENDERIZED and INJECTED MEATS; and COMMINUTED FISH, MEAT, GAME ANIMALS commercially raised for FOOD as specified under
WAC 246-215-03230 (1)(a), GAME ANIMALS under a voluntary inspection program as specified under WAC 246-215-03230 (1)(a); and raw EGGS that are not prepared as specified under (a)(i) of this subsection. (c) 165°F (74°C) or above for < 1 second (instantaneous) for poultry BALUTS; wild GAME ANIMALS; stuffed FISH; stuffed MEAT; stuffed pasta; stuffed POULTRY; stuffed RATITES; or stuffing containing FISH, MEAT, POULTRY, or RATITES."

Record review of the facility's policy "Labeling - DS-04.028," revised on 5/10 (date as shown), showed "All food items must be labeled and dated before storing."

Bridge Side Kitchenette

In an observation and interview on 11/01/2023 at 9:25 AM the Bridge side kitchenette refrigerator was unlocked and on the bottom shelf of the door was a sandwich with meat and orange cheese that was wrapped with clear plastic. The orange cheese was soft to touch and smashed to the clear plastic wrap. There was sandwich was undated and unlabeled. There was another sandwich in a zip lock bag that was unlabeled and undated. On the bottom shelf on the door under the wrapped sandwiches, there was a red and brown sticky substance. When one of the wrapped sandwiches were lifted there was a tacky sticky noise. There was one drink pitcher half full of orange liquid inside that was not labeled or dated. There was another drink pitcher that was three quarters full of red liquid that was not labeled or dated. There was one carton of nectar thick water and one carton of nectar thick apple juice that had been opened. There was no date documented on the cartons to show when they were opened. Inside the freezer of the refrigerator were two small bowls of brown hard substance that resembled chocolate ice cream. Both the small

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bowls were uncovered, unlabeled, and undated. On the shelf next to the refrigerator was four bowls of cooked oats with brown granules on top that were uncovered, unlabeled, and undated. There was a white ceramic plate with an English muffin, a round cooked brown patty that resembled sausage, and a round yellow substance that resembled scrambled eggs were uncovered, unlabeled, and undated. Staff B, Registered Nurse/Health and Wellness Director, stated all drink pitchers, food, or anything edible that had been opened were to be labeled, covered, and dated. Staff B stated the plate and four bowls of food on the shelf were from breakfast and should have been covered.

Clare Side Kitchenette

In an observation on 11/01/2023 at 11:17 AM, the Clare side kitchenette showed the refrigerator was unlocked. Inside the refrigerator was an unlabeled cup filled with an unknown brown liquid inside the unlocked refrigerator. Two unlabeled, undated pitchers half full of red liquid; one unlabeled, undated pitcher three quarters full of yellow liquid; and one unlabeled, undated pitcher half full of orange liquid, all sat inside the refrigerator. There were also two unlabeled, undated cream-colored plastic squeeze bottles, three quarters full of liquid. There was one unlabeled, undated sandwich that had meat and orange cheese wrapped in clear wrap. In the refrigerator freezer were two small bowls of hard yellow substance that resembled ice cream that were uncovered and undated.

Main Kitchen

Record review of the facility's posted temperature log, dated October 2023, showed for the walk-in refrigerator there were no temperatures documented for 10/18/2023, 10/20/2023, 10/21/2023 and 10/23/2023 – 10/31/2023.

In an observation on 11/01/2023 at 12:47 PM, inside the main kitchen walk-in refrigerator showed an opened, undated container of cream cheese spread, a bowl covered in plastic wrap that contained unidentified liquid with no date, and an unlabeled, undated white condiment bottle containing a white substance. Half a cantaloupe wrapped in plastic, undated, sat on a shelf inside the walk-in refrigerator.

In an observation 11/01/2023 at 12:50 PM, food debris, butter wrappers, dirt, and sticky substances were observed on the walk-in refrigerator floor.

In an observation on 11/01/2023 at 12:53 PM, showed a large, nearly full box of bruised bananas sitting on the kitchen floor.

In an observation on 11/01/2023 12:54 PM, showed a large blue bag of undated, unlabeled frozen food in the freezer.

In an observation on 11/01/2023 at 12:56 PM, showed two heads of cabbage with large black spots and black spackled matter covering both cabbages, inside an unlabeled box in the walk-in refrigerator.

In an interview on 11/01/2023 at 1:03 PM, Staff L, Cook, said that they weren't sure what was on the cabbages and that it looked like dirt, mildew, or mold. Staff L stated, "We should throw it out." Staff L stated that they did not know how long the undated cream cheese, unlabeled bowl, and unlabeled white condiment bottle had been in the refrigerator. Staff L said that the containers should have been dated.

This document was prepared by Residential Care Services for the Locator website.

In an observation on 11/01/2023 at 1:07 PM, showed a cart with dirty dishes from earlier meals. Staff L stated that they had not had time to get to it as they were short staffed.

In an observation on 11/01/2023 at 1:12 PM, showed a dry storage room with multiple boxes of product sitting on the floor. The department licensors' shoes stuck to the floor and made a suction noise with each step while walking the storage room. Observation showed onion wrappers, debris, and dust on the floor of the dry storage room.

In an observation on 11/02/2023 at 12:16 PM, showed the cantaloupe and the two heads of cabbage remained in the walk-in refrigerator. The bruised bananas remained sitting on the kitchen floor.

In an observation and interview on 11/02/2023 at 12:27 pm showed the ice machine scoop lying on kitchen counter, touching the soiled metal countertop. When asked about the ice scoop being on the dirty counter, Staff O, Caregiver, stated, "That should not be there."

In an interview on 11/03/2023 at 9:29 AM, Staff F, Maintenance Technician, who had been assisting with food preparation and cooked, stated they would heat ground beef to a temperature of "120 degrees Fahrenheit (F)." Staff F stated they would hot holding temperature to "120 degrees F." Staff F stated they would cook poultry to "135 degrees F." Staff F stated "I have no idea" when they were asked what temperature fish was cooked to.

Food Worker Card

Record review of the ALF's "Associate Roster," undated, showed Staff E, Cook, was hired on 10/09/2023.

Record review of Staff E's records showed there was no Washington State food worker card for review.

In an interview on 11/03/2023 at 11:30 AM, Staff E stated he did not have a current food worker card.

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 Olympia West is or will be in compliance with this law and / or regulation on (Date) 01/28/24

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

Administrator (or ~~Representative~~) — Date 12/21/23

This document was prepared by Residential Care Services for the Locator website.

In an observation on 11/01/2023 at 1:07 PM, showed a cart with dirty dishes from earlier meals. Staff L stated that they had not had time to get to it as they were short staffed.

In an observation on 11/01/2023 at 1:12 PM, showed a dry storage room with multiple boxes of product sitting on the floor. The department licensors' shoes stuck to the floor and made a suction noise with each step while walking the storage room. Observation showed onion wrappers, debris, and dust on the floor of the dry storage room.

In an observation on 11/02/2023 at 12:16 PM, showed the cantaloupe and the two heads of cabbage remained in the walk-in refrigerator. The bruised bananas remained sitting on the kitchen floor.

