



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Emeritol Evergreen Lodge LLC
Brookdale Federal Way
31002 14th Ave S
Federal Way, WA 98003

RE: Brookdale Federal Way License # 2526

Dear Administrator:

This letter addresses Compliance Determination(s) 41800 (Completion Date 05/28/2024) and 35932 (Completion Date 02/15/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/28/2024 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-2480-1, WAC 388-78A-2520-1-c, WAC 388-78A-2520-2, WAC 388-78A-2970-1-c-i, WAC 388-78A-2970-1-c-iii, WAC 388-78A-3000-3, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-d

The Department staff who did the on-site verification:

Claudia Allis, Community Complaint Investigator

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

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
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 2526	Compliance Determination # 35932
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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 01/29/2024 and 02/12/2024 of:

Brookdale Federal Way
31002 14th Ave S
Federal Way, WA 98003

This document references the following SOD dated: 02/15/2024

The following sample was selected for review during the unannounced on-site visit: 2 of 87 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, Community Complaint Investigator
Michelle Yip, ALF Licenser
Holly George, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Laurie Anderson
Residential Care Services

02/28/2024
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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Michelle D. Graham
Administrator (or Representative)

03/07/24
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.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 4 staff (Staff HH, Staff II, and Staff JJ) were screened for tuberculosis (TB), a serious respiratory disease, within three days of employment. This placed all the residents at risk of contracting a contagious and serious illness.

Findings included...

Record review of the Department of Social and Health Services Secure Tracking and Reporting Systems (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 10/19/2023 for Staff A and Staff D. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/15/2024.

Review of facility's undated personnel records showed the facility hired Staff HH, Health and Wellness Director, on 01/14/2024, Staff II, Medication Technician, on 01/17/2024, and Staff JJ, Caregiver, on 01/17/2024.

Review of Staff HH's personnel records showed from 01/14/2024 through 02/06/2024, Staff HH worked at the facility. Staff HH supervised staff who provided care and services for residents. There was no documentation in Staff HH's records that showed the facility screened Staff HH for TB within three days of employment. The records showed documentation that Staff HH completed a blood test on 05/17/2023, 266 days prior to Staff HH's date of employment.

Review of Staff II's personnel records showed from 01/17/2024 through 02/06/2024, Staff II worked at the facility. Staff II provided care and services for residents. There was no documentation in Staff II's records that showed the facility screened Staff II for TB within three days of employment. The records showed documentation that Staff II completed a blood test on 09/07/2023, 153 days prior to Staff II's date of employment.

Review of Staff JJ's undated personnel records showed from 01/17/2024 through 02/06/2024, Staff JJ worked at the facility. Staff JJ provided care and services for residents. There was no documentation in Staff JJ's records that showed the facility screened Staff JJ for TB within three days of employment. The records showed documentation that Staff JJ completed a blood test on 11/24/2023, 75 days prior to Staff JJ's date of employment.

During an interview on 01/31/2024 at 5:30 PM, Staff LL, Executive Director, confirmed that

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when Staff HH, Staff II, and Staff JJ were hired, they were not screened for tuberculosis. Staff A stated that they were, unaware that testing for tuberculosis was required for all facility staff within three days of employment.

This is an uncorrected deficiency previously cited on 10/19/2023.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>03/06/24</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>03/07/24</u> Date

WAC 388-78A-2520 Administrator qualifications General.

- (1) The licensee must appoint an administrator who is:
- (c) Qualified to perform the administrator's duties specified in WAC 388-78A-2560 .
- (2) The licensee must only appoint as an assisted living facility administrator an individual who meets the requirements of at least one of the following sections in WAC 388-78A-2522 through 388-78A-2527 .

This requirement was not met as evidenced by:

Based on record review and interview, the licensee failed to ensure 1of 1 sampled staff (Staff LL, Executive Director) met the Washington State qualifications and requirements to be an assisted living facility administrator. This failure placed all 87 facility residents at risk for unmet care needs by an untrained and unqualified staff.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 10/19/2023 for Staff LL. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/15/2024.

Review of the facility staff records showed that the facility hired Staff A on 10/30/2023. Further review of available documents showed that Staff LL did not meet the requirements to be a long-term care facility administrator as outlined in WAC 388-78A-2522 through WAC 388-78A-2527. There was no documentation that showed Staff LL obtained certification for completion of administrator training and had three years paid experience

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providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults. There was no documentation that showed Staff LL obtained an associate degree in a related field of study, completed administrator training, and had two years paid experience providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults. There was no documentation that showed Staff LL obtained a bachelor's degree in related field of study, completed administrator training, and had one-year paid experience providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults. There was no documentation that showed Staff LL had five years of paid experience providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults.

During an interview on 01/30/2024 at 4:10 PM, Staff LL stated that in their past employment, they had not provided direct care to vulnerable adults. Staff LL stated that they received an associate degree in science. Staff LL stated that they did not have any certification or credentials as a Home Care Aide. Staff LL stated that they did not have certification for required specialty training.

During a phone interview on 02/06/2024, at 4:30 PM, Staff P, District Director of Corporate Operations, stated that the corporation hired Staff LL based on the documented experience in advocacy for elder care and long-term care operations and marketing. Staff P stated that they were unaware that Staff LL did not meet the qualifications for the administrator position upon hire.

This is an uncorrected deficiency previously cited on 10/19/2023.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 03/25/24.

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

Nichelle D. Graham
Administrator (or Representative)

03/07/24
Date

WAC 388-78A-2970 Garbage and refuse disposal. The assisted living facility must:

- (1) Provide an adequate number of garbage containers to store refuse generated by the assisted living facility:
- (c) Cleaned and maintained to prevent:
 - (i) Entrance of insects, rodents, birds, or other pests;
 - (iii) Other nuisances.

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This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain 1 out of 1 outdoor garbage containers. This failure placed all residents at risk for potential pest infestations.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 10/19/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/15/2024.

Observation during the environmental tour on 01/29/2024 at 12:15 PM, showed one garbage dumpster and one recycling dumpster, located behind the facility, accessible through the parking lot. The garbage container lid was bent, which left a gap between the lid and container. The size of the gap was five to six inches wide. The damaged lid on the container was large enough for rodents or other pest to easily access the garbage inside.

Observation on 01/30/2024 at 11:10 AM, showed one garbage dumpster and one recycling dumpster, located behind the facility, accessible through the parking lot. The garbage container lid was bent and propped open, which left an opening estimated to be four feet by seven feet between the lid and container. Facility staff were notified of the open dumpster. Observation on 01/30/2024 at 3:28 PM, showed the garbage bin remained propped open.

During an interview on 01/30/2024 at 3:30 PM, Staff LL, Executive Director, stated that the damaged containers were readily accessible, and many times homeless individuals foraged in the containers. Staff A stated that they were unaware of the condition of the container.

This is an uncorrected deficiency previously cited on 10/19/2023.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 03/07/24.

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

Michelle D. Graham
Administrator (or Representative)

03/07/24
Date

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WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure window screens were appropriately placed and maintained without rips, tears, and intact frames on 17 of 218 (screen 1 to screen 17) operable, exterior windows throughout the facility. This failure placed all residents at potential risk of possible illness from unnecessary airborne contamination or insect and rodent borne diseases.

Findings included...

Record review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 10/19/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/15/2024.

Observation during the environmental tour on 01/30/2024 at 11:15 AM with Staff KK, Activity Program Director, showed there were 12 screens missing on operable, exterior windows. Observation showed there were five screens with tears, holes, and bent/broken frames on operable, exterior windows. The missing and damaged screens were on both the first and second floors of the facility. Observation showed screens were missing from the windows of residents' rooms.

During an interview on 01/30/2024 at 12:15 PM, Staff A confirmed that there were several windows with missing and broken screens. Staff A stated that they were unaware there were screens missing from so many of the windows.

This is an uncorrected deficiency previously cited on 10/19/2023.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 03/12/24.

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

Michelle D. Graham
Administrator (or Representative)

03/07/24
Date

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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;
- (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 observation and interview the facility failed to provide a clean, safe, and well-maintained environment. This failure placed all residents at risk of injury and a diminished quality of life.

Findings included...

Record review of the Department of Social and Health Services "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 10/19/2023. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/15/2024.

INDOOR COMMON AREAS

Observations on 01/29/2024 at noon showed the common areas and hallways throughout the facility were carpeted. Observations showed the carpets were significantly stained with multiple dark brown and black areas that varied in size. Observations showed the carpets were torn and frayed in multiple doorways areas. Observations showed multiple ceiling ventilation screens in the dining room, activity room, activity room kitchen, medication room, and hallways covered with dust, grime, and water stains.

Observations on 01/29/2024 at 12:05 PM in the main dining room showed a table in disrepair with loose leg supports and dust and cobwebs visibly hung from multiple ceiling light fixtures. Observations in the dining showed dietary staff wiped tables with a moist cloth. All the tables in the dining room were wiped by the same moistened cloth without the cloth being re-moistened and sanitized after each table was cleaned. Observations showed the dining tables covered with food crumbs and sticky areas.

Observation on 01/29/2024 at 12:10 PM in the first-floor activity room showed worktables held dirty dishware and food debris. The activity room furniture was stained and dirty. The activity room kitchen counter tops, dining table, stove, microwave oven and toaster oven were dirty and sticky.

During an interview on 01/30/2024 at 10:24 AM, Staff O, Chef, acknowledged that the dining table was in disrepair. Staff O further stated that they attempted to repair the dining

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table. Staff O stated that there were things in the facility that needed repairs and the repairs were not addressed.

During an interview on 01/31/2024 at 5:35 PM, Staff LL stated that building maintenance and repairs remained unresolved and were in progress for resolution.

RESIDENT APARTMENTS

Observation of Resident 21's apartment on 01/30/2024 at 12:15 PM showed one clothes closet with two sliding doors. Further observation showed one of the closet doors was detached from its sliding track at the top and the door leaned against the residents' clothes.

Observation of Resident 7's apartment on 01/30/2024 at 12:20 PM showed two clothes closets with sliding doors. Further observation showed three of four closet doors were detached from its sliding track at the top and the doors leaned against the residents' clothes.

Observation on 01/30/2024 at 12:20 PM showed Staff KK, Activity Program Director, attempt to lift the closet door in Resident 7's apartment to reset the door on to the top sliding track. Staff KK was unable to lift the door. Staff KK left the door leaning on the clothing that hung in the closet.

