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) 42391 (Completion Date 06/07/2024) and 34919 (Completion Date 04/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/07/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630-1-b

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

If you have any questions, please contact me at (509)598-0182.

Sincerely,

Selena Clemons

Selena Clemons, Field Manager
Region 1, Unit C
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Walla Walla
Provider Type: Assisted Living Facility
License/Cert.#: 2498
Compliance Determination #: 34919
Intake ID: 111982
Investigator: Gwin Kaercher
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 01/09/2024 through 04/23/2024
Complainant Contact Date(s):

Allegation(s):

1, The Identified Resident is left in clothing soiled with feces and urine due to poor verbal behaviors with staff.
2. Another unidentified resident has to provide incontinent care the to the Identified Resident and wash their clothing when they have soiled themselves because staff don't.
3. The Identified Resident does not get fed properly, only eats cookies and has gained a significant amount of weight from not getting up from their bed or chair.
4. The Identified Resident does not want help and the Reporter has been told there is no help for them.

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 6 Closed records sample size: 0
Observations:	N/A
Interviews:	N/A
Record Reviews:	N/A

Investigation Summary:

1, 2, 3 & 4. The resident representative of the (alleged victim,) Identified Resident returned call, clarified their spouse does not currently live in either a skilled nursing facility, assisted living facility or adult family home. The resident representative lives in the facility and has been there approximately a year. They and their brother reported the alleged victim left a local skilled nursing facility AMA and returned to live in a trailer, where they are self-neglecting. Made notes, provided them the contact information for the complaint resolution unit after reviewing what services/jurisdiction DSHS/RCS provides. Field managers notified. No failed practice identified.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Walla Walla
Provider Type: Assisted Living Facility
License/Cert.#: 2498
Compliance Determination #: 34919
Intake ID: 119884
Investigator: Gwin Kaercher
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 01/09/2024 through 04/23/2024
Complainant Contact Date(s):

Allegation(s):
The Identified Resident (alleged victim, AV) may have been sexually abused by an Identified Staff (alleged perpetrator, AP).

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Personnel files Staff training records

Investigation Summary:
All staff -resident and resident-resident interactions were appropriate and respectful. The AV recollection of the incident involving the AP remained consistent with what she reported when interviewed by the facility administrator. The AP was suspended pending the investigation once it was reported. The facility investigation met minimal regulatory guidelines, the AV reported they felt safe in the facility and knew the AP was not there. The AV reported the AP had come to them the day before the incident with gifts for Valentine's Day. All sampled residents denied feeling, seeing or hearing abuse, all reported they felt safe in the facility. Interview and record review showed the facility

did not contact local law enforcement of the allegation per WAC 388-78A-2630, failed practice identified.

Conclusion / Action:

- ☐ 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 # 34919
Plan of Correction	Brookdale Walla Walla	Completion Date
Page 1 of 3	Licensee: Emerichip Walla Walla LLC	04/23/2024

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 complaint investigation on 01/09/2024 and 04/23/2024 of:

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

This document references the following complaint number(s): 110627, 111982, 111361, 114078, 118954, 119884, 122436, 126069

The following sample was selected for review during the unannounced on-site visit: 6 of 44 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Krista Connelly, Community Nurse Consultant
Gwin Kaercher, Community Field Manager

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

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

Gwin Kaercher
Residential Care Services

05/06/2024
Date

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 #34919
Plan of Correction	Brookdale Walla Walla	Completion Date
Page 1 of 3	Licensee: Emerichip Walla Walla LLC	04/23/2024

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

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Gwin Kaercher, Community Field Manager

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

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Gwin Kaercher
Residential Care Services

05/06/2024
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.

Administrator (or Representative) 5/7/2024 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to immediately report an allegation of sexual abuse to Local Law Enforcement (LLE) for 1 of 1 resident (Resident 1). This failure placed the resident at risk of continued abuse

Findings included...

Review of the facility's policy titled, "Abuse, Neglect and Exploitation," revised on 05/2021, showed instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported in accordance with this policy for investigation and appropriate follow-up. The policy showed sexual abuse includes any sexual contact between an associate, who is also not a resident, and a resident, whether it is consensual or not. The policy showed if there is reason to believe sexual assault occurred, local law enforcement should be notified.