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In an interview on 11/03/2023 at 9:29 AM, Staff F, Maintenance Technician, who had been assisting with food preparation and cooked, stated they would heat ground beef to a temperature of "120 degrees Fahrenheit (F)." Staff F stated they would hot holding temperature to "120 degrees F." Staff F stated they would cook poultry to "135 degrees F." Staff F stated "I have no idea" when they were asked what temperature fish was cooked to.

Food Worker Card

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In an interview on 11/03/2023 at 11:30 AM, Staff E stated he did not have a current food worker card.

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_____ _____

Administrator (or Representative) Date

This document was prepared by Residential Care Services for the Locator website.

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the facility failed to perform a preadmission assessment for 1 of 4 sampled residents (Resident 3 [R3]). This failure placed Resident 3 at risk for not having an assessment to identify and meet the resident's healthcare needs.

Findings included...

Record review of the facility policy titled, "Admission Move In Review Criteria Policy," revised on 09/2021, showed the preadmission review process "should occur as soon as possible after the referral has been received so a timely and prompt decision can be made."

Record review of R3's Admission Record showed R3 was admitted to the facility on [redacted]2023.

Record review of R3's records as of 11/02/2023 showed there was no preadmission assessment to review.

In an interview on 11/15/2023 at 11:31 AM, Staff B, Registered Nurse/Health and Wellness Director, stated that Staff S, Registered Nurse/District Director of Clinical Services, conducted R3's preadmission assessment. Staff B stated they were unable to provide the preadmission assessment to the department for review.

Record review of an email sent to the Department on 11/22/2023 at 11:43 AM, Staff U, Executive Director, reported that Staff S did the initial assessment on [redacted]2023 and it was both the pre and the initial assessment. A copy of R3's initial assessment, dated [redacted]2023, was attached to the email. No separate preadmission assessment was attached.

The facility was unable to provide a record as evidence that a preadmission assessment had been completed for R3.

Plan/Attestation Statement

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WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the facility failed to perform a preadmission assessment for 1 of 4 sampled residents (Resident 3 [R3]). This failure placed Resident 3 at risk for not having an assessment to identify and meet the resident's healthcare needs.

Findings included…

Record review of the facility policy titled, "Admission Move In Review Criteria Policy," revised on 09/2021, showed the preadmission review process "should occur as soon as possible after the referral has been received so a timely and prompt decision can be made."

Record review of R3's Admission Record showed R3 was admitted to the facility on [redacted]/2023.

Record review of R3's records as of 11/02/2023 showed there was no preadmission assessment to review.

In an interview on 11/15/2023 at 11:31 AM, Staff B, Registered Nurse/Health and Wellness Director, stated that Staff S, Registered Nurse/District Director of Clinical Services, conducted R3's preadmission assessment. Staff B stated they were unable to provide the preadmission assessment to the department for review.

Record review of an email sent to the Department on 11/22/2023 at 11:43 AM, Staff U, Executive Director, reported that Staff S did the initial assessment on [redacted]/2023 and it was both the pre and the initial assessment. A copy of R3's initial assessment, dated [redacted]/2023, was attached to the email. No separate preadmission assessment was attached.

The facility was unable to provide a record as evidence that a preadmission assessment had been completed for R3.

Plan/Attestation Statement

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Administrator (or Representative) Date 12/21/23

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

(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 the care for 3 of 7 resident (Resident 2 [R2], Resident 5 [R5], and Resident 19 [R19]) was provided in a dignified manner. This failure placed these residents at risk for experiencing decreased quality of life.

Findings included...

"RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality... (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered."

R19
In an observation on 11/1/2023 at 08:28 AM from of the exterior of the facility on the sidewalk that aligned the public road, Licensors were able to observe R19 through the open blinds of their room's window was receiving assistance from an unknown staff person. The unknown staff person was standing to the left of R19 who was seated in the center of the room. R19 was observed to have the unknown staff member performing a circular motion around R19's arm with medical supplies.

In an observation on 11/03/2023 at 10:05 AM, Licensor was standing on the sidewalk that aligned the public road of the exterior of the facility, Resident 20 (R20), roommate of R19, and another Licensor were visualized conversing through the open blinds of their room's window, directly next to the window of R19.

R2
In an interview on 11/03/2023 at 10:10 AM, R2 stated they had not gotten many showers since they moved in. R2 stated they recalled having five. R2 stated they preferred to not have facial hair. R2 was noted to have brown and white facial hair on their cheeks, upper lip, and chin area. R2 stated they had difficulty finding staff to help them with a shower or to get shaved.

In an interview on 11/09/2023 at 3:35 PM, Collateral Contact 6 (CC6), Daughter of R2, stated R2 preferred to be shaved with minimal facial hair. CC6 stated they had addressed these concerns with Staff P, Former Executive Director, and Staff A, District Director of Operations/Executive Director without any follow-up or changes.

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Administrator (or Representative) Date

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

(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 the care for 3 of 7 resident (Resident 2 [R2], Resident 5 [R5], and Resident 19 [R19]) was provided in a dignified manner. This failure placed these residents at risk for experiencing decreased quality of life.

Findings included…

“RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality… (5) A resident has the right to: (a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.”

R19
In an observation on 11/1/2023 at 08:28 AM from of the exterior of the facility on the sidewalk that aligned the public road, Licensors were able to observe R19 through the open blinds of their room’s window was receiving assistance from an unknown staff person. The unknown staff person was standing to the left of R19 who was seated in the center of the room. R19 was observed to have the unknown staff member performing a circular motion around R19’s arm with medical supplies.

In an observation on 11/03/2023 at 10:05 AM, Licensor was standing on the sidewalk that aligned the public road of the exterior of the facility, Resident 20 (R20), roommate of R19, and another Licensor were visualized conversing through the open blinds of their room’s window, directly next to the window of R19.

R2
In an interview on 11/03/2023 at 10:10 AM, R2 stated they had not gotten many showers since they moved in. R2 stated they recalled having five. R2 stated they preferred to not have facial hair. R2 was noted to have brown and white facial hair on their cheeks, upper lip, and chin area. R2 stated they had difficulty finding staff to help them with a shower or to get shaved.

In an interview on 11/09/2023 at 3:35 PM, Collateral Contact 6 (CC6), Daughter of R2, stated R2 preferred to be shaved with minimal facial hair. CC6 stated they had addressed these concerns with Staff P, Former Executive Director, and Staff A, District Director of Operations/Executive Director without any follow-up or changes.

This document was prepared by Residential Care Services for the Locator website.

R5
Record review of the R5's "Admission Record", dated 09/13/2023, showed R5 admitted to the facility on [redacted]/2019, with multiple [redacted] diagnoses that included [redacted].

Record review of R5's Personal Service Plan, dated 07/09/2023, showed R5 required physical hands-on assistance with their dressing and grooming needs. Staff were to assist R5 with washing their face, hands, and brush their teeth every morning and night.

In an observation on 11/02/2023 at 2:08 PM, R5 was lying flat on their back in bed. R5's fingernails were long in length and had brown matter underneath the nails. When R5 smiled there were large amounts of white and red substance in front of R5's bottom teeth, on the teeth, and between lower their lip. R5 was observed to be chewing. R5 then spit out red substance and stated it was food from lunch.