During an interview on 01/30/2024 at 12:15 PM, Staff KK stated that the closet door design throughout the facility was the same in all resident rooms. Staff KK stated the closet doors easily detached from the sliding tracks, located at the top of the doors. Staff KK stated that residents should not be expected to reattach the doors to the sliding tracks. Staff KK stated that the maintenance staff would be notified.

This is an uncorrected deficiency previously cited on 10/19/2023.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 03/28/24.

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

Michelle D. Graham
Administrator (or Representative)

03/07/24
Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

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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 on 09/18/2023 and 09/27/2023 of:

Brookdale Federal Way
31002 14th Ave S
Federal Way, WA 98003

The following sample was selected for review during the unannounced on-site visit: 61 of 86 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Angelica Rios, ALF Licenser
Steven Garrett, LTC Licenser
Laurie Anderson, Community Field Manager
Thomas Forkgen, ALF Licenser
Jane Hermans, NCJ
Claudia Machado, Community Complaint Investigator
Michelle Yip, ALF Licenser

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Laurie Anderson

Residential Care Services

11/02/2023

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)

11/10/2023
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(c) Other conditions that may require behavioral intervention strategies;

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence, and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to assess safety considerations for medical devices and smoking for 7 of 51 sampled residents (Resident 11, Resident 12, Resident 16, Resident 17, Resident 22, Resident 23, and Resident 37). This failure placed residents at risk of injury including entrapment and burns.

Findings included...

MEDICAL DEVICES

Review of the Department of Social and Health Services "Dear Provider Letter", dated 05/15/2013, showed a letter was issued to Assisted Living Facility Providers related to the safety risks associated with the use of all medical devices. The letter showed some

examples of medical devices with known safety risks when used include transfer poles, Posey or lap belts, and side bed rails. Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted.

During an interview on 09/18/2023 at 9:55 AM Staff A, Executive Director, stated that there were no residents that used any medical devices, such as bed enablers. Staff A stated that if there were any residents that used a bed enabler, an assessment would have been completed.

RESIDENT 11

Review of Resident 11's Personal Service Plan (PSP) dated 08/04/2023, showed Resident 11 transferred independently. The service plan did not identify that Resident 11 used a Halo device (a circular mobility transfer device). Further review of Resident 11's records showed no assessment for any medical device.

Observation of Resident 11's apartment on 09/18/2023 at 3:20 PM showed an adjustable bed with a Halo safety ring mounted to the right side of the bed. Observation showed the Halo device was securely attached to the bed.

During an interview on 09/18/2023 at 3:20 PM, Resident 11 stated that they used the Halo device to pull themselves up, and to get in-and-out of the bed. Resident 11 did not recall if the facility assessed the device for function, purpose, and safety.

RESIDENT 12

Observation of Resident 12's apartment on 09/27/2023 at 10:42 AM showed a bed cane installed on the left side of the bed. Further observation showed the bed cane was not secured to the bed frame. With minimal effort, the bed cane moved out of place when pulled.

During an interview on 09/27/2023 at 12:50 PM Staff S, Clinical Nurse Specialist, stated that they were unaware of Resident 12's bed cane. Staff S stated that an assessment for a medical device was not completed. Staff S further stated that they were aware of the requirement to complete an assessment for medical devices.

RESIDENT 16

Review of Resident 16's PSP dated 04/26/2023 showed they used a transfer pole. Review of Resident 16's facility records showed no documentation Resident 16 used a bed cane. Further review of Resident 16's record showed no assessment for any medical device.

Observation of Resident 16's apartment 09/21/2023 at 1:30 PM showed a bed enabler installed on the right side of their bed. The device was not secured and leaned towards the mattress. The bedrail was not fastened to the bed frame. With minimal effort, the bedrail slid out from under the mattress, away from the bed, and towards the floor.

During an interview on 09/21/2023 at 1:30 PM, Resident 16 stated that their son installed the bed cane for them about five months ago. Resident 16 stated that without the device they would not be able to lift themselves off their bed. Resident 16 stated the bed enabler has been in its current state of disrepair for several weeks. Resident 16 stated that staff were aware of device's condition. Resident 16 stated that the facility neither monitored nor maintained the bed cane for them.

During an interview on 09/26/2023 at 12:45 PM, Staff S stated they were aware Resident 16 used a bed cane. Staff S stated that they were aware of the requirement to complete an assessment for medical devices. Staff stated a medical device assessment for a bed enabler was not completed.

RESIDENT 17

Review of Resident 17's facility records showed no documentation Resident 17 used a bed enabler. Further review of Resident 17's records showed no assessment for any medical device.

Observation of Resident 17's apartment on 09/24/2023 at 1:30 PM showed a bed enabler made of PVC pipe (plastic pipe used for plumbing) mounted on the right side of their bed. The enabler was 18 inches in height, 19 inches in width and taped together with painter's tape.

During an interview on 09/25/2023 at 1:30 PM, Resident 17 stated that their late spouse made the bed enabler for them. They stated that they used the bed enabler since they moved into the facility in 2023. Resident 17 stated that facility staff did not assess the device to ensure it was safe to use.

During an interview on 09/26/2023 at 12:45 PM, Staff S stated that they were unaware of Resident 17's bed enabler. Staff S further stated that a medical device assessment was not completed.

RESIDENT 22

Review of Resident 22's "Assessment Summary", dated 05/22/2023, showed that Resident 22 had a history of falls and required a bedside mobility device. Further review of Resident 22's records showed no medical device assessment.

Observation of Resident 22's apartment on 09/26/2023 at 8:35 AM showed there were two halo bed enablers installed. Each enabler was attached to the sides of a hospital bed.

During an interview on 09/26/2023 at 8:35 AM, Resident 22 stated that when the facility replaced the bedrails with two different bed enablers, the facility told them only the halo bed enablers were allowed. Resident 22 stated that the facility did not explain the risks and

safety concerns for the use of bed enablers to them. Resident 22 stated that the facility did not assess the use of the bed enablers. Resident 22 stated that the halo bed enablers were not useful to them.

During an interview on 10/05/2023 at 3:22 PM, Staff B, Health and Wellness Director, stated that they were aware Resident 22 used a bed enabler. Staff B further stated that they did not complete a medical device assessment for Resident 22 when they completed the annual assessment this year. Staff B stated that they were aware of the requirement to complete an assessment medical devices.

RESIDENT 23

Review of Resident 23's "Assessment Summary", dated 07/16/2023, showed no documentation Resident 23 used a bedrail. Further review of Resident 22's records showed no assessment medical device assessment.

Observation of Resident 23's apartment on 09/20/2023 at 10:45 AM showed that there were two half-length bedrails, each bedrail attached to each side of a hospital bed. Observation showed the bedrail on the left side of the bed was loosely attached. Observation showed the left-sided bedrail moved toward and away from the mattress by touch. Further observation showed a three-inch gap between the bed mattress and the left-sided bedrail.

During an interview on 09/20/2023 at 10:45 AM, Resident 23 stated that they used the bedrails since they moved into the facility in [REDACTED] 2023. Resident 23 stated that they used the bedrails to get in and out of the bed every day. Resident 23 stated that the facility staff did not assess the bedrail for proper use. The staff did not explain the safety concerns of the bedrails. Resident 23 stated that the facility did not monitor or maintain the bedrails. Resident 23 further stated that they were unable to tighten the bedrails when the bedrails loosened from the bed frame.

During an interview on 09/20/2023 at 12:45 PM, Staff S stated that they were unaware of Resident 23's bedrails. Staff S stated that they did not complete Resident 23's admission assessment.

During an interview on 10/05/2023 at 3:22 PM, Staff B stated that they were unaware of Resident 23's bedrails. Staff B stated that they did not complete an assessment for any medical device when they completed Resident 23's initial assessment in [REDACTED] 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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

Glenna Winkett
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2160 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
- (3) Any public or private case manager for the resident, if available

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure for 3 of 5 sampled residents' (Resident 3, Resident 7, and Resident 9) Personal Service Plan (PSP) were updated and signed annually. This failure placed Resident 3, Resident 7, and Resident 9 at risk of being uninformed about their assessed care and services and the potential for unmet care needs.

Findings included...

Review of the facility's "Assisted Living Facility Resident Characteristic Roster", dated 09/18/2023, showed that the facility admitted Resident 3 in [REDACTED] 2022, Resident 7 in [REDACTED] 2019, and Resident 9 in [REDACTED] 2016. The document showed that Resident 3, Resident 7, and Resident 9 received [REDACTED] paid services.

RESIDENT 3

Review of Resident 3's previous PSP, dated 05/16/2022, showed no resident or representative signature, no facility signature, no case manager's signature, and no date of agreement to the plan. Review of the current PSP, dated 05/22/2023, showed no resident or representative signature. There was no facility representative signature. There was no case manager signature. There was no date of agreement to the plan by the resident, facility, and case manager.

RESIDENT 7

Review of Resident 7's previous PSP, dated 11/17/2021, showed no resident or representative signature, no facility signature, no case manager's signature, and no date of agreement to the plan. Review of Resident 7's current PSP, dated 08/09/2023, showed that on 08/20/2023, Resident 7's legal representative and the facility signed the PSP three days after the state licensors initiated the full licensing inspection and informed the facility of the deficiency.

RESIDENT 9

Review of Resident 9's previous PSP, dated 01/18/2022, showed no resident or representative signature, no facility signature, no case manager's signature, and no date of agreement to the plan. Review of Resident 9's current PSP, dated 02/16/2023, showed no resident or representative signature. There was no facility representative signature. There was no case manager signature. There was no date of agreement to the plan by the resident, facility, and case manager.

During an interview on 10/03/2023 at 10:52 AM, Collateral Contact 1 (CC1), Home and Community Services Case Manager, stated that the Department required the facility to send the updated PSP for Medicaid residents to the case manager. CC1 stated that the case manager reviewed the updated plans when received from facilities. CC1 stated that this facility did not consistently send them the updated PSP for Medicaid residents. CC1 stated that in March 2023, Resident 3 converted to [REDACTED] services and CC1 was the assigned case manager. CC1 stated that the facility did not send them Resident 3's PSP for review after Resident 3 started on [REDACTED] services.

