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

Emerichip Walla Walla LLC
Brookdale Walla Walla
1460 DALLES MILITARY RD
WALLA WALLA, WA 99362

RE: Brookdale Walla Walla License # 2498

Dear Administrator:

This letter addresses Compliance Determination(s) 33853 (Completion Date 12/15/2023) and 30636 (Completion Date 10/23/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/15/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2130-1, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-2, WAC 388-78A-2210-2-a, WAC 388-78A-2660-2, RCW 70.129.140.1

The Department staff who did the on-site verification:
Elaine Lopez, Licensor

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

Sincerely,

Gwin Kaercher

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Walla Walla
Provider Type: Assisted Living Facility
License/Cert.#: 2498
Compliance Determination #: 30636
Intake ID: 100625
Investigator: Elaine Lopez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/09/2023 through 10/23/2023
Complainant Contact Date(s):

Allegation(s):

1. The named resident and family have not had a care conference.
2. The named resident's medication were not being given at the appropriate times.
3. The named resident's glaucoma eye drops not being administered and an early AM medication not being given.
4. The named resident call light takes anywhere from 45 minutes to 1 hour for staff to respond.
5. When the named resident's spouse asked how the named resident was getting their medication when the staff were not waking them, staff responded with "Is it that important to you."
6. The named resident was sent to the local emergency room and the spouse was never notified.
7. The named resident had been quarantined to apartment and the facility nurse was to check on them, although the nurse had only been in the named resident's apartment to check 2-3 times.
8. None of the staff were checking on the named resident's hearing aids, or placing them correctly to be recharged, and staff handed the hearing aids back uncharged causing the resident not to be able to hear.
9. None of the staff were cleaning the apartment, linen not changed, and when the named resident fell and bled on the sheets, staff just made the bed with the soiled sheets.
10. On 08/14/2023 the facility made the care plan and put it on the 'back burner.' Facility staff were not following the care plan, the nurse's station did not have a copy of the care plan.
11. The named resident's spouse discussed concerns with the facility administrator although the concerns were dismissed, and the facility nurse was accusatory.
12. The facility had lack of transportation and the bus was a shared bus with a sister community.

Investigation Methods:

Sample: Total residents: 46
Resident sample size: 5
Closed records sample size: 0

Observations: The facility common areas, sampled resident apartments, noon dining room, resident to resident and resident to staff interactions were observed.

Interviews: Sampled residents, facility staff, and others not associated with the facility.

Record Reviews: Resident characteristic roster, resident records (care plans, medication administration records (MAR), and progress notes), facility policy's, staff roster, and disclosure of services.

Investigation Summary:

1. 8. 10. The facility failed to have an initial care plan as required. The facility had deficient practice and a citation was written for WAC 388-78A-2130 Reference State of Deficiencies dated 10/23/2023.
2. 5. Record review showed the early morning thyroid medication was given at the prescribed time. Although, record review also showed there were four doses of medication that were not given and no explanation for not being given. The facility had deficient practice and a citation was written for WAC 388-78A-2210 Reference State of Deficiencies dated 10/23/2023.
3. Interviews showed that the Glaucoma eye drop medication had been changed by the named resident's doctor and the order was filled and processed in August 2023. The facility contacted the doctor's office after the licensor and the named resident's family informed them of the concern. The facility received new orders and updated their MAR. No failed practice identified.
4. Interview and record review showed that sampled resident call lights were not being answered in a timely manner. The facility had deficient practice and a citation was written for WAC 388-78A-2660/RCW 70.129 Reference State of Deficiencies dated 10/23/2023.
6. Interview with facility staff showed that the staff had made a call to the spouse of the named resident although they had not picked up the phone. Technical assistance was provided to the facility regarding phone calls made to responsible parties were being made and to continue to attempt until someone is reached. No failed practice identified.
7. Record review showed facility staff documented monitoring of the named resident. No failed practice identified.
9. Interview with the facility administrator showed that they interviewed and investigated the facility staff regarding the named resident's room not being cleaned or sheets not being changed when soiled with blood. Facility staff denied not cleaning or there being bloody sheets. Observations during an on-site visit showed the named resident's room and bathroom to be clean, no odors, and the bed was made. No failed practice identified.
10. Interview and record review showed care plan was not developed. failed practice identified WAC 388-78A-2130 Reference State of Deficiencies dated 10/23/2023.
11. Interviews with facility staff showed that interactions and conversations with the named resident's family member were respectful. No failed practice identified.
12. Facility staff interviews showed that the facility's bus recently was repaired, returned to the facility, and ready for resident use. Further staff interviews showed that the facility had a bus available when their bus was out of order. Residents were still able to go to appointments, store trips, and outings. Observations showed signs posted in the hallway and in the elevator stating that the bus was back and ready for operation. No failed practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2498	Compliance Determination # 30636
Plan of Correction	Brookdale Walla Walla	Completion Date
Page 1 of 8	Licensee: Emerichip Walla Walla LLC	10/23/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 10/09/2023 and 10/18/2023 of:

Brookdale Walla Walla
1460 DALLES MILITARY RD
WALLA WALLA, WA 99362

This document references the following complaint number(s): 100625, 102375

The following sample was selected for review during the unannounced on-site visit: 5 of 46 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Elaine Lopez, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Gwin Kaercher
Residential Care Services

11/01/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

11/13/23
Date

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

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

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

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

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

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an initial service plan was developed and had the required elements for 1 of 5 residents (Resident 2), who moved into the ALF within the last five months. This failed practice placed the resident at risk of having their care needs not met.

Findings included...

Review of the ALF's policy titled, "Service Plan Process Policy – CS-70-3," dated 04/2015, showed that resident service plans were developed through the evaluation process or other identified systems and provide information about the resident's needs for the care associates. In addition, the policy showed that the initial service plan should be developed on move in/admission into the facility.

On 10/05/2023 at 11:36 AM during a telephone interview with Collateral Contact 1 (CC1), Resident's Representative, stated that Resident 2 had moved into the ALF in late [redacted] or [redacted] 2023. CC1 stated that there was no initial care meeting to discuss Resident 2's care needs. In addition, CC1 stated that they had requested to look at the resident's service plan and the facility could not show or provide a service plan for them to review. CC1 also stated that a care meeting with the facility occurred on 10/02/2023 (more than four months after move-in).

On 10/09/2023 at 10:35 AM, Staff A, Administrator stated that they were asked for the ALF's process/policy for care plans and updating care plans. Staff A stated that there should be a care plan completed when the resident moved-in, then another care plan completed in 14 to 30 days after move-in. Staff A also stated that when Resident 2 moved in, the facility did not have a nurse or business office manager, and that all staff were learning their job tasks.

Record review showed service plans dated 08/14/2023 and 10/05/2023 both were not signed or dated. Another service plan dated 08/15/2023 was provided by Staff A and it contained typed information and handwritten comments regarding Resident 2. The 08/15/2023 service plan was the only service plan with signatures by the resident's representative, the ALF representative, and the facility nurse's signature with a date of 10/03/2023.

On 10/10/2023 at 2:30 PM, clarification was made with Staff A, that the service plan signed and dated 10/03/2023 was the only service plan that the facility had for Resident 2.

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 Walla Walla is or will be in compliance with this law and / or regulation on (Date) ~~12/15/23~~ 12/7/23 qm

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

Juanita Muhlbeier — Administrator (or Representative)

11/13/23 — Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 residents (Resident 2), who were assisted with their medication received their medication as prescribed. This failure placed the resident at risk for complications to their health conditions.

Findings included...

Review of the ALF's policy titled, "Medication & Treatment – Administration/ Assistance – CS-40-2," dated 08/2010, showed that the policy overview for medication administration/assistance and or treatment would be provided in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider.

An interview with Resident 2's Collateral Contact 1 (CC1), Resident's Representative on 10/05/2023 at 11:30 AM, stated that the facility's Medication Technician (MT) was not giving Resident 1 their scheduled 5:00 AM medication.

On 10/09/2023 at 10:35 AM, Staff A, Administrator, was asked about the ALF's process for assisting residents with their medication. Staff A stated that Resident 2 was assisted with their medication.

Review of Resident 2's Service Plan signed and dated 10/03/2023 showed that the ALF was to order, provide medication assistance, and store medication for Resident 2. The Service Plan also showed Resident 2's diagnoses that included: [redacted] and [redacted], and [redacted]

Review of Resident 2's physician's orders dated 05/08/2023, showed an order for Levothyroxine (thyroid (regulates hormones)) 25 Micrograms (MCG), give one tablet one time a day, to be given at 5:00 AM for hypothyroid (decrease in thyroid hormone).

Dashboard

Review of the August 2023 Medication Administration Record (MAR) showed that for the Levothyroxine on 08/07/2023 and 08/21/2023 were blank as medication not given.

Review of the September 2023 MAR showed that for the Levothyroxine on 09/13/2023 and 09/28/2023 was blank as medication not given.