In an interview on 11/09/2023 at 1:15 PM, Collateral Contact 5 (CC5), Power of Attorney for R5, stated R5's nail care did not get completed by the facility. CC5 stated a friend and themselves clean and trim R5's nails. CC5 stated they had requested the facility to do R5's nail care and never gets completed. CC5 stated they had constantly reminded the staff to assist and brush R5's teeth. CC5 stated R5 often would have residual food on their teeth when CC5 came to visit. CC5 stated when they visit R5 at the facility it is difficult to find any staff member or caregiver to help provide care or ask questions.

In an interview on 11/03/2023 at 10 AM, Staff J, Caregiver, stated they were to provide nail care for the residents when they had a shower. Staff J stated they had not been providing routine nail care like they were expected to.

This is a recurring deficiency previously cited on 04/21/2022.

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

WAC 388-110-220 Enhanced adult residential care service standards.

(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(f) Make available multiple common areas, at least one of which is outdoors, that vary by size and arrangement such as: various size furniture groupings that encourage social

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R5
Record review of the R5's "Admission Record", dated 09/13/2023, showed R5 admitted to the facility on [redacted]/2019, with multiple [redacted] diagnoses that included [redacted].

Record review of R5's Personal Service Plan, dated 07/09/2023, showed R5 required physical hands-on assistance with their dressing and grooming needs. Staff were to assist R5 with washing their face, hands, and brush their teeth every morning and night.

In an observation on 11/02/2023 at 2:08 PM, R5 was lying flat on their back in bed. R5's fingernails were long in length and had brown matter underneath the nails. When R5 smiled there were large amounts of white and red substance in front of R5's bottom teeth, on the teeth, and between lower their lip. R5 was observed to be chewing. R5 then spit out red substance and stated it was food from lunch.

In an interview on 11/09/2023 at 1:15 PM, Collateral Contact 5 (CC5), Power of Attorney for R5, stated R5's nail care did not get completed by the facility. CC5 stated a friend and themselves clean and trim R5's nails. CC5 stated they had requested the facility to do R5's nail care and never gets completed. CC5 stated they had constantly reminded the staff to assist and brush R5's teeth. CC5 stated R5 often would have residual food on their teeth when CC5 came to visit. CC5 stated when they visit R5 at the facility it is difficult to find any staff member or caregiver to help provide care or ask questions.

In an interview on 11/03/2023 at 10 AM, Staff J, Caregiver, stated they were to provide nail care for the residents when they had a shower. Staff J stated they had not been providing routine nail care like they were expected to.

This is a recurring deficiency previously cited on 04/21/2022.

Plan/Attestation Statement

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_____ _____
Administrator (or Representative) Date

WAC 388-110-220 Enhanced adult residential care service standards.

(3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(i) Make available multiple common areas, at least one of which is outdoors, that vary by size and arrangement such as: various size furniture groupings that encourage social

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interaction; areas with environmental cues that may stimulate activity, such as a resident kitchen or workshop; areas with activity supplies and props to stimulate conversation; a garden area; and paths and walkways that encourage exploration and walking. These areas must accommodate and offer opportunities for individual or group activity;

(j) Ensure that the outdoor area for residents:

(i) Is accessible to residents without staff assistance;

(v) Has suitable outdoor furniture;

(n) Ensure residents have access to their own rooms at all times without staff assistance; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents had unrestricted access to their rooms for 1 of 1 resident reviewed (Resident 8 [R8]), and failed to provide unrestricted access to outdoor areas with well maintained furniture for 2 of 2 courtyards (Clare side and Bridge side courtyards). These failures resulted in residents not being able to freely use their rooms or outdoor areas without staff assistance, and placed the residents at risk for a decreased quality of life.

Findings included…

Record review of the facility's Disclosure of Services, revised date 02/2007, showed under the section titled, "security services", showed the facility had four outdoor secure garden and walking area's with tall no climb fencing that surrounded them.

In an observation on 11/01/2023 at 10:08 AM, Staff K, Health and Wellness Coordinator, unlocked the door to the Bridge side outside walking area. The walking area had raised garden boxes and six-foot-tall fence that enclosed the area. Upon walking back into the facility from outside, Staff K locked the door.

In an observation on 11/01/2023 at 10:13 AM, Staff K, Health and Wellness Coordinator, unlocked the Bridge side door to the outdoor covered sitting area, garden boxes, and walking around that was enclosed for the residents to use. Under the covered area to the right was outdoor furniture chair. The seat part of the chair was a cloth brown material. There was a large vertical rip that was from the back of the seat to the front. The chair was unable to be sat on without going through the cloth material.

In an observation on 11/01/2023 at 11:00 AM, Staff B, Health and Wellness Director/Registered Nurse, was observed to unlocked the door to Clare side's outside common walking area. Outside was raised garden boxes and enclosed working area that was fenced with six-foot-tall fence.

In an observation on 11/02/2023 at 01:52 PM, both doors to the Clare side outside walking and garden areas were locked and unable to be opened manually without a key.

In an observation on 11/03/2023 at 10:23 AM, both doors to the Clare side outside walking and garden area doors were locked. The dead bolt lock of the doors were observed through crack to be extended and engaged. The doors were unable to be opened without a

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key.

In an interview on 11/03/2023 at 10:49 AM, Staff J, Caregiver, stated the doors to the garden boxes and outside walking paths for both Clare and Bridge side were to be unlocked during the day. Staff J stated the doors on Clare side had been locked since a resident eloped (left the facility) and the facility required construction to the fence.

In an interview on 11/03/2023 at 2:04 PM, Staff A, District Director of Operations/Executive Director, stated the courtyard doors were to be unlocked unless there was inclement weather.

In an interview on 11/14/2023 at 8:28 AM, Collateral Contact 4 (CC4), daughter of Resident 8 (R8), stated they had requested a key to R8's room. CC4 stated they had to find a staff member to open R8's door. CC4 stated they typically wait 15 through 20 minutes for a staff member to appear to unlock R8's door. CC4 stated they had been requesting a key for R8's room for the past two months. CC4 stated the had requested a key from Staff P, Former Executive Director, and Staff D, Medication Technician.

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WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility to provide housekeeping, resident care needs and services as written on their personal services plan for 4 of 4 sampled residents (Resident 2 [R2], Resident 8 [R8], Resident 5 [R5], and Resident 18 [R18]. This failure placed all 53 residents at risk for decreased quality of life.

Findings included...

Record review of the facility's Disclosure of Services, undated, showed the facility must provide the care and services listed below, according to what has been agreed to in the

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key.

In an interview on 11/03/2023 at 10:40 AM, Staff J, Caregiver, stated the doors to the garden boxes and outside walking paths for both Clare and Bridge side were to be unlocked during the day. Staff J stated the doors on Clare side had been locked since a resident eloped (left the facility) and the facility required construction to the fence.

In an interview on 11/03/2023 at 2:04 PM, Staff A, District Director of Operations/Executive Director, stated the courtyard doors were to be unlocked unless there was inclement weather.

In an interview on 11/14/2023 at 9:29 AM, Collateral Contact 4 (CC4), daughter of Resident 8 (R8), stated they had requested a key to R8's room. CC4 stated they had to find a staff member to open R8's door. CC4 stated they typically wait 15 through 20 minutes for a staff member to appear to unlock R8's door. CC4 stated they had been requesting a key for R8's room for the past two months. CC4 stated the had requested a key from Staff P, Former Executive Director, and Staff D, Medication Technician.