During an interview on 10/05/2023 at 3:22 PM, Staff B, Health and Wellness Director, stated that the facility's Health and Wellness Director, licensed nurses, or designated staff were responsible to complete the PSP initially at the admission then annually for all residents. Staff B stated that whoever completed the PSP then obtained the resident or representative's signature. Staff B stated that the facility required a family conference when staff completed the PSP. Staff B stated that at the family conference, they explained the PSP and obtained the signature from the resident or representative. Staff B stated that they were unaware that some residents' PSPs were not signed and dated, as required.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

Glenn Winkert
Administrator (or Representative)

11/10/2023
Date

WAC 366-78A-2180 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement medication and treatment regimen as agreed upon in the Personal Service Plan (PSP) for 3 of 3 sampled residents (Resident 18, Resident 22, and Resident 23). Additionally, the facility failed to provide shower/bath assistance as agreed upon in the PSP for 2 of 2 sampled residents (Resident 5 and Resident 23). These failures placed the residents at risk for worsening medically diagnosed conditions and unmet care needs.

Findings included...

RESIDENT 18

Review of Resident 18's "Personal Service Plan" (PSP), dated 03/04/2023, showed that Resident 18 was diagnosed with [REDACTED] [REDACTED]. The PSP showed that Resident 18 needed their medications crushed and put in apple sauce or pudding. The PSP showed that Resident 18 chose to have the medications crushed and to swallow them with thin liquids. The PSP also showed that staff prepared Resident 18's medications and handed the medications to Resident 18.

Observation of Resident 18's apartment on 09/21/2023 at 12:15 PM, showed a medication cup sat on a coffee stand. The cup contained seven pills. Observation showed no water or other fluids available for Resident 18 to drink when they took the medications.

During an interview on 09/21/2023 at 12:16 PM, Resident 18 stated that the Medication Technician (unlicensed person who assists and administers medications) provided the medication around noontime. Resident 18 stated that two of the pills were too large for them to swallow. Resident 18 stated that the large pills needed to be crushed and mixed in applesauce. Resident 18 also stated that their primary provider wrote an order for the two pills to be crushed. Resident 18 stated that the facility provided no assistance to crush the pills. Resident 18 stated that their family purchased a pill crusher that Resident 18 used to crush their own pills on a regular basis.

RESIDENT 22

Review of Resident 22's "Admission Record", dated 09/20/2023, showed that the facility admitted Resident 22 in [REDACTED] 2018. The record showed Resident 22 admitted with medical diagnoses that included [REDACTED] and [REDACTED]. Review of the facility's document titled "Order Summary Report" for Resident 22, dated

09/26/2023, showed the provider's orders of "change suprapubic (above the pubic bone) drain sponge every day after cleaning area with wound cleanser or normal saline, then pat dry and apply dry drain sponge". The report showed two prescriptions. Nystatin Powder (a medication treats fungal or yeast infections of the skin) 100000 Unit/Gram, applied to panus [sic] (abnormal tissue) topically every day and Polysporin Ointment (an antibiotic medication that treats or prevents skin infection) 500-10000 Unit/Gram, applied to suprapubic area topically every day.

Review of Resident 22's "Assessment Summary", dated 05/22/2023, showed that Resident 22 required assistance with daily medicated lotions, cream, or ointments. The assessment showed that Resident 22 required routine urinary catheter and ostomy care. Review of Resident 22's "Skin Observation Form", dated 03/21/2021, showed that the facility last completed a skin assessment over two years ago.

Review of Resident 22's PSP, dated 05/22/2023, showed that Resident 22 had a suprapubic catheter (a hollow flexible tube that is inserted to the lower abdomen and used to drain urine from the bladder) with a catheter bag. The PSP showed that facility staff were responsible to assist with perineal (the bodily part between the thighs) care, catheter care, and emptying the catheter bag. The PSP showed that Resident 22 experienced leakage from the suprapubic catheter. The PSP showed facility staff were responsible to provide skin check and skin care. The PSP showed no instructions to staff how often to provide skin check and skin care.

Review of Resident 22's "Treatment Administration Record (TAR)", dated between June 2023 and September 2023, showed that facility staff signed off the dressing change and topical application. The TAR showed that Resident 22 completed the dressing change and topical application by themselves.

Observation on 09/20/2023 at 8:35 AM, Resident 22 pulled up the shirt to show their lower abdomen to the Licensors. As Resident 22 raised their shirt, a bandage soaked with discharge and unpleasant smell fell off. Observation of Resident 22's abdomen showed a suprapubic urinary catheter (a tube that drains urine from the bladder) inserted to the lower abdomen and connected to a catheter bag. Observation showed redness of the skin around the catheter exit site and the lower abdomen.

During an interview on 09/20/2023 at 8:36 AM, Resident 22 stated that they had a skin infection around the catheter site and the lower abdomen. Resident 22 stated that their doctor ordered a change of the catheter bandage and topical medication applied daily. Resident 22 stated that they were unable to see their lower abdomen so they were unable to independently perform the bandage change and application of medication. Resident 22 stated that the facility staff were responsible to clean the catheter exit site, change the bandage at the catheter exit site, and apply ointment to the abdominal area. Resident 22 stated that the facility staff last changed the bandage and applied ointment for them on 09/17/2023. Resident 22 stated that they were concerned their skin infection was worsened.

During an interview on 09/20/2023 at 10:15 AM, Staff S, Licensed Practical Nurse, Clinical Nurse Specialist, stated that they were unfamiliar with Resident 22's physician orders and treatments. Staff S stated that they did not know when their staff last changed Resident 22's dressing and applied the topical medication.

During an interview on 09/27/2023 at 11:20 AM, Staff J, Medication Technician, confirmed stated that staff did not change Resident 22's sponge of the suprapubic catheter and did not apply the topical medication to the area since Resident 22 self-administered their own care. Staff J stated that the former Health Wellness Director's instructed them to sign off the orders on Resident 22's TAR. Staff J reported that they just signed off the orders on the TAR. Staff J stated that they did not ensure Resident 22 change the sponge and apply the topicals.

During an interview on 10/05/2023 at 3:22 PM, Staff B, Registered Nurse, Health and Wellness Director, stated that after the former nurse resigned in July 2023, they were informed of Resident 22's suprapubic catheter. Staff B stated that the former nurse provided Resident 22's catheter and skin care. Staff B stated that the medication technicians were responsible to monitor and provide the catheter and skin care. The technicians were instructed to notify Staff B when there was any concern. Staff B stated that they were unaware the staff did not provide the care, as listed on Resident 22's PSP.

RESIDENT 23

Review of Resident 23's "Admission Record", dated 09/27/2023, showed that the facility admitted Resident 23 in [REDACTED] 2023. The record showed Resident 23 admitted with medical diagnoses that included [REDACTED].

Review of Resident 23's PSP, dated 07/16/2023, showed that Resident 23 required stand-by assistance with the use of oxygen or respiratory equipment and showers. The PSP showed that the staff would assist Resident 23 with any aspects of these tasks that the Resident 23 was unable to complete. The PSP also showed that the staff would assist as needed and report to license nurse.

Review of the facility's document titled "Shower and Refusal Log" showed that between [REDACTED]/2023 and 08/23/2023, there was no documentation that showed the facility provided Resident 23 any assistance with showers. There was no documentation that showed Resident 23 refused shower assistance.

Observation on 09/26/2023 at 10:30 AM showed Resident 23 walked with a four-wheel walker. Observation showed that as Resident 23 walked, they became short of breath. Resident 23 paused multiple times to catch their breath while they walked down the hallway to their apartment. Observation of Resident 23's room showed an oxygen concentrator (a medical device that supplies oxygen) was plugged into the wall with a coil of nasal cannula tubing (a tube that delivers oxygen through the nose) connected to it.

During an interview on 09/26/2023 at 10:30 AM, Resident 23 stated that they required oxygen therapy. Resident 23 stated the oxygen company supplied the oxygen and maintained the oxygen equipment for them. Resident 23 stated that staff provided no assistance to Resident 23 with their oxygen use and equipment care. Resident 23 stated that the facility billed them for these oxygen services even though there was no assistance provided. Additionally, Resident 23 stated that they received no staff assistance with showers between [REDACTED] 2023 and August 2023. Resident 23 stated that the facility billed them for shower assistance, even though there was no assistance provided.

During an interview on 09/26/2023 at 2:00 PM, Staff J, Medication Technician, and Staff DD, Medication Technician, stated that they were unaware Resident 23 used oxygen.

During an interview on 09/26/2023 at 2:01 PM, Staff BB, Medication Technician, reported that Resident 23 used oxygen independently. Staff BB stated that they did not provide Resident 23 assistance with their oxygen therapy.

During an interview on 09/26/2023 at 12:27 PM, Staff Q, Assistant Executive Director, Brookdale Foundation House, stated that after staff provided shower assistance to the resident, staff were required to document the assistance provided on the shower log in the resident's record. Staff Q also stated that when the resident refused shower assistance, staff were required to document the refusal on the shower log in the resident's record. Staff Q stated they were unaware that the staff kept a binder of shower and refusal log to record shower assistance provided and offered. Staff Q further stated that if staff assistance or resident refusal were not documented in the shower log, then no assistance or refusal occurred.

During an interview on 09/27/2023 at 3:05 PM, Staff Q, confirmed that the facility was responsible to provide Resident 23 with oxygen care and service and shower assistance. Staff Q stated that they were unaware that staff did not provide Resident 23 with the care and services as agreed upon in the PSP.

RESIDENT 5

Review of Resident 5's resident record showed that the facility admitted Resident 5 in [REDACTED] 2020. Review of Resident 5's undated PSP showed that Resident 5 admitted with a diagnosis of [REDACTED] in their shoulder. Resident 5 had problems raising their left arm up. The PSP showed that Resident 5 required assistance with shower. The PSP also showed that Resident 5 preferred their shower/bath days on Wednesday and Sunday.

Review of the facility's document titled "Shower and Refusal Log" showed that between 05/25/2023 and 06/10/2023, between 06/19/2023 and 07/01/2023, between 07/03/2023 and 07/11/2023, between 07/13/2023 and 08/06/2023, and between 09/10/2023 and 09/24/2023, there was no documentation that showed the facility provided Resident 5 with weekly shower assistance. There was no documentation that showed Resident 5 refused any shower assistance offered by the staff.