Washington State Administrative Code (WAC) 388-78A-2020 defines Vulnerable Adult as includes any person sixty years of age or older who has the functional, mental, or physical inability to care for themselves; Admitted to any facility, including any assisted living facility.
Revised Code of Washington (RCW) 74.34 (2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

Review of the facility's Incident Report dated 02/26/2024, showed that on 02/15/2024, Staff B, Facility Bus Driver, drove Resident 1, via the facility's bus to a location away from the Assisted Living Facility, approached the resident and sat in the bus seat next to the resident and smoked cigarettes with the resident. The incident report showed that on 02/19/2024 at 11:40 AM, Staff A, Administrator conducted an interview with Resident 1. Resident 1 stated that Staff B took them to a parking lot, away from the ALF and wanted to

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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Revised Code of Washington (RCW) 74.34 (2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

Review of the facility's Incident Report dated 02/28/2024, showed that on 02/15/2024, Staff B, Facility Bus Driver, drove Resident 1, via the facility's bus to a location away from the Assisted Living Facility, approached the resident and sat in the bus seat next to the resident and smoked cigarettes with the resident. The incident report showed that on 02/19/2024 at 11:40 AM, Staff A, Administrator conducted an interview with Resident 1. Resident 1 stated that Staff B took them to a parking lot, away from the ALF and wanted to

have sex. Resident 1 stated an act of sexual intimacy occurred while they were seated together on the facility bus.

During an interview on 02/22/2024 at 10:15 AM, Staff A stated that on 02/19/2024 they were informed of an allegation of sexual abuse which occurred on 02/16/2024 where Staff B had made sexual advances toward Resident 1. Staff A stated that Resident 1 was alert and oriented and the way the resident described the incident was consistent throughout the interview. Staff A stated that they then conducted a phone interview with Staff B on 02/19/2024 at 12:30 PM. Staff A stated Staff B denied any sexual intimacy occurred, however confirmed they had previously, for Valentines, given Resident 1 a card, candy and cigarettes. Staff B told Staff A that Resident 1 had previously been "flirting" with him and acknowledged he sat beside the resident on the bus to talk about their relationship. Staff A informed Staff B they were immediately suspended from work and an investigation was being conducted.

During an interview on 02/23/2024 at 10:08 AM, Staff A stated that they made a report to LLE on 02/22/2024 (four days after becoming aware of the allegation). Staff A stated they delayed notification to LLE because the thought the incident was "consensual".

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) 05/31/2024 .

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

Administrator (or Representative)

5/7/2024
Date

have sex. Resident 1 stated an act of sexual intimacy occurred while they were seated together on the facility bus.

During an interview on 02/22/2024 at 10:15 AM, Staff A stated that on 02/19/2024 they were informed of an allegation of sexual abuse which occurred on 02/15/2024 where Staff B had made sexual advances toward Resident 1. Staff A stated that Resident 1 was alert and oriented and the way the resident described the incident was consistent throughout the interview. Staff A stated that they then conducted a phone interview with Staff B on 02/19/2024 at 12:30 PM. Staff A stated Staff B denied any sexual intimacy occurred, however confirmed they had previously, for Valentines, given Resident 1 a card, candy and cigarettes. Staff B told Staff A that Resident 1 had previously been "flirting" with him and acknowledged he sat beside the resident on the bus to talk about their relationship. Staff A informed Staff B they were immediately suspended from work and an investigation was being conducted.

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

_____ _____

Administrator (or Representative) Date

Gwen Kaercher, Field Manager
Residential Care Services Region 1, Unit G
1200 Alder St
Union Gap, WA 98903

The following is the Plan of Correction for Brookdale Walla Walla regarding the Statement of Deficiencies dated 05/07/2024. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Deficiency #1: WAC 388-78A-2630 Reporting abuse and neglect.

POC Element 1. Mr. [redacted], Bus Driver, no longer works at Brookdale Walla Walla. Brookdale Walla Walla will have an in-service to address the facility's "Abuse, Neglect and Exploitation" policy.

POC Element 2. A resident sample was taken on 02/22/2024 during investigation to identify other residents with the potential of being affected by the alleged deficient practice.

POC Element 3. Executive Director and Health and Wellness Director is responsible for POC.

POC Element 4. The corrective measures will be monitored during our daily standup to prevent the recurrence of the alleged deficiency.

POC Element 5. These corrections will be complete by 05/31/2024.