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility to provide housekeeping, resident care needs and services as written on their personal services plan for 4 of 4 sampled residents (Resident 2 [R2], Resident 8 [R8], Resident 5 [R5], and Resident 18 [R18]. This failure placed all 53 residents at risk for decreased quality of life.

Findings included…

Record review of the facility's Disclosure of Services, undated, showed the facility must provide the care and services listed below, according to what has been agreed to in the

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residents negotiated service agreement. Under the section titled, “laundry”, showed the facility must provide laundry services to keep the residents clothes clean and in good repair, and provide you with clean towels, washcloths and bed linens at least once per week. Once per week linen services was included in the monthly fee. Under the section titled, “housekeeping”, showed the facility must maintain the resident’s living quarters and other areas the resident may use in a safe, clean, and comfortable condition. Light housekeeping services were provided once per week that were included in the monthly fee. Additional services could be provided at an additional cost per the resident evaluation/negotiated service agreement. Under the section titled, “bathing”, showed if the resident required assistance with showering the facility would provide.

R2
Record review of R2’s “Admission Record”, dated 09/13/2023, showed R2 moved into the facility on [redacted]/2023. R2 had multiple [redacted] diagnoses that included [redacted]).

Record review of R2’s Personal Service Plan (facility’s version of the negotiated service plan), dated [redacted]/2023, showed R2 required stand by and set up assistance with their showers. R2 was scheduled for showers on Wednesday and Saturdays in the morning.

Record review of the facility’s document titled, “weekly shower schedule” undated, showed R2 was scheduled to have showers on Mondays and Fridays at 1 PM.

Record review of the facility’s document titled, “weekly shower schedule”, dated 10/02/2023 through 10/08/2023, showed R2 was documented to have received a shower on 10/07/2023. There was no documentation for R2’s scheduled shower dated 10/04/2023 that it had been provided.

Record review of the facility’s document titled, “weekly shower schedule”, dated 10/09/2023 through 10/15/2023, showed there was no documentation or initials for R2’s scheduled showers on 10/11/2023 and 10/14/2023 at 3 PM.

Record review of the facility’s document titled, “weekly shower schedule”, dated 10/16/2023 through 10/22/2023, showed there were initials documented for R2’s shower on 10/18. There were no initials documented next to the scheduled shower dated 10/21 for R2.

In an interview and observation on 11/03/2023 at 10:10 AM, inside R2‘s bathroom on the front of the white toilet bowl were vertical yellow streaks that resembled urine stains. There was multiple candy wrappers and white particles on the floor of R2’s room. R2 stated they had gotten five showers since they moved into the facility. R2 stated they had not taken a shower since last week. R2 stated they preferred to not have facial hair. R2 was noted to have brown and white facial hair on their cheeks, upper lip, and chin area. R2 stated they had difficulty finding staff to help them with a shower or to get shaved. R2 stated the facility did not provide housekeeping services and their daughter, Collateral Contact 6 (CC6), Daughter of R2, had cleaned and swept the floors in their apartment.

In an interview on 11/08/2023 at 10:31 AM, Collateral Contact 6 (CC6), Daughter of R2 stated Staff P, Former Executive Director, never followed up when they expressed concerns. CC6 stated they had to hire a private caregiver to ensure R2 received a bath as it was hit and miss if the staff at the facility would be able to provide and assist R2 with their

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showers as scheduled and agreed upon. CC6 stated they pay for housekeeping services for R2's room and the service had not been provided. CC6 stated their trash cans were overflowing with garbage, R2's apartment floor would have lots of debris and garbage. CC6 stated they would clean R2's apartment as it was unkept. CC6 stated they pay extra every month for R2 to get extra showers, to be shaved, and groomed, but it does not happen. CC6 stated R2 paid for two showers a week and on average R2 had been assisted with one shower a week. CC6 stated R2 preferred to be shaved daily with minimal facial hair left on their face.

R8
Record review of R8's Personal Service Plan, dated 08/04/2023, showed R8 had a cat and required staff to change the litter box every Tuesday and scoop and maintain the litter box daily. Staff were to provide food and water for the cat once a day.

In an interview on 11/14/2023 at 9:29 AM, Collateral Contact 4 (CC4), Daughter of R8, stated R8's room does not get cleaned. CC4 stated they had asked to get a broom and wet wipes to clean R8's apartment floor. CC4 stated R8's bed was not made and there was only a blanket that was covering R8's mattress. CC4 stated they pay extra money to have the facility clean R8's cat's litter box. CC4 stated they had been out of town, came back and the cat box had not been cleaned. CC4 stated they had to clean R8's room themselves.

R5
Record review of the R5's "Admission Record", dated 09/13/2023, showed R5 admitted to the facility on [redacted]/2019, with multiple [redacted] diagnoses that included [redacted].

Record review of R5's Personal Service Plan, dated 07/09/2023, showed R5 required physical hands-on assistance with their dressing and grooming needs. Staff were to assist R5 with washing their face, hands, and brush their teeth every morning and night.

In an observation on 11/02/2023 at 2:08 PM, R5 was lying flat on their back in bed. R5's fingernails were noted to be long in length and had brown matter underneath the nails. When R5 smiled there were large amounts of white and red substance in front of R5's bottom teeth and between lower lip. R5 was observed to be chewing. R5 then spit out red substance and stated it was food from lunch.

In an observation on 11/02/2023 at 2:08 PM, in R5's room by the head of the bed on the left side in between the side table was a trash can. Inside the trash can was a soiled white and yellow brief and disposable gloves. The trash can bag was wide open and had a pungent odor that resembled urine.

In an interview on 11/09/2023 at 1:15 PM, Collateral Contact 5 (CC5), Power of Attorney for R5, stated R5's nail care did not get completed by the facility. CC5 stated a friend and themselves clean and trim R5's nails. CC5 stated they had constantly reminded the staff to assist and brush R5's teeth. CC5 stated R5 often would have residual food on their teeth when CC5 came to visit. CC5 stated when they visit R5 at the facility it is difficult to find any staff member or caregiver to help provide care or ask questions. CC5 stated they pay a lot of money for R5 to be in the facility to not have enough staff available to provide the care and services for R5. CC5 stated they had the code to the front door so they could come into the facility to visit R5 anytime. CC5 stated the facility has since changed the code and they have waited over 15 minutes for a staff member to come to the door after

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the doorbell was rung, to open the door and allow CC5 to come into the facility. CC5 stated the facility often had an odor of urine present when they come to the facility to visit R5.

R18
In an interview on 11/22/2023 at 11:34 AM, Collateral Contact 7 (CC7), Daughter of R18, stated they had express multiple concerns in person with Staff S, Registered Nurse/District Director of Clinical Services, and sent an email a few weeks prior about the same concerns as they had not been addressed.

Record review of an email sent to the Department from CC7 of an email sent to Staff S by CC7 on 11/03/2023 at 10:48 AM, showed R18's room was not being cleaned and trash not taken out daily. CC7 expressed concerns about the "stench in the resident area as soon as the door is opened". CC7 stated the smell had been there since they moved R18 into the community and was told new carpets were going to be installed. CC7 documented concerns that the front of the building was dark without any lighting to see. The email showed CC7 left the facility often around 9:30 PM and felt very uncomfortable leaving the facility in the dark. CC7 had expressed that R18's laundry was not washed for four days and once it had been washed and fold was not returned to R18 for use that resulted in R18 was required to wear pajama pants for the day. The email showed CC7 sent another concern to another corporate employee that showed CC7 had not received a response about the concerns expressed and requested that they be addressed as soon as possible.