During an interview on 09/20/2023 at 12:40 PM, Collateral Contact 3 (CC 3), Resident 5's representative, stated that the facility inconsistently provided a bath to Resident 5 every week. CC 3 stated that unless Resident 5's family requested it, the facility did not provide Resident 5 a weekly shower. CC 3 stated that there were some weeks when Resident 5 did not get a shower or bath. CC 3 stated that they requested for Resident 5's shower record. CC3 stated that the facility never provided the record. CC 3 stated that they were concerned about Resident 5's personal hygiene needs being unmet.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

Glenn Wickoff
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2180 Activities. The assisted living facility must:

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

This requirement was not met as evidenced by:

Based on observation, interview, and record review Assisted Living Facility (ALF) failed to provide activities for 86 of 86 residents (Resident 1 to Resident 86). This failure placed all 86 residents at risk for decreased quality of life and a lack of a home-like environment.

Findings included...

Review of the ALF's undated Disclosure of Services showed structured activities were offered throughout the day, to serve a variety of residents' needs and preferences. The life enrichment program includes music, arts, crafts, wellness, exercise, outings, socials, and other past times. A posted schedule indicates current events.

Review of the facility's website and marketing materials advertised daily activities

During an interview on 09/20/2023 at 12:40 PM, Collateral Contact 3 (CC 3), Resident 5's representative, stated that the facility inconsistently provided a bath to Resident 5 every week. CC 3 stated that unless Resident 5's family requested it, the facility did not provide Resident 5 a weekly shower. CC 3 stated that there were some weeks when Resident 5 did not get a shower or bath. CC 3 stated that they requested for Resident 5's shower record. CC3 stated that the facility never provided the record. CC 3 stated that they were concerned about Resident 5's personal hygiene needs being unmet.

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 Federal Way 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-2180 Activities. The assisted living facility must:

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

This requirement was not met as evidenced by:

Based on observation, interview, and record review Assisted Living Facility (ALF) failed to provide activities for 86 of 86 residents (Resident 1 to Resident 86). This failure placed all 86 residents at risk for decreased quality of life and a lack of a home-like environment.

Findings included...

Review of the ALF's undated Disclosure of Services showed structured activities were offered throughout the day, to serve a variety of residents' needs and preferences. The life enrichment program includes music, arts, crafts, wellness, exercise, outings, socials, and other past times. A posted schedule indicates current events.

Review of the facility's website and marketing materials advertised daily activities

scheduled from crafting classes to Bible study. The website showed the facility advertised a B-Fit exercise program designed to give you a fun social fitness experience, scheduled excursions to nearby restaurants, shops, and social attractions. The website and brochure showed that with a social calendar full of engaging activities, classes, and outings, there was always something interesting to do.

Observations from 09/18/23 to 09/21/2023 between 7:00 AM and 4:00 PM and 09/25/2023 to 09/27/2023 between 8:00 AM and 4:00 PM, showed the facility did not provide any structured activities facilitated by the facility staff. Further observation showed no posted schedule of facility arranged activities. Observations showed residents walked around in the facility, went outside to smoke, or went to the store. Request for the facility's activity calendar for August 2023 and September 2023 found the facility did not have any activity calendar for residents. Observation showed the facility did not have an activity program or activity director or assigned staff to provide activities.

During an interview on 09/18/2023 at 11:03 AM, Staff A, Executive Director, stated that the facility did not currently have an Activities Director. Staff A stated that the facility's last, most recent activity calendar was from February 2023. Staff A stated that the activity room was always open and had craft supplies. Staff A stated the activity room also had a television available for residents. Staff A stated the facility did not organize, schedule, or conduct activities for residents. Staff A stated that the facility did not have a bus driver to drive the facility's activity bus. Staff A stated that it was the Activity Director's responsibility to drive the bus. Staff A stated that the facility currently did not provide transportation services for residents to go on shopping trips, restaurant outings, medical appointments, or church services. Staff A stated, "I'm trying to hire someone for activities. I haven't had anyone apply who can drive the van ... and that's part of the job description."

RESIDENTS

Review of the facility's document titled "Assisted Living Facility Resident Characteristic Roster", dated 09/18/2023, showed that the facility admitted Resident 1 in [REDACTED] of 2023, Resident 3 in [REDACTED] 2022, Resident 8 in [REDACTED] 2019, Resident 9 in [REDACTED] 2018, and Resident 10 in [REDACTED] 2009.

RESIDENT 1

Review of Resident 1's Personal Service Plan (PSP), dated [REDACTED]/2023, showed that facility staff were to involve Resident 1 in community activities and encourage Resident 1 to participate in the "B-Fit" exercise program.

During an interview on 09/20/2023 at 1:51 PM, Resident 1 stated "there are no activities" in the facility.

RESIDENT 3

Review of Resident 3's PSP, dated 05/22/2023, showed that Resident 3 mobilized with a wheelchair and required exercise. The PSP showed that the facility was responsible to encourage participation in the facility exercise programs.

During an interview on 10/03/2023 at 11:23 AM, Resident 3 stated that for months now, the facility did not provide activities for them. Resident 3 stated that they enjoyed going out in the facility's van for an activity. Resident 3 stated that the facility fired the former van driver, and the facility never replaced them. Resident 3 stated that the facility stopped the van service and provided no activities outside the facility for them.

RESIDENT 8

Review of Resident 8's PSP, dated 07/16/2023, showed that Resident 8 required exercise. The PSP showed that the facility was responsible to encourage Resident 8's participation in the exercise programs.

During an interview on 09/20/2023 at 10:42 AM, Resident 8 stated that the facility did not have activities for them. Resident 8 stated that they liked riding the facility van to go out. Resident 8 stated that the facility had not provided van service for a long time. Resident stated the last time they rode the facility van was over a year ago.

RESIDENT 9

During an interview on 09/18/2023 at 2:45 PM and on 09/19/2023 at 11:25 AM, Resident 9 reported that the ALF had not offered activities for the residents since February 2023. Resident 9 stated that Staff A told Resident 9 that the facility was in the process of hiring a new Activities Director. Resident 9 stated that since the former Activities Director left, the facility had not hired or assigned anyone to lead the activity program. Resident 9 stated that the facility did not have a van driver and there were no activities offered outside of the facility. Resident 9 also stated that some of the residents tried to organize activities on their own. Resident 9 stated that personally, they needed the activities to keep them going. Resident 9 stated that the residents missed the fitness activities, crafts, and outings. Resident 9 further stated that they were a member of the ALF's Resident Council and regularly received complaints from other residents about the lack of activities.

RESIDENT 10

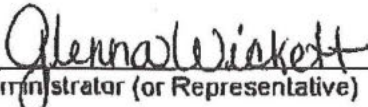
Review of Resident 10's PSP, dated 08/10/2023, showed that Resident 10 had a history of depression. Further review of the PSP showed facility staff were to encourage Resident 10 to participate in the "B-Fit" program and encourage Resident 10 to participate in programs "as a means to increase observations". The PSP showed Resident 10 used the facility "activity bus" to go shopping and attend church services.

During an interview on 09/20/2023 at 1:51 PM, stated "there are no activities offered here".

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

 Administrator (or Representative)	11/10/2023 Date
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WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(a) Provide a minimum of three meals a day:

(i) At regular intervals;

(c) Ensure all menus:

(iv) Are kept at least six months;

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered.

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(3) The assisted living facility may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

(a) Modified or therapeutic diets;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide specialized diets for 21 Residents (Resident 2, Resident 3, Resident 4, Resident 6, Resident 8, Resident 9, Resident 10, Resident 25, Resident 26, Resident 32, Resident 45, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 80, and Resident 61). The facility failed to provide snacks for 86 Of 86 residents (Resident 1 to Resident 86) This failure put the residents at risk for compromised health and unmet nutritional needs.

Findings included...

Review of the Assisted Living Facility's (ALF) undated Disclosure of Services showed that in addition to the Regular diet, the ALF provided the following therapeutic diets: no added salt (also known as a low sodium diet), controlled/consistent carbohydrate diet (a diet in which the portions of carbohydrate-rich foods are served in fairly equal amounts) for residents with diabetes (a condition where the body has difficulty managing blood sugar levels), mechanical soft (a diet in which meat is chopped or ground, raw fruits and salads are provided as tolerated), pureed (a diet in which all food is pureed based on menu items offered for the above diets). The Disclosure of Services also showed that the ALF may

accept or retain a resident that required a liberalized renal diet (a diet that eliminates all or most of the potassium, sodium, and phosphorus sources in food) at the "discretion of the community Executive Director" based on the needs of the individual resident or collective community.

Review of the ALF's Diet Manual, dated May 2013, showed that the diet manual was to be used as a reference guide to for ALF Staff to ensure that the Regular and all therapeutic diets were planned and prepared as ordered by the resident's physician. The Diet Manual also stated that any menu served in the ALF will be consistent with Community Diet Manual.

Review of the ALF's Characteristics Roster, dated 09/18/2023, showed that only two residents received a therapeutic diet. The Characteristics Roster identified 16 residents diagnosed with [REDACTED].

Review of the ALF's Main Kitchen White Board, located on the wall at the front of the kitchen and service line, showed 15 residents identified to receive a controlled/consistent carbohydrate Diet. The Main Kitchen White Board also identified two residents as vegetarian and one listed as vegan.

SPECIALIZED DIETS

RESIDENT 2

Review of Resident 2's Personal Service Plan, (PSP) dated 03/17/2023, showed Resident 2 had diabetes. The PSP showed that Resident 2 required a controlled/consistent carbohydrate diet.

During an interview, on 09/19/2023 at 2:08 PM, Resident 2 reported that the ALF regularly served bread, pasta, and other highly processed foods. Resident 2 stated that the facility seldom served fruit with their meals. Resident 2 stated that they were not given a choice of low-sugar desserts.

RESIDENT 3

Review of Resident 3's resident record showed that the ALF admitted Resident 3 in [REDACTED] 2022. Review of Resident 3's PSP showed that Resident 3 was to receive a "regular meal portion".

During an interview, on 10/03/2023 at 11:23 AM, Resident 3 stated that the food was "inconsistent and bad." Resident 3 stated that they rated the food quality a two on a 10-point scale. Resident 3 stated that they liked vegetables, and the facility did not provide enough fresh vegetables. Resident 3 stated the food portions were small and they received only one sausage link for breakfast. Resident 3 stated the food was often cold and tasted like it was uncooked. Resident 3 stated that they found mold on their toast at least twice in the past. Resident 3 stated that they were concerned about weight loss.