The August and September 2023 MARs did not document the reason for the medication not being given.

On 10/10/2023 at 2:05 PM, Staff A stated did not know why there were blanks as if medication not given for the Levothyroxine on the August and September 2023 MARs.

This is a recurring deficiency previously cited on 01/25/2023 subsection 2a.

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 Walla Walla is or will be in compliance with this law and / or regulation on (Date) 12/15/23 ~~12/7/23~~

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

Juanita Muhlbeier — Administrator (or Representative)

11/13/23 — Date

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.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff responded to call lights/pendants in a timely manner for 3 of 3 residents (Resident 1, 2, 3), who pressed their call buttons for staff assistance and staff response was more than 30-minute wait time or staff did not respond. This failure placed residents at risk of diminished quality of life and delays in response to care needs.

Findings included...

Resident 3

Interview on 10/09/2023 at 1:25 PM with Resident 3, they stated that usually when they pressed the call button, they had to wait from 30 minutes to an hour for staff to respond. Resident 3 stated they waited an hour for the Medication Technician (MT).

Review of Resident 3's service agreement dated 08/17/2023 showed that staff assisted the resident with medication, and they were to do stand by assist with activities of daily living. The service agreement also showed Resident 3's diagnosis included [redacted] and [redacted]

Review of the ALF's call light system:

On 10/09/2023 at 3:15 PM review of the facility's electronic call light system that registered to the main computer in the medication room was reviewed with Staff D, Maintenance Manager. The call light system discontinued tracking after a 45-minute wait. The call light response for the last seven days:

-Resident 3's call light button was pressed on 10/02/2023 at 11:28 PM and no staff responded as of 12:13 AM.

-Resident 3's call light button was pressed on 10/03/2023 at 2:19 AM and no staff responded as of 3:04 AM.

-Resident 3's call light button was pressed on 10/04/2023 at 1:50 AM and no staff responded as of 2:35 AM

-Resident 3's call light button was pressed on 10/04/2023 at 3:30 AM and no staff responded as of 4:15 AM

-Resident 3's call light button was pressed on 10/05/2023 at 12:14 AM and no staff responded as of 12:59 AM.

-Resident 3's call light button was pressed on 10/05/2023 at 2:53 AM and no staff responded as of 3:38 AM.

-Resident 3's call light button was pressed on 10/05/2023 at 3:51 AM and no staff responded as of 4:36 AM.

-Resident 3's call light button was pressed on 10/06/2023 at 4:57 AM and no staff responded as of 5:42 AM.

-Resident 3's call light button was pressed on 10/09/2023 at 12:22 AM and no staff responded.

Resident 1

Review of the facility's characteristic roster showed that Resident 1 moved into the ALF in [redacted] 2020 and had diagnosis that included [redacted] and required wound care.

Review of the facility's electronic call light system for the last seven days showed:

-Resident 1's call button was pressed on 10/07/2023 at 10:07 AM and staff responded at 10:36 AM.

-Resident 1's call button was pressed on 10/08/2023 at 2:05 PM and staff responded at 2:30 PM.

-Resident 1's call button was pressed on 10/08/23 at 8:01 PM and as of 8:46 PM staff had not responded to the call button.

Resident 2

Review of Resident 2's Personal Service Plan (PSP) signed and dated 10/03/2023 showed that the ALF was to assist the resident with medication, hearing devices, putting on and taking off compression stockings, and stand by assist when getting into and out of the wheelchair. The PSP also showed Resident 2's diagnoses included: [redacted] and [redacted] and [redacted]

On 10/09/2023 at 3:15 PM review of the facility's electronic call light system showed that for the last seven days:

-Resident 2's call button was pressed on 10/05/2023 at 12:24 AM and no staff responded as of 1:09 AM, 10/06/2023.

-Resident 2's call button was pressed on 10/05/2023 at 3:22 AM and no staff responded as of 4:07 AM.

-Resident 2's call button was pressed on 10/08/2023 at 11:39 AM and no staff responded

as of 12:24 AM.

-Resident 2's call button was pressed on 10/09/2023 at 4:30 AM and no staff responded as of 5:15 AM.

On 10/09/2023 at 3:45 PM, Staff A, Administrator, stated they were unaware why it took staff so long to answer the call buttons and or why there was no staff response. Staff A acknowledged the ALF had no system to audit call light response time.

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 Walla Walla is or will be in compliance with this law and / or regulation on (Date) ~~12/15/23~~ 12/7/23 jm

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

Juanita Muehlbauer
Administrator (or Representative)

11/13/23
Date