As of 11/28/2023, CC7 sent to the Department an email that showed her concerns were still not addressed and had yet to receive a response from either facility corporate staff members to address the concerns.

In an interview on 11/03/2023 at 10 AM, Staff J, Caregiver, stated they were to provide nail care for the residents when they had a shower. Staff J stated they have not been providing routine nail care like they were expected to.

In an interview on 11/01/2023 at 10:25 AM, Staff B, Registered Nurse/Health and Wellness Director, stated there hadn't been a housekeeper hired at the facility since the beginning of September 2023. Staff B stated the housekeeping duties were reassigned to the caregivers. Staff B stated the caregivers put the resident's care needs first and were unable to complete the housekeeping responsibilities.

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

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WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 2 of 2 memory care buildings (Bridge and Clare) for staff and residents to use. Additionally, the facility failed to implement proper infection control hand washing measures when care and services were provided by 2 of 2 sampled staff (Staff I and Staff J). These failures placed all 53 of 53 residents, staff, and visitors at risk for spread of infectious disease.

Findings included…

Record review of the facility's document "Handwashing/Hand Hygiene", dated 10/2021, showed "regular hand washing, and hand hygiene is the primary means to prevent the spread of infections. Associates, residents, family members, and visitors should be encouraged to wash their hands or use an alcohol-based hand sanitizer (ABHS) solution. The Centers for Disease Control and Prevention (CDC) promotes regular handwashing as one of the best ways to remove germs, avoid getting sick, and prevent the spread of germs to others". All associates should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other associates, visitors, and residents. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) should be readily accessible and convenient for associates use to encourage compliance with hand hygiene policies. Hands were to be washed with soap and water any time hands were visibly soiled, before eating, after contact with a resident that had an infectious disease, and after personal use of toilet or conducting personal hygiene. CDC recommended using alcohol-based hand sanitizer with 60-95% alcohol in healthcare settings. Unless hands were visibly soiled, an alcohol-based hand rub was preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water during routine resident care. Use of alcohol-based hand sanitizer included before and after coming on duty, before and after direct contact with residents, before and after handling an invasive device (urinary catheters), after contact with objects (medical equipment), after removing gloves, before and after assisting a resident with meals. The use of gloves did not replace hand washing/hand hygiene. Under the section titled "procedure: how to wash hands", step three "applying and removing gloves", showed staff were to perform hand hygiene before applying non-sterile gloves.

Record review of the Center of Disease Control and Prevention (CDC) Hand Hygiene Guidance In Health Care Settings, dated 01/30/2020, showed, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where

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patient care is being delivered."

Record review of CDC's fact sheet titled, "Hand Hygiene at Work", undated, showed good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It also meant using alcohol-based hand sanitizer with at least 60 percent alcohol if soap and water was not readily available. Under the section titled, "Tips for Protecting Employee Health", showed increased access to sinks that was accessible to all employees and in places such as bathrooms, food preparation areas, or in eating areas. Provide soap, water, and a way to dry hands so employees can wash and dry hands properly. Place hand sanitizer dispensers with at least 60% alcohol near frequently touched surfaces, in areas where soap and water were not easily accessible, such as near shared equipment, building entrances and exits and more.

Handwashing supplies

In an observation on 11/01/2023 at 9:59 AM, the laundry room door inside the Bridge country kitchen dining room on the wall by the sink was a soap dispenser. Inside the soap dispenser it was observed that the pearly white soap was thick, dried, and curdled (when a substance separates into lumps or curds). The soap dispenser's lever was expressed with no soap dispensed. There was no trash can in the room to use to dispose of soiled garbage and/or paper towels.

In an observation on 11/01/2023 at 10:08 AM, the public bathroom on Bridge side of the facility near "E"
side of the rooms was observed to have multiple crumpled, used, and soiled white paper towels that were under the sink on the ground. There was no trash can in the bathroom to use.

In an observation on 11/01/2023 at 11:15 AM, inside the laundry room attached to the Clare country kitchen dining room had a handwashing sink. There was no soap or trash can available for use.

In an observation on 11/03/2023 at 11:06 AM, the "A" court laundry room sink was observed to have no paper towels or a trash can available for use.

Handwashing

In an observation on 11/01/2023 at 10:11 AM, Staff I, Caregiver, walked out of a resident's room from the bridge side "E" room area with their left hand ungloved and the right hand with a gray disposable glove on. Staff E carried a tied-up bag with soiled items inside with their gloved right hand. Staff E opened the laundry door with their ungloved left hand and keys. Staff E reached in the laundry door with their right hand and dropped the bag of soiled items inside the room to the right. Staff E then removed their gray disposable glove and disposed in the garbage can. Staff E then closed the closet door. Staff E walked over to a different resident's room, knocked, and walked in. During the entire observation Staff E was not observed to wash their hands or use hand sanitizer after they removed their glove or prior to entering a new resident's room.

In an observation and interview on 11/01/2023 at 11:05 AM, Staff I was observed holding two bags of soiled linens with ungloved hands. Staff I placed the bags on the ground in front of the laundry room door. Staff I opened the laundry room door, picked the bags up and disposed them inside the laundry room. Staff I walked out of the laundry room. Staff I

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was not observed to use hand sanitizer. Staff I stated they had hand sanitizer and pulled out a small bottled with orange liquid with small black dots inside out of their scrub top.

In an observation on 11/01/2023 at 1:02 PM, Staff I, Caregiver, was assisting two residents (Resident 17 [R17] and Resident 11 [R11]) eating lunch. Staff I was observed to wipe their nose with their bare hands, pick up R11's spoon feed them a bite of their lunch. Staff I then assisted R17 with a bite of food. Staff I was not observed to use hand sanitizer after they touched their nose and prior to assisting R11 to eat. At the same table was a third Resident 12 (R12). R12 was observed to stack their lunch bowls and cups at the table. R12 poured their pink drink inside one of their bowls. Staff I gave R12 a dish of thick white substance that resembled pudding. R12 began to eat a spoon full of the white substance and then spit the substance out of their mouth back into the bowl. R12 began to put their hands inside the white substance. R12 had the white substance all over their hands and fingers. Staff I assisted R12 to wipe their hands off with a napkin. Staff I took the soiled napkins and discarded them into the trash located in the kitchenette area. Staff I returned to the table, picked up the spoon and fed R11 a bite of their lunch. Staff I was not observed to wash or use hand sanitizer after they assisted R12 with cleaning up their hands and prior to feeding R11 and R17 their lunch.