RESIDENT 4

Review of Resident 4's Admission Assessment, dated 06/06/2023, showed that Resident 4 did not eat meat or seafood and was on a controlled/consistent carbohydrate diet. This preference was reflected on Resident 4's PSP, dated 06/24/2023.

During an interview, on 09/20/2023 at 11:05 AM, Resident 4 stated the food was, "garbage." Resident 4 stated that consistently received carbohydrate-rich foods and meat for their meals. Resident 4 stated "I don't eat meat".

During an interview, on 09/19/2023 at 8:10 AM, Collateral Contact 4 (CC4) Resident 4's Representative, stated that when Resident 4 moved in, Staff FF, Former Marketing Director, told CC4 that vegetarian diets were available. CC4 stated that after Resident 4 moved in, Staff FF stated that the Chef did not prepare vegetarian meals.

RESIDENT 6

Review of Resident 6's resident record showed that the ALF admitted Resident 6 in [REDACTED] 2023. Review of Resident 6's PSP, dated 03/05/2023, showed that Resident 6 requested a vegetarian diet, and that the ALF would "provide a vegetarian diet".

During an interview, on 09/20/2023 at 9:20 AM, Resident 6 stated that when they admitted, they notified the ALF they were vegetarian, and they did not eat meat. Resident 6 stated that in August 2023, when they were on COVID isolation in their apartment, the ALF delivered their meals to their room. Resident 6 stated that they were not asked what they would like to eat, and that food was just delivered. Resident 6 said that there were meat dishes on their meal trays. Resident 6 stated that the ALF Staff did not provide them with enough water during the isolation period. Resident 6 stated that the ALF Staff did not come into the apartment to check whether Resident 6 had enough water to drink or that they were hydrated.

RESIDENT 9

Review of Resident 9's resident record showed that the ALF admitted Resident 9 in [REDACTED] 2010. Review of Resident 9's PSP, undated showed that Resident 9 was on a carbohydrate-controlled diet.

During an interview on 09/19/2023 at 11:25 AM, Resident 9 stated that the facility used to provide a bowl of fresh fruits for residents at 10:00 AM and 3:00 PM which stopped during the summer. Resident 9 stated that snacks were not available during the day and food was not available from the kitchen after 7:00 PM. Resident 9 stated that they were to have a high protein diet and instead were provided a diet that was high in carbohydrates. Resident 9 stated that they could not eat any type of gravy and the facility offered no alternative options. Resident 9 also stated that they required a high protein diet and instead the facility provided food high in carbohydrates and food that was not nutritious. Resident 9 stated that the facility did not provide a special diet to meet their dietary needs.

RESIDENT 45

Review of the ALF's Resident Characteristics Roster, dated 09/18/2023, showed that the ALF admitted Resident 45 in [REDACTED] 2023.

During an interview, on 09/25/2023 10:23 AM, Resident 45 stated that when they moved in, they were assured by Staff I, Business Office Manager, that meals could be saved if a resident was at an appointment during the mealtime. Resident 45 stated that on four occasions after a dialysis appointment, they returned to the ALF and did not receive dinner. Resident 45 stated that the ALF Staff did not save a dinner meal as requested. Resident 45 stated one night, a night shift ALF Staff Member gave Resident 45 their lunch because Resident 45 was hungry and needed to eat after dialysis and was taking a phosphorous binder (a medication that reduces the amount of phosphorus entering the blood). The ALF Staff Member offered Resident 4 the meal because there was no access to the kitchen and there were no snacks available for the residents. Resident 45 stated that the few times a meal was saved for them after an appointment, it was left in their apartment, which was not placed in the refrigerator and instead, left out with no temperature control. Resident 45 stated they did not eat the food out of concern the food would make them sick. Resident 45 stated that on weekends, "it's a carnival in the dining room." Resident 45 stated that on a Sunday in June, there was no kitchen staff on premises and the front desk reception person ordered pizza for the residents' dinner.

There were similar findings for Residents 8, 9, 10, 25, 26, 32, 52, 53, 54, 55, 56, 57, 58, 59, 60, and 61 who were, per the ALF's Resident Characteristics Roster, identified as diabetic.

MENUS

Review of the facility's menus for the month of September 2023 showed menus for three meals a day. Review of the menus showed multiple selections of carbohydrate rich food items for lunch and dinner.

Observations on 09/18/2023, 09/19/2023, 09/21/2023, 09/26/2023, and 09/27/2023, showed Staff EE, line cook, plated food during the lunch hour. Observation showed that Staff EE used the same serving utensil and plated approximately the same portion size of foods for all residents.

During an interview, on 09/25/2023 at 12:32 PM, Staff EE, Cook, stated they followed the menu and had no idea whether the food provided met the requirement for a controlled/consistent carbohydrate diet or met the nutritional requirements for residents with diabetes. Staff EE stated they were not aware of the ALF's Diet Manual and did not use it.

Review of the ALF's menus showed that there were no weekly menus for March 2023 through July 2023.

During an interview, on 09/19/2023 at 1:52 PM, Staff YY, Business Office Manager, stated that after the chef and cook walked out in February 2023, they took responsibility for operating the kitchen. Staff YY stated that they would look to see what food the facility had available and determine what to cook for the day. Staff YY stated that they did not always remember to do a daily menu due to working in two departments. Staff YY stated that they lived close by and felt responsible for the residents so they would come in on weekends and other times of the day to fill in if there was no cook. Staff YY stated they were not able to provide weekly menus or special menus, and not able to prepare therapeutic diets. Staff YY stated that the previous systems to monitor quality food control, inventory, and cleaning schedules were not continued due to staffing issues. Staff YY stated they continued to manage the kitchen in this manner until Staff O, Chef, was hired on 07/05/2023 to fill the position.

During an interview, on 09/18/2023 at 1:21 PM, Staff O, stated that prior to their arrival there were no menus. Staff O stated they initiated a weekly menu.

During an interview, on 09/25/2023 at 12:22 PM, Staff O stated that they have not had an opportunity to review the ALF's Diet Manual due to staff shortages and their need to work as the line cook. Staff O stated that they were aware several residents were on controlled/consistent carbohydrate diets. Staff O stated that they do not provide a controlled/consistent carbohydrate diet. Staff O stated that they asked the cooking staff why they used so many carbohydrate-rich foods. Staff O stated that the only item the ALF provided specifically for residents with diabetes was sugar-free ice cream. Staff O stated that they doubted that Staff EE knew what a controlled/consistent carbohydrate diet was.

Observation showed the ALF had a Diet Manual, dated 08/29/2023. The Diet Manual was still wrapped in plastic and was not placed into binder.

During an interview, on 10/19/2023 at 12:43 PM, Staff GG, Receptionist, stated that on 6/18/2023 there was no cook to prepare the dinner meal. Staff GG stated that they were concerned for the residents, and they contacted Staff A, Executive Director. Staff GG stated that some of the residents suggested pizza and Staff A authorized the purchase. Staff GG stated that they ordered three types of pizza. Staff GG stated they were not aware that some of the residents were vegetarian or vegan and therefore did not order any vegetarian or vegan pizza options. Staff GG stated that the kitchen struggled on weekends with staff shortages, which affected the food service.

SNACKS

Review of the ALF's undated Disclosure of Services showed that the ALF would provide three meals per day and offer nutritious snacks for the residents.

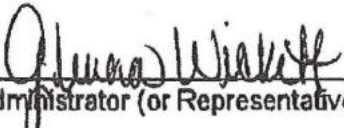
On 09/19/2023 at 1:45 PM, Resident 11 reported that the ALF did not offer any snacks since moving into the ALF. Resident 11 stated that the ALF Staff only put bowls of fresh fruit, juice, and coffee out during ALF tours, "pretending that's what it's like all the time".

During an interview on 09/19/2023 at 1:35 PM, Resident 21 stated that when they moved in, ALF Staff said there was always fresh fruit and snacks available. Resident 21 stated that they have not found that to be true. Resident 21 stated that the ALF Staff, "lock things up so tight" that the ALF Staff cannot even go into the kitchen or pantry to get something to

eat.

During an interview, on 09/19/2023 at 3:20 PM, Staff A stated the ALF Staff always had access to the kitchen and could get snacks for the residents outside of mealtimes upon their request.

During interview, on 09/19/2023 at 4:50 PM, Staff P, District Director of Operations, Corporate, stated the kitchen and kitchen storage areas were kept locked because, "the residents and staff were using them like they're personal grocery shops."

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>12/15/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/10/2023</u> Date

WAC 246-215-02310 Hands and arms When to wash (FDA Food Code 2-301.14).
 foodemployees 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:

(5) After handling soiled equipment or utensils,

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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to implement systems to ensure all dishwashing staff performed proper handwashing between the handling of soiled dishes to clean dishes, the main kitchen dishwasher temperatures reached the required temperatures for sanitation, temperatures for hot and cold foods were held at the correct temperatures, and dining room tables, silverware, and condiment items were cleaned in-between meal services. This failure placed all the of residents living at the ALF at risk for foodborne illness and cross-contamination.

Findings included...

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

Review of the ALF's policy titled "Hot Holding," dated 2005, stated, "temperatures must be monitored by taking the innermost temperature with a thermometer and recorded".

Review of the ALF's document, policy titled "Chilling and Cooling," dated 2005, stated, "cold foods must be held at 40 degrees Fahrenheit or lower at all times." The policy stated that food temperatures were to be taken and recorded every 30 minutes. The policy stated, "cold foods being held for meal service should be placed in an ice bath or any other method of maintaining cold temperatures in accordance with state regulations".

WASHING DISHES

Observations made on 09/19/2023 between 9:33 AM and 9:50 AM, showed Staff M, Sous Chef, utilized the ALF's main kitchen dishwasher to wash soiled dishes. Staff M wore disposable gloves while they washed the soiled dishes and placed them in a rack to run through the dishwasher. Staff M continued to wear the same pair of gloves to put away the clean pots and pans from the clean side of the dishwasher. Staff M did not change their disposable gloves or wash their hands between washing the soiled dishes and putting away the clean dishes.