In an observation and interview on 11/03/2023 at 10:30 AM, Staff J, Caregiver, walked into the "A" court left side laundry room door. Staff J grabbed a pair of disposable gloves from their pants pocket. Staff J put the gloves on. Staff J was not observed to wash their hands or use hand sanitizer prior to putting the gloves on. Staff J opened the bag with soiled linins inside the sink. Staff J grabbed the soiled bed linen out of the bag and put them in the washing machine. Staff J with their gloved hands closed the washing machine lid, turned the dial to turn the washing cycle on. Staff J then took the disposable gloves off, balled them together and held them in their hand. Staff J was observed to look for a trash can and was unable to find one. Staff J opened the left side laundry room door and exited the room. Staff J was not observed to wash their hands or use hand sanitizer before they left the laundry room. Staff J walked down the hallway into the small activity room. Staff J picked up a wooden puzzle and placed on a table for a resident to use. Staff J walked down to the dining room still holding the soiled gloves in their hand. At 10:49 AM, Staff J was observed to throw the soiled disposable gloves away and walked out of the dining room. Staff J still had not been observed to wash or use hand sanitizer for their hands. Staff J stated they did not have any hand sanitizer in their pocket or on them for use.

In an interview on 11/03/2023 at 10:51 AM, Staff O, Caregiver, stated they were to wash their hands any time after before or after care was provided, before and after touching any food, before and after use of disposable gloves.

In an interview on 11/01/2023 at 10:31 AM, Staff B stated all staff were to have a bottle of hand sanitizer with them all the time to use. Staff B stated there were hand sanitizer dispensing machines around the facility, but they had to be removed when one of the residents with dementia (a progress brain disease that is a loss of cognition function, thinking, remembering, reasoning, and can interfere with ability to perform daily life activities) were observed to drink the hand sanitizer solution.

In an interview on 11/15/2023 at 11:31 AM, Staff B, Health and Wellness Director/Registered Nurse stated all employees were to wash their hands all the time. Staff B stated before and after use of the bathroom, before putting gloves on and then after they take their gloves off, before meals, and anytime their hands were soiled.

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This is a recurring deficiency previously cited on 09/09/2021.

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Administrator (or Representative) 12/21/23 Date

WAC 388-78A-3060 Storage space. The assisted living facility must:

(3) Maintain storage space to prevent fire or safety hazards.

This requirement was not met as evidenced by:

Based on observation, and interview the facility failed to maintain 4 of 4 linen closest in a safe and sanitary manor. This failure placed 53 of 53 residents and 42 staff members at risk for fire or safety hazards.

Findings included...

In an observation on 11/01/2023 at 10:20 AM, inside the Bridge linen closet in the "D" court had a red and black plaid blanket and a white blanket with pink roses that were stored on the ground under the bottom shelf. There was a sign posted inside the linen doors that showed no linens or blankets were to be stored on the ground under the bottom shelf or above the red taped line above the top shelf.

In an observation and interview on 11/01/2023 at 10:48 AM, inside Clare's linen closet in the "A" court had multiple quilts and blankets stored on the ground and above the red taped area on the wall observed above the top shelf. Staff B stated the linens were not to be stored or stacked above the red tape line or on the ground under the bottom shelf. There were multiple blankets on the top shelf and were unable to observe the red tape that was on the wall that the sign referenced.

In an observation on 11/01/2023 at 11:12 AM, inside Clare's linen closet in the "C" court had multiple quilts and blankets stored on the ground and above the red taped area on the wall observed above the top shelf.

In an observation on 11/02/2023 at 2:09 PM, inside Bridge's linen closet in the "F" court had multiple quilts and blankets stored on the ground.

In an interview on 11/30/2023 at 1:15 PM, Staff U, Executive Director, stated no linens were to be stored on the ground for sanitary purpose or above the 18-inch line for safety

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This is a recurring deficiency previously cited on 08/09/2021.

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In an observation and interview on 11/01/2023 at 10:48 AM, inside Clare’s linen closet in the “A” court had multiple quilts and blankets stored on the ground and above the red taped area on the wall observed above the top shelf. Staff B stated the linens were not to be stored or stacked above the red tape line or on the ground under the bottom shelf. There were multiple blankets on the top shelf and were unable to observe the red tape that was on the wall that the sign referenced.

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In an observation on 11/02/2023 at 2:09 PM, inside Bridge’s linen closet in the “F” court had multiple quilts and blankets stored on the ground.

In an interview on 11/30/2023 at 1:15 PM, Staff U, Executive Director, stated no linens were to be stored on the ground for sanitary purpose or above the 18-inch line for safety

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reasons.

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WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 7 of 7 areas within the building (Bridge laundry room, Bridge shower and public bathroom, Clare shower and public bathroom, Resident 5's [R5] room, Resident 2's [R2] room, Resident 10's [R10], Bridge oxygen storage room, and the kitchen). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures placed 53 of 53 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's Disclosure of Services, revised dated 02/2007, showed housekeeping must maintain a resident's living quarters and other areas they may use in a safe, clean, and comfortable condition. Light housekeeping services once a week were included in the monthly fee.

Residents Rooms

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reasons.

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 7 of 7 areas within the building (Bridge laundry room, Bridge shower and public bathroom, Clare shower and public bathroom, Resident 5's [R5] room, Resident 2's [R2] room, Resident 10's [R10], Bridge oxygen storage room, and the kitchen). The facility failed to keep exterior grounds in good repair, equipment, and furnishings clean. These failures placed 53 of 53 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

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Residents Rooms

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R10
Observation on 11/03/2023 at 11:40 AM, R10's room showed their bed linens had several dried red stains on their pillowcase and sheets, and a dried brown substance on their comforter. Observation of R10's bathroom found their wall mounted grab bar had a dried red substance on the surface, and their toilet seat had a dried brown smear along the outer rim.

In an interview on 11/03/2023 at 11:40 AM, Collateral Contact 3 (CC3), Family Member of R10, stated they regularly found unclean sheets in R10's room though staff were supposed to change them weekly. CC3 stated the housekeeping services had been an ongoing problem.

R5
In an observation on 11/02/2023 at 2:08 PM, in R5's room by the head of the bed on the left side in between the side table was a trash can. Inside the trash can was a soiled white and yellow brief and disposable gloves. The trash can bag was wide open and had a pungent odor of urine.

R2
In an observation on 11/03/2023 at 10:10 AM, inside R2's bathroom on the front of the white toilet bowl were vertical yellow streaks that resembled urine stains. There was multiple candy wrappers and white particles on the floor of R2's room.

R4
In an observation on 11/02/2023 at 2:24 PM, in R4's bathroom on the front of the toilet bowl from the toilet seat down to the ground were multiple yellow stain lines. There was yellow stains and liquid around the toilet bolt on the right side closest to the sink on the base of the toilet. The bathroom had a pungent odor of urine.

Bridge Side Building.

In an observation and interview on 11/01/2023 at 9:35 AM, one of two medication carts on Bridge side of the facility did not have a sharps container. Staff B stated they were out of new sharps containers and were waiting on them to arrive at the facility. Inside of one of the medications carts sharp container holder was a disposed used blood sugar finger poker disposed inside and not in a sharps container.

In an observation and interview on 11/01/2023 at 9:41 AM, on the Bridge side of the facility, inside the oxygen supply room was a large square brown box with a red plastic bag inside the box. There were multiple red and white closed sharp containers stored inside and on top of the box. There were seven sharps containers on top of numerous other sharp containers that were closed and had the word "FULL" showed in red writing on the lid. There were used needles, syringes, and disposed items that were observed inside of the seven sharps containers. Staff B stated they did not have any more specific boxes to dispose the full sharp containers in properly. Staff B stated they were waiting on the supplies to be delivered and the full box of full sharp containers to be picked up.