Observations made on 09/19/2023 between 11:45 AM and noon showed Staff M utilized the dishwasher, to wash soiled dishes. Staff M wore disposable gloves while they washed the soiled dishes and placed them in a rack to run through the dishwasher. Staff M continued to wear the same pair of gloves to put the clean rack of dishes away. Staff M did not change their disposable gloves or wash their hands between the two tasks. Staff M was observed to repeat this process several times.

Observations made on 01/19/2023 between 5:33 PM and 5:45 PM, showed Staff N, Server, spray off soiled dishes, pots, and pans, and then placed them in dishwasher rack and then through the ALF's main kitchen high-temperature dishwasher. Staff N then, while wearing the same pair of gloves, went to the clean side of the dishwasher and put away clean dishes. Staff N repeated the same process without changing their gloves or washing their hands between the two tasks.

During an interview, on 01/19/2023 at 5:50 PM, Staff O, Chef, stated that when staff wash dishes, they are supposed to wash their hands or change their gloves between handling the soiled and clean dishes.

HIGH TEMPERATURE DISHWASHER

Observations made on 09/18/2023 at 1:21 PM, showed a high temperature dishwasher in the main ALF kitchen. Observation showed the rinse cycle reached 179 degrees Fahrenheit (F) and not 180 degrees F. There was no dishwasher temperature log to review. The facility did not have a system in place to regularly monitor the dishwasher temperature to ensure it consistently met requirements.

During an interview, on 09/18/2023 at 1:21 PM, Staff O stated that they were relatively new and did not have the opportunity to review all the kitchen systems. Staff O stated they

would call the dishwasher company to come in immediately to address the temperature issue. Staff O stated they would implement a system and initiate a temperature log to monitor the dishwasher temperature to ensure it operated within the correct temperature range of 180 or higher.

FOOD TEMPERATURES

During observation, on 09/21/2023 at 12:15 PM, Staff EE, cook, removed the foil from the four-inch pans of hot foods that were sitting in the steam table wells. Staff EE was observed plating the hot food for service. Staff EE did not take the temperatures of the hot foods.

Review of the kitchen food temperature logs showed that the date of the last recorded food temperatures was on 02/24/2023.

During an interview, on 09/21/2023 at 12:25 PM, Staff EE stated they adjusted the hot foods temperature by adjusting the controls of the steam table. Staff EE adjusted the control knobs to demonstrate what they do to increase or decrease the temperature of the steam wells. Staff EE stated that they did not take the temperature of the food when cooking the food or prior to food service.

During an interview, on 09/21/2023 at 12:30 PM, Staff O stated that the kitchen did not have any temperature logs for food. Staff O stated that the temperature log stopped when the previous chef left in February 2023.

COLD FOOD HOLDING

Observation on 09/19/2023 at 12:30 PM, showed sandwiches and beet salad in an uncovered clear plastic container on the service counter next to the steam table. There was no ice bath container for the cold foods to be set in. The service counter had no cold food holding storage.

Observation on 09/20/2023 at 12:40 PM, showed sandwiches sitting in a plastic container with no ice and no cold food holding provided during the lunch service.

During an interview, on 09/20/2023 at 12:50 PM, Staff O stated that the sandwiches were to be kept in the reach in refrigerator during lunch service and pulled out as needed.

DINING ROOM SANITATION BETWEEN MEALS

Failed properly clean and sanitize the main dining room after meals. See WAC 388-78A-2610 for observed deficiency.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

Glenn Wickett
Administrator (or Representative)

11/10/2023
Date

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

(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:

(b) Chapter 18.88A RCW, Nursing assistants;

(d) Chapter 246-841 WAC, Nursing assistants; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to develop an operational system for nurse delegation to ensure the safe delivery of nurse delegated services to 13 of 13 residents (Residents 2, 8, 10, 15, 25, 26, 27, 28, 29, 30, 31, 32, and 33). This failure placed all 13 residents at risk for receiving unsafe nurse delegated services from unsupervised and improperly trained staff.

Findings included...

Review of Washington Administrative Code (WACs) 246-840, 246-841, 246-888, and review of the Revised Code of Washington (RCW) 18.78, 18.88A showed that the components of for intermittent nursing services are; Signed consent forms for all residents who received nurse delegation services, written instructions for medication and task delegated i.e., insulin administration, ensuring Nurse Delegation documentation and instruction was available to staff delegated to administer and perform task; provide the four follow-up visits required for delegation of insulin administration, and review delegated staff credentials to they are qualified to be delegated prior to nurse delegation.

Review of the ALF's undated document titled "Disclosure of Services Required by RCW 18.20.300," showed the ALF provided intermittent nursing services and medication assistance that included administration of insulin injections by non-licensed staff through nurse delegation.

Review of the ALF's document titled "Nurse Delegation Policy-WA-27," dated January 2023,

showed that the ALF required all nurse delegation to be done in accordance with the State requirements. The policy showed they were written in line with the WACs and RCWs reviewed above.

CONSENTS

Review of the ALF's nurse delegation documentation showed there were no signed consents for nurse delegation services for Residents 2, 8, 10, 15, 25, 26, 27, 28, 29, 30, 31, 32, and 33.

During an interview, on 09/21/2023 at 4:44 PM, Staff B, Registered Nurse, Health and Wellness Director, acknowledged the resident nurse delegation consents were not signed by the residents who received nurse delegation services, or their representatives.

INSULIN ADMINISTRATION

Review of the ALF's undated "Staff Roster" showed that the ALF hired: Staff B, on 01/30/2023, Staff C, Resident Care Coordinator / Medication Technician (a non-licensed staff who assists with the administration of medications and under nurse delegation, which includes administering insulin injections, abbreviated as Med Tech) on 08/04/2023, Staff J, Medication Technician, on 07/10/2023, Staff W, Resident Care Coordinator/Medication Technician, on 10/06/2022; and Staff W, Medication Technician on 03/25/2022.

RESIDENT 8

Review of Resident 8's "Admission Record," dated 09/18/2023, showed that the ALF admitted Resident 8 in [REDACTED] 2019. Resident 8 admitted with a medical diagnosis of [REDACTED] ([REDACTED]).

Review of Resident 8's Personal Service Plan (PSP), dated 07/16/2023, showed that Resident 8 was unable to check their own blood sugar and unable to self-administer insulin. The PSP showed that a licensed nurse monitored the blood glucose levels and administered insulin for Resident 8.

Review of the ALF's nurse delegation documentation, dated 08/08/2023, showed that Resident 8 received nurse delegation for blood sugar check and insulin administration.

Review of the ALF's document, titled "Nurse Delegation: Nursing Visit," showed that on 08/08/2023, Staff B delegated nursing services to three staff: Staff C, Staff J, and Staff W. The document showed that Staff B did not delegate any nursing services to Staff X. Staff B documented they verified the staff credentials and nurse delegation training completion for the delegated staff. There was no documentation that showed Staff B supervised and evaluated Staff C, Staff J, and Staff W insulin administration weekly for the first four weeks, as required.

Review of Resident 8's Treatment Administration Records (TARs) for June 2023, July 2023, August 2023, and September 2023, showed that Resident 8 received long-acting insulin (a

medication used to control high blood sugar over a longer period of time), via a KwikPen (a prefilled disposable pen that contains multiple unit doses of insulin with that can be adjusted by a dial) based on orders to inject seven units subcutaneously (inject under the skin) and to inject an amount of insulin based on Resident 8's blood glucose level subcutaneously three times a day. The TAR showed that Staff C administered both orders twenty-six times. The TAR showed that Staff W administered both orders 157 times in June 2023, July 2023, and August 2023. The TAR showed Staff W signed they administered insulin injections 127 times prior to being delegated on 08/08/2023. The TAR showed Staff J administered both orders forty times for Resident 8. The TARs showed that Staff X administered both orders on 09/01/2023 and 09/08/2023 to Resident 8. Staff X was not delegated to do so at that time.

During an interview, on 09/20/2023 at 10:55 AM, Resident 8 stated that they received blood sugar checks and insulin injections from ALF Staff. Resident 8 stated that they were unable to use needles and do finger sticks on themselves.

RESIDENT 9

Review of the Resident 9's Nurse Delegation Instructions, dated 08/08/2023, showed that Resident 9 received insulin via KwikPen. The Nurse delegation Instructions provided the delegated staff with step-by-step instructions on how to administer insulin appropriately.

Observation on 09/19/2023 at 5:20 PM showed Staff C used a regular insulin syringe (insulin syringes have marks that measured by units) for long-acting insulin and a Monoject Tuberculin (also known as a TB syringe) for short-acting insulin. Staff C drew an unidentified amount of Admelog insulin from a vial. Observation showed Staff C used the TB syringe to inject the insulin into Resident 9's right arm. Staff C administered the insulin to Resident 9 in the main dining room in front of Resident 9's table mates and other residents who were sitting at adjoining tables.

Observation, on 09/19/2023 at 5:20 PM, showed Staff C used a standard insulin syringe (insulin syringes have marks that show the number of units drawn) to draw long-acting insulin out of a multi-dose vial. Staff C then used a Monoject Tuberculin Syringe (also known as a TB syringe which has marks indicating the number of milliliters) to draw an unknown amount of short-acting insulin (insulin that was designed to operate for a shorter period of time). Staff C approached Resident 9 in the main dining room, seated at a table with other residents sitting nearby. Staff C administered both insulins into Resident 9's right arm.

During an interview on 09/19/2023 at 5:13 PM, Staff C stated that Resident 9 did not use an insulin pen. Staff C stated that Resident 9's insulin came in multi-dose vials provided by Staff B along with the syringes for insulin injection. Staff C stated that they used the TB syringe when they gave the short acting insulin, as they pointed at a used Monoject Tuberculin syringe on the medication tray. Staff C stated that they gave the second insulin injection, the long-acting insulin, using a 1a standard insulin syringe, as they pointed at a used insulin syringe on the medication tray. Staff C stated that Staff B was the registered nurse delegator. Staff C stated that they were delegated by Staff C to administer insulin to residents who required nurse delegation services for insulin administration which included

Resident 9. Staff C stated they completed the required delegation training for nurse delegation and diabetes. Staff C stated that Staff B initially delegated them on 08/12/2023. Staff C stated that when they were initially delegated Staff B provided verbal instructions, demonstrated blood sugar checks, demonstrated insulin subcutaneous injections, and then watched them do a return demonstration. Staff C stated that Staff B observed them for the first week before they were allowed to independently administer insulin injections to residents. Staff C stated that during the first three weeks there were days there was no nurse on duty. Staff C stated that when Staff B was not around, they would ask other medication technicians to watch them administer insulin to residents.

During an interview on 09/20/2023 at 8:56 AM, Staff C stated they would not normally use a TB syringe for insulin. Staff C was unable to provide an explanation as to why they used a TB syringe for Resident 9's short-acting insulin the evening before other than they were nervous. Staff C was unable to show how much insulin they drew up in the TB syringe to equal 5 units of the short-acting insulin ordered for Resident 9. Staff C initially stated, "maybe 0.5 milliliters or less," then stated that they made a "guesstimate" as to how much short-acting insulin to draw up with the TB syringe.

NURSE DELEGATION BINDER ACCESS

During an interview, on 09/21/2023 at 4:44 PM, Staff B stated that they kept the Nurse Delegation Documentation in a binder (Nurse Delegation Binder) which contained the instructions for delegated Med Techs was locked inside the Health and Wellness Director's office. Staff B stated that the Med Techs did not have access to the office or the Nurse Delegation Binder.

During an interview, on 09/18/2023 at 1:00 PM, Staff J, Med Tech, stated that Staff B delegated them to administer insulin. Staff J stated that they were not familiar with the Nurse Delegation Binder and did not know where it was kept.

During an interview, 09/19/2023 at 5:13 PM, with Staff C stated that Staff B delegated them to administer insulin. Staff C stated that they did not know where the Nurse Delegation Binder was kept.

INSULIN DELEGATION VISITS

Review of the Nurse Delegation Binder showed multiple Nurse Visit records for Residents 2, 15, 26, 27, 29, 31, and 33. The Nurse Visit records showed the initial visit for the delegation of insulin administration for each resident. There were no additional records to show that any follow-up visits took place.

During an interview, 09/19/2023 at 10:00 AM, Staff J stated they were shown by Staff B how to administer insulin. Staff J stated they were delegated to administer insulin at the last ALF where they worked. Staff J stated that other nurses and Med Techs observed them dispense medications and administer insulin during their training and orientation period.

During an interview on 09/19/2023 at 5:19 PM, Staff C stated that Staff B completed the

initial delegation insulin administration education training. Staff C stated that another Med Tech shadowed them during their orientation on the medication care and observed them for insulin administration.

During an interview on 09/21/2023 at 4:44 PM, Staff B confirmed that they delegated Staff C for insulin administration. Staff B stated that the ALF recently implemented the nurse delegation program and assigned they were chosen to be the ALF's Registered Nurse Delegator (RND). Staff B stated that they verified the delegated staffs' credentials and nurse delegation training certificates prior to delegation. Staff B stated that when beginning the delegation process, they spend one day with the ALF Staff member to go through the training which included how to do a blood sugar checks, insulin injection, and the application of eye drops and topicals. Staff B stated that they demonstrated the procedures to the ALF staff member and then the ALF staff did a return demonstration. Staff B stated they document all the trainings in the Nurse Delegation Binder. Staff B stated they were unaware that part of the Nurse Delegation process was to conduct four additional visits (one visit a week) to observe and supervise the delegated ALF staff. Staff B stated that they did not do the four weekly visits to ensure the delegated staff administered insulin injections to the residents correctly. Staff B stated that they did not teach Staff C to use a TB syringe to draw up insulin. Staff B did not respond when asked why Staff C used a TB syringe for the Resident 9's short acting insulin. Staff B did not respond when asked why Resident 9's Nurse Delegation Instructions showed delegated ALF staff were to use an insulin KwikPen and why there were no instructions on how to draw insulin from a multi-dose vial in an insulin syringe. Staff B stated that they did not do a delegation demonstration and observation for each individual resident who received nurse delegation services for insulin administration.

UNQUALIFIED STAFF ADMINISTERING INSULIN

Review of the undated ALF's Staff Roster showed that the ALF hired Staff X on 03/25/2022. Review of Staff X's Nurse Delegation Credential Verification document showed Staff X's Nurse Assistant-Certified was current, expiring on 06/03/2024. The ALF documentation showed Staff X completed the Department of Social and Health Services nine-hour core nurse delegation course on 09/28/2023, and the three-hour special focus on diabetes course on 09/29/2023. The verification document was signed by Staff Z on 09/29/2023 to show they verified Staff X's credentials.

During an interview on 10/05/2023 at 3:22 PM, Staff B reported that they and Staff Z, Registered Nurse, Director of Clinical Services was the ALF's Registered Nurse Delegators. Staff B stated that when the ALF started the nurse delegation program, they delegated insulin administration to four medication technicians: Staff W, Staff C, Staff J, and former staff member, Staff CC, Med Tech. Staff C stated that there were three medication technicians currently delegated to administer insulin: Staff W, Staff C and Staff J. Staff B stated that they did not delegate any tasks to Staff X, Medication Technician, and did not know why Staff X administered insulin prior to being delegated. Staff B stated that they did not verify Staff X's credentials and nurse delegation certificates. Staff B stated that Staff X was a newly delegated medication technician, who was still in training with Staff Z. Staff B stated that they started nurse delegation training with Staff X in September 2023.

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

initial delegation insulin administration education training. Staff C stated that another Med Tech shadowed them during their orientation on the medication care and observed them for insulin administration.

During an interview on 09/21/2023 at 4:44 PM, Staff B confirmed that they delegated Staff C for insulin administration. Staff B stated that the ALF recently implemented the nurse delegation program and assigned they were chosen to be the ALF's Registered Nurse Delegator (RND). Staff B stated that they verified the delegated staffs' credentials and nurse delegation training certificates prior to delegation. Staff B stated that when beginning the delegation process, they spend one day with the ALF Staff member to go through the training which included how to do a blood sugar checks, insulin injection, and the application of eye drops and topicals. Staff B stated that they demonstrated the procedures to the ALF staff member and then the ALF staff did a return demonstration. Staff B stated they document all the trainings in the Nurse Delegation Binder. Staff B stated they were unaware that part of the Nurse Delegation process was to conduct four additional visits (one visit a week) to observe and supervise the delegated ALF staff. Staff B stated that they did not do the four weekly visits to ensure the delegated staff administered insulin injections to the residents correctly. Staff B stated that they did not teach Staff C to use a TB syringe to draw up insulin. Staff B did not respond when asked why Staff C used a TB syringe for the Resident 9's short acting insulin. Staff B did not respond when asked why Resident 9's Nurse Delegation Instructions showed delegated ALF staff were to use an insulin KwikPen and why there were no instructions on how to draw insulin from a multi-dose vial in an insulin syringe. Staff B stated that they did not do a delegation demonstration and observation for each individual resident who received nurse delegation services for insulin administration.

UNQUALIFIED STAFF ADMINISTERING INSULIN

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

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

Glenna Winkett
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

- (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and
- (4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to investigate unwitnessed falls that resulted in an injury for 2 of 2 residents (Resident 8, and Resident 12). The facility also failed to investigate change of health condition that resulted in hospitalization for 1 of 1 resident (Resident 3). These failures placed Resident 3, Resident 8, and Resident 12 at risk of additional harm and potential abuse and neglect.

Findings included...

Review of the facility policy document titled "How To – Complete the Assisted Living Incident Investigation Form", dated October 2018, showed that the facility required staff complete an internal investigation for any alleged incidents involving abuse, neglect, exploitation or mistreatment including injuries of unknown source. The document showed that the incident investigation included summary of incident, investigation, timeline, supporting documents, and immediate actions taken, other notifications, and post investigation actions.

RESIDENT 3

Review of the "TriMed Ambulance Report" showed that on [REDACTED] 2023, Resident 3 called for emergency medical service (EMS) due to troubled breathing, leg swelling, and inability to walk for two or three days. The document showed that EMS transported Resident 3 to the emergency room.

Review of the facility's documents titled "Incident log", dated between 06/01/2022 and [REDACTED]/2023, and "Preliminary Draft Notes of Reported Incidents", dated [REDACTED] 2023, showed no documentation of any incidents for Resident 3. There was no documentation that showed Resident 3 sought emergency medical care. There was no documentation that showed Resident 3 was hospitalized in [REDACTED] 2023.

Review of Resident 3's "Medication Administration Records (MARs)", dated between June 2023 and [REDACTED] 2023, showed that between 06/01/2023 and [REDACTED]/2023, the staff performed two-hour safety checks on Resident 3. The MARs showed no documentation staffed observed any medical concerns of Resident 3 during the safety checks.

Review of Resident 3's "Progress Notes", dated between 06/01/2023 and [REDACTED]/2023, showed no documentation that facility staff were aware Resident 3 was out of the facility when EMS transported Resident 3 to the emergency department on [REDACTED]/2023.

On [REDACTED]/2023 at 3:45 PM, Staff I, Business Office Coordinator, stated that they were unaware Resident 3 was transported to the emergency room and the reason for hospitalization. Staff I stated that the staff notified them today that Resident 3 was hospitalized since [REDACTED]/2023.

During an interview on 09/21/2023 at 11:38 AM, Staff B, Health and Wellness Director, stated that they were out of the facility between [REDACTED]/2023 and [REDACTED]/2023. Staff B stated that while they were absent, all resident incidents were reported to Staff A, Executive Director. Staff B stated that they returned to work on 09/21/2023. Staff B stated that no resident incidents were reported to them during their absence from work. Staff A stated that they were unaware Resident 3 admitted to the hospital. Staff B stated that there was no investigation completed by any other facility staff for Resident 3's incident.

On 09/21/2023 at 4:00 PM, Staff A stated that the facility required staff to investigate incidents that involved any resident sent to the hospital. Staff A stated that they were unaware EMS transported Resident 3 to the emergency room. Staff A stated they were unaware Resident 3 was hospitalized since [REDACTED]/2023. Staff A stated that the facility did not conduct any investigation to rule out any abuse and neglect for this incident that involved Resident 3.

RESIDENT 8

Observation on 09/20/2023 at 10:42 AM, showed Resident 8 had a one-inch laceration wound on the forehead above the left eyebrow. Observation showed the wound was closed and healing. The wound was not covered with dressing.

Review of the "TriMed Ambulance Report" showed that on 09/13/2023, the facility called EMS for Resident 8 due to loss of consciousness and head injury. The document showed that EMS transported Resident 8 to the emergency room.