In an observation on 11/01/2023 at 9:44 AM, the Bridge laundry room showed one of the washing machines had a clear round tube that was coming from a container on the wall and down into the top of the washing machine lid. The clear round tube had large amounts of dried, crusty, and flaking white substance up and down the entire length of the tube.

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In an observation and interview on 11/01/2023 at 9:52 AM, inside the Bridge shower room on the wall to the left of the entry way by the light switch were areas of dried brown substance the protruded from the wall. The areas were a quarter to halfway up the wall in multiple spots. Staff B stated the brown areas looked like feces. In front of the walk in shower on the ground was a raised dried brown substance that resembled feces. The shower gray padded shower bench had one of the cushions with a crack that showed the white foam material. The exposed foam material was a darker yellow and brown color. One of the four legs of the gray padded shower bench was missing a rubber cap. The shower bench was unlevel and wobbly. Throughout the floor of the shower room, there were multiple brown dried smudged areas on the floor that resembled feces.

In an observation on 11/01/2023 at 9:59 AM, the laundry room door inside the Bridge side country kitchen dining room was unlocked. Inside the laundry room was white tall laundry basket that had broken jagged edges for handles and around the top of the garbage can. Inside the garbage can on the bottom was a thick layer of brown and green fuzzy matter. The white bottom of the garbage can was unable to be visualized through the thick brown and green fuzzy matter.

In an observation on 11/01/2023 at 10:01 AM, the shower room bathroom contained a toilet bowl filled to the brim with a thick, grayish-brown, dried-out substance. Brown marks were smeared across the shower room walls.

In an observation on 11/01/2023 at 10:03 AM, off of the Bridge side of the facility small television room, the workshop bench had multiple crumpled up used white napkins, soiled and used small blue drinking cups, empty water bottle, and a clump of loose hair that sat to the right of the work bench. There was no trash can in the area to dispose the trash.

In an observation on 11/01/2023 at 10:05 AM, off of the Bridge side of the facility's small television room under the television set inside the right side cabinets was a plastic tub that was labeled "sand and sea". Inside the tub was large amounts of sand with seashells and three size "D" batteries that were not locked up.

In an observation on 11/01/2023 at 10:08 AM, the public bathroom on Bridge side of the facility near "E" side of the rooms was observed to have brown smudges and streaks that resembled feces on the toilet seat. There were multiple crumpled, used, and soiled white paper towels that were under the sink on the ground. There was no available trash can to use in the bathroom.

In an observation and interview on 11/01/2023 at 10:21 AM, inside the Bridge shower room, was a white shower bench chair that was sitting inside the walk-in shower. On the white seat part of the shower bench was a brown smeared area in the middle towards the back of the seated part of the chair. Up against the wall before entering into the bathroom that was attached to the shower room was a tall white trash can that had handwritten words on the side that showed "Bridge linen". There were multiple brown dots and dried splattered areas on the outside of the trash can. Staff K, Health and Wellness Coordinator, stated the brown area's resembled feces. The toilet in the bathroom had brown ring inside the toilet bowl with brown particles floating.

Clare Side Building

In an observation and interview on 11/01/2023 at 11:13 AM, there was a large brown area on the carpet on the corner of the wall by the charting room on Clare side of the facility.

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The brown area was the size of a softball. The green color of the carpet was unable to be visualized where the brown area was located. Staff B stated that area of the carpet needed to be cleaned.

In an observation on 11/01/2023 at 11:15 AM, the laundry room door inside the Clare side country kitchen dining room was unlocked. Inside the laundry room was a large picture frame that was leaned up against the wall and half of the glass that covered the picture was broken with a sharp edge exposed. The door to the laundry room from the hallway was unlocked.

In an observation on 11/01/2023 at 11:23 AM, the Clare side kitchenette area off the main dining room on the white wall where the garbage can was placed, were multiple dried red, brown, and orange splattered spots. The white color of the wall was unable to be visualized where the splatters were located.

In an interview on 11/01/2023 at 10:25 AM, Staff B stated there hadn't been a housekeeper for the facility since they started employment on 10/02/2023. Staff B stated the previous housekeeper was terminated in the beginning of September 2023. Staff B stated the housekeeping duties and responsibilities were reassigned to care staff. Staff B stated the care staff put the residents needs before the housekeeping responsibilities and were unable to keep up.

In an observation on 11/03/2023 at 10:04 AM, the laundry room that was attached to the Clare side of the country kitchen dining room's door was unlocked. Inside the laundry room remained the large picture frame with the broken glass. The door that led out to the hallway was unlocked and able to be opened.

Kitchen

In an observation on 11/01/2023 at 9:20 AM, the Bridge side kitchenette showed drinking glasses stained with lipstick and an unknown dried-on substance, sitting on a shelf.

In an observation and interview on 11/01/2023 at 1:10 PM, the main kitchen microwave showed an interior covered with food splatter. Staff L, Cook, said, "Oh yeah that needs to get cleaned."

In an interview on 11/01/2023 at 10:25 AM, Staff B stated there had not been a housekeeper employed at the facility since September 2023 when the housekeeper was terminated. Staff B stated there had not been any housekeeping available since then. The caregivers were to assume the duties but have not been able to complete.

In an interview on 11/08/2023 at 10:31 AM, Collateral Contact 5 (CC5), Power of Attorney for R5, stated the facility often had an odor of urine when they came to visit R5.

This is a recurring deficiency previously cited on 06/16/2021.

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

Administrator (or ~~Representative~~) — Date: 12/21/23

RCW 70.129.060 Grievances. A resident has the right to:

(1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow their grievance system as written for 4 of 4 residents (Resident 8 [R8], Resident 18 [18], Resident 8 [R8] and Resident 2 [R2]) and their representatives. This failure placed each resident or their responsible party at risk of having their reported concerns unresolved.

Findings included...

Record review of the facility's "Grievance Procedure – Resident", dated September 2003, showed residents or their responsible parties should submit grievances about the community, its services, treatment, or the behavior of other residents by discussing the complaint with "the associate" and Executive Director. If unable to resolve the concern, they should submit the complaint in writing to the Executive Director, who would respond within 14 days.

Record review on 11/02/2023 at 10:55 AM of the facility's provided binder labeled Grievances containing documentation of resident and representative's grievances showed the facility's Grievance Forms did not provide a method for documenting the facility's response to reported concerns. One undated grievance and grievances dated 06/18/2023, 06/27/2023, and 09/05/2023 were assigned to staff members other than the Executive Director. No follow-up efforts by the facility were documented.

R18

Record review of an email sent to the Department from Collateral Contact 7 (CC7), daughter of R18, showed they had sent an email to Staff S, Registered Nurse/District Director of Clinical Services, on 11/03/2023 at 10:48 AM, that showed CC7 expressed concerns that they had talked to Staff S about on 10/18/2023. The concerns included R18's clothes, knee high socks, and bath towels had been missing for a month, laundry services not being provided, bed linens were not changed and cleaned routinely, and R18's room

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not being cleaned.

In an interview on 11/22/2023 at 10:40 AM, CC7 stated they had expressed concerns about the facility in an email that was sent to Staff S on 11/03/2023. CC7 stated they told the facility staff they were not leaving the facility until R18's bathroom toilet was cleaned.

R8

Record review of a facility's grievance form for R8, dated 10/02/2023, was provided by Collateral Contact 4 (CC4), Daughter of R8, showed CC4 expressed concerns that R8 required more assistance with care and services since they had a broken arm. The grievance form was not for review in the facilities binder labeled grievances.

In an interview on 11/14/2023 at 9:29 AM, Collateral Contact 4 (CC4), Daughter of R8, stated they had turned in a grievance form expressing the concerns of R8's need for increase in care since R8 had a broken arm. CC4 stated they never heard from anyone or had a follow up. CC4 stated they had turned the grievance form into Staff P, Former Executive Director, that gave a copy of the grievance form to CC4. CC4 stated administration had not followed up on anything they had expressed concerns about. CC4 stated they expressed concerns that R8 required more assistance with care after they had broken their arm. CC4 stated they had observed the "Safely You" camera system video recording of R8's room with the medication technician of R8 after R8 was found kneeling by their bed. CC4 stated R8's call light cord was not within reach for R8 to use and R8 tried to get up out of bed and was unable to as they only had one arm to use to get up with. CC4 stated as of 11/14/2023 their grievance had remained unresolved.

R2

In an interview on 11/08/2023 at 10:31 AM, Collateral Contact 6 (CC6), Daughter of R2, stated Staff P, Former Executive Director, never followed up when they expressed concerns. CC6 stated they pay extra every month for R2 to get extra showers, to be shaved, and groomed, but it does not happen. CC6 stated they expressed the concerns to Staff A, District Director of Operations/Executive Director, and nothing has been changed since Staff P no longer was employed at the facility as Staff P was the person CC6 initially reported the concerns to.

In an Interview on 11/03/2023 at 2:04 PM, Staff A described the grievance system as providing someone with the Grievance Form when they had a complaint. They stated if the response from the facility was not acceptable, someone with a complaint could then speak with regional management. Staff A stated they were unsure if there was any system to document efforts to resolve grievances within the facility, but that regional management did track concerns that rose to their attention.

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Statement of Deficiencies	License #: 2497	Compliance Determination # 32047
Plan of Correction	Brookdale Olympia West	Completion Date
Page 55 of 57	Licensee: BKD Clare Bridge of Olympia LLC	12/14/2023

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 Olympia West is or will be in compliance with this law and / or regulation on (Date) 4/28/24

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Administrator (or Representative) — Date 12/21/23

WAC 388-78A-2550 Administrator training documentation. The assisted living facility must maintain for department review, documentation of the administrator completing:

(1) Training required by chapter 388-112A WAC;

(2) Department training in an overview of Washington state statutes and administrative rules related to the operation of an assisted living facility.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to provide documentation to show 1 of 1 staff members (Staff P) had the required trainings for their position. This failure placed 53 residents and 42 staff members at risk for not having the proper guidance and leadership to provide the care and services for the residents.

Findings included...

WAC 388-112A-0040 When did the seventy-hour long-term care worker basic training requirements go into effect? (1) The seventy-hour long-term care worker basic training requirements in this chapter for long-term care workers in adult family homes and assisted living facilities and their administrators or administrator designees went into effect January 7, 2012.

WAC 388-112A-0080 Who is required to complete the seventy-hour long-term care worker basic training and by when? Assisted living facilities. (4) Assisted living facility administrators or their designees within one hundred twenty days of date of hire.

WAC 388-112A-0105 Who is required to obtain home care aide certification and by when? (1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC. (c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire

WAC 388-112A-0800 What is residential care administrator training? (1) Residential care administrator training is specific training on the administration of the care and services

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required to obtain a license or manage a facility. The training covers the facility specific Washington state statutes and administrative rules related to the operation of a long-term care facility. (3) Assisted living facility (ALF) administrator training. (a) ALF administrator training curricula must be based on the requirements described in chapter 388-78A WAC. (b) DSHS will work with stakeholders to develop, update, and approve ALF administrator training curricula, instructors, and training programs.

Record review of the Department of Social and Health Services letter, dated 03/04/2022, showed on 06/07/2022 the suspension for administrator training had ended.

Record review of an email sent to the Department on 12/07/2023 at 7:46 AM, showed Staff P, former Executive Director, was employed at the facility for dates 09/10/2021 through 10/17/2023.

Record review of Staff P's, Former Executive Director, resume undated, showed they had an assisted living administrators license for Washington state since October 2016 to present (no month, day, or year shown). The resume showed they had an Oregon administrators license for assisted living that was "present" (no dates shown). Staff P's resume showed for education they had a diploma from high school. There was no other documentation of any other educational degrees.

Record review on 11/03/2023 at 12:11 PM, Staff P's employee file showed there were no department of health credential certifications for review. There were no certifications for review that showed Staff P completed a training that reviewed the Washington state statutes and administrative rules related to the operation of an assisted living facility.

Record review on 11/30/2023 at 11:45 AM, of Staff P's employee file showed there were no further documentation that showed there were any certificates of training of Washington state statutes and administrative rules related to the operation of an assisted living facility, any department of health credentials, no certificate of completion of seventy-hour long-term care worker basic training, and certificate of license of administrator for Oregon or Washington as showed on Staff P's resume.

In an interview on 11/30/2023 at 12:05 PM, Staff H, Business Office Coordinator, stated if an employee had any certificates or trainings they had completed they would have been filed in their employee file for review.

In an interview on 11/30/2023 at 1:04 PM, Staff H stated all administrators at the facility were considered corporate. Staff H stated the corporate office should have Staff P's certificates for review.

As of 12/01/2023 at 5 PM, the Department had not received any certificates or training for Staff P for review from the facility or the corporation.

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Statement of Deficiencies	License #: 2497	Compliance Determination # 32047
Plan of Correction	Brookdale Olympia West	Completion Date
Page 57 of 57	Licensee: BKD Clare Bridge of Olympia LLC	12/14/2023

In an interview on 12/07/2023 at 10:48 AM, Staff H stated the facility, or the corporation does not have a license or certification that showed Staff P had a license of administrator for Washington. Staff H stated they did not have a certification for Staff P that showed they completed a training that reviewed the Washington state rules and statues around assisted living facility operations for review.

Record review on 12/05/2023 on the Washington Department of Health's provider credential verification web site showed there were no credentials found for Staff P.

Record review of an email sent to the Department on 12/05/2023 at 7:52 AM showed Staff P had credentials for Nursing Assistant Registered that expired 08/09/2023. Staff P was identified with a different last name.

Record review on 12/08/2023 on the Washington Department of Health's provider credential verification web site showed under Staff P's different last name, showed their credentials were still expired as of 08/09/2023.

As of 12/11/2023 the Department has not received any trainings or certificates that showed Staff P had completed the required trainings for administrator.

Record review of an email sent to the Department on 12/14/2023, showed Staff H was unable to locate and provide any documentation, trainings, or certificates that were completed for Staff P.

Plan/Attestation Statement

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Administrator (or Representative) — Date 12/21/23

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Record review on 12/06/2023 on the Washington Department of Health's provider credential verification web site showed under Staff P's different last name, showed their credentials were still expired as of 06/09/2023.

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