Review of the facility's documents titled "Incident log", dated between 06/01/2022 and 09/18/2023, and "Preliminary Draft Notes of Reported Incidents", dated September 2023, showed no documentation of any incidents for Resident 8. There was no documentation that showed Resident 8 sought emergency medical care. There was no documentation that showed Resident 8 was transported to the emergency department in September 2023.

During an interview on 09/20/2023 at 10:42 AM, Resident 8 stated that the forehead injury resulted from an unwitnessed fall that happened a few days ago. Resident 8 stated that they were alone in the apartment when the fall happened. Resident 8 stated that they did not know how the fall occurred. Resident 8 stated that they passed out after they fell. Resident 8 stated that they felt they were unconscious on the floor for three hours. Resident 8 stated that when they regained consciousness, they found themselves next to the recliner. Resident 8 stated that they crawled to the bathroom and pulled the cord for help. Resident 8 stated that an unidentified caregiver came to the room in response to the call. The caregiver called 911 for them. Resident 8 stated that they were transported to the emergency department for treatment and returned to the facility in the morning the next day.

On 09/21/2023 at 11:38 AM, Staff B stated that they were unaware Resident 8's fall and injury that occurred on 09/13/2023. Staff B stated that no staff reported to them on any resident incidents. Staff B stated that the facility staff did not investigate Resident 8's fall and injury.

On 09/21/2023 at 4:00 PM, Staff A stated that they were unaware Resident 8's fell and sustained a head injury. Staff A stated that the facility staff did not conduct any investigation related to Resident 8's fall to determine where, when, how, and why the injury occurred. The facility staff did not investigate the incident to rule out abuse and neglect.

On 09/27/2023 at 2:15 PM, Staff D, Medication Technician stated that on 09/13/2023, they were on duty for the night shift. Staff D stated that an unidentified caregiver notified them Resident 8 had a fall with injury in the apartment. Staff D stated that they went to Resident 8's apartment in response to the call. Staff D stated that while they were in Resident 8's room, they observed Resident 8 with a forehead injury. The bleeding had already stopped, and the blood was dried. Staff D stated that Resident 8 did not remember how the fall happened. Staff D stated that they called 911 for Resident 8. During the same interview, Staff D stated that they sent a telephone text message to Staff B that notified of Resident 8's incident. Staff D stated that they planned to complete an incident report the next day. Staff D stated that they forgot to complete an incident report, as required.

RESIDENT 12

Review of Resident 12's record showed the ALF admitted Resident 12 on [REDACTED]/2023 with multiple diagnoses. Resident 12's assessment, dated [REDACTED]/2023, showed Resident 12 had a history of falls.

Review of Resident 12's progress notes, dated 09/12/2023 at 2:21 AM, showed Staff CC documented that they received a phone call from Resident 12's Power of Attorney who

reported that Resident 12 fell in their room and did not receive any assistance for 45 minutes. Staff CC stated they told Resident 12's Power of Attorney that there were only two ALF Staff Members working that night and that they both were assisting other residents when Resident 12's call light turned on. Staff CC stated they went to Resident 12's room and observed Resident 12 on the floor in their room. Staff CC stated that Resident 12 reported right leg and knee pain and that Resident 12 was unable to bear weight on their right leg. Staff CC stated that Resident 12 reported they had already called for Emergency Services. Staff CC stated that Emergency Services took Resident 12 to the hospital for an evaluation.

During an interview, on 09/27/2023 at 10:50 AM, Resident 12 stated that they were concerned about their safety because the ALF Staff do not respond to residents' requests for assistance when a call bell or resident pendant device is activated. Resident 12 stated that they fell early in the morning on 09/12/2023. Resident 12 stated they called for Emergency Services as no staff came to their aid when using the communication system. Resident 12 stated that when they got back to the ALF, there was no nurse on duty and Emergency Services took them back to their room. Resident 12 stated they did not know if the ALF Staff knew they had been taken to the hospital. Resident 12 stated Emergency Services left their hospital discharge paperwork with them. Resident 12 stated that after they returned to the facility the facility nurse had not come to check on them or to do a re-assessment. Resident 12 stated that it took the facility several days before they received their pain medication.

Review of Resident 12's progress notes, dated 09/15/2023 at 5:57 PM, showed Staff X (Medication Technician), administered one tablet of a pain medication per Resident 12's request. Review of Resident 12's record showed no other documentation regarding the fall. Review of Resident 12's negotiated service agreement showed no updates or changes in interventions to reduce the risk of another fall or reduce the risk of injury should a fall occur.

During an interview on 09/21/2023 at 11:45 AM, Staff B stated that they were unaware of the fall. Staff B stated that they were not sure why the ALF Staff did not complete an incident report or update Resident 12's plan of care regarding the fall.

During an interview, on 09/21/2023 at 1:35 PM, Staff A was asked for an incident report for the unwitnessed fall and transportation to the hospital for Resident 12. Staff A stated that they were unaware of Resident 12's fall as they were out of the facility at that time. Staff A stated that they would try to locate an incident report for this occurrence.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/18/2023.

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

Glenn Winkett
Administrator (or Representative)

11/10/23
Date

WAC 365-76A-2400 Protection of resident records. The assisted living facility must:

- (1) Maintain a systematic and secure method of identifying and filing resident records for easy access;
- (2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 86 of 86 residents' (Resident 1 to Resident 86) medical records were securely stored for privacy. This failure placed Residents' personal information at risk of exposure to unauthorized persons and violated residents' right to privacy and confidentiality of their personal information.

Findings included...

Observation on 08/19/2023 at 11:05 AM, showed the first-floor medication cart in the hallway. Licensors observed the cart for 23 minutes, from 11:05 AM until 11:28 AM. During this time, no facility staff attended the medication cart. There were no facility staff visible anywhere in the first-floor hallway. Observation showed an open notebook laid on top of the medication cart. The notebook contained resident names, medication names, the resident diagnosis for which the medications were prescribed, dosages of the medication, and the schedule when residents received the medications. Further observations showed other residents and visitors to the facility walked by the unattended medication cart. Each person had the opportunity to view what was documented in the book.

Observation on 09/19/2023 at 1:05 PM, showed the second-floor medication cart located in the hallway, against the wall and next to the elevator doors. Licensors observed the cart for 15 minutes, from 1:05 PM until 1:20 PM. During this time, no facility staff attended the medication cart. There were no facility staff visible in the second-floor hallway. Observation showed a stack of nine medication bubble-packages (a packaging method used to keep individual doses of medications separated) laid on top of the medication cart. Each of the bubble-wrap packages were labelled with a resident name, name of the medication, reason for the medication, dosage of the medication, and the schedule when residents received the medications. Further observations showed three residents walked by

the unattended medication cart. Each person had the opportunity to view the information on the unsecured medication packages.

During an interview on 09/19/2023 at 2:50 PM, Staff A, Executive Director, stated that they were unaware of the unsecured resident information found in the medication notebook and the bubble-packaged medications on the carts. Staff A stated, "That's not supposed to happen. That's not what they're trained to do, I'll look into it".

Observation on 09/20/2023 at 2:05 PM, showed the second-floor supply room door unlocked. Observation inside the room showed seven cardboard boxes, without lids. Four of the cardboard boxes were labelled "Resident records", "thinned – archive 2022", "archive – do not discard 2020 – 22". The boxes contained loose pages of resident assessments, medication administration records, and resident billing.

On 09/20/2023 at 2:20 PM, the Licensors notified Staff A and Staff I, Business Office Manager, of the unsecure second-floor supply room that contained boxes of resident records. Staff A stated that they were unaware the room was unlocked. Staff A stated "That should be locked. They (the staff) know that, but they just leave it open". Staff I stated that they would secure the door immediately.

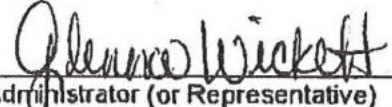
Observation on 09/20/2023 at 2:25 PM showed the second-floor medication cart located in the hallway, against the wall and next to the storage room, near room 278. Licensors observed the cart for 10 minutes, from 2:25 PM until 2:35 PM. During this time, no facility staff attended the medication cart. There were no facility staff visible in the second-floor hallway. Six empty medication bubble-packages and three full medication bubble-packages laid on top of the medication cart. Each of the bubble-wrap packages were labelled with a resident name, name of the medication, reason for the medication, dosage of the medication, and the schedule when residents received the medications.

Observation on 09/26/2023 at 11:05 AM showed the second-floor supply room door unlocked. Observation inside the room showed the same boxes of resident records as observed on 09/20/2023. At 11:55 AM, the Licensors again notified facility management staff, Staff Q, Interim Executive Director, and Staff A, of the unsecured supply room. Staff A stated that they would immediately secure the room.

Plan/Attestation Statement

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 Administrator (or Representative)	<u>11/10/2023</u> Date
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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;
- (d) Cardiopulmonary resuscitation and first aid; and
- (e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 6 of 7 staff (Staff A, Executive Director; Staff C, residential care coordinator/nursing assistant registered (NAR); Staff D, medication technician/nursing assistant registered (NAR); Staff E, caregiver/nursing assistant registered (NAR); Staff F, caregiver/nursing assistant certified (NAC); and Staff G, caregiver/nursing assistant registered (NAR) completed all required training to perform their job duties and responsibilities. This failure placed all the residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff A on 09/12/2022; Staff C on 08/04/2023; Staff D on 04/21/2020; Staff E on 11/04/2019; Staff F on 04/23/2015; and Staff G on 08/01/2014.

CPR and FIRST AID

Review of Staff C's undated personnel records showed on 08/26/2022, Staff C completed on-line cardiopulmonary resuscitation (CPR) training. The on-line training did not require Staff C to demonstrate hands-on skills proficiency for performing CPR. The on-line training did not meet Department of Social and Health Services (DSHS) regulatory training requirements. There was no documentation in Staff C's records that showed Staff C completed the required first aid training.

Review of Staff F's undated personnel records showed on 05/19/2022, Staff F completed on-line CPR training. The on-line training did not require Staff F to demonstrate hands-on skills proficiency for performing CPR. The on-line training did not meet DSHS regulatory training requirements. There was no documentation in Staff F's records that showed Staff F

completed the required first aid training.

CONTINUING EDUCATION

Review of Staff D's undated personnel records showed from 04/21/2020 through 09/27/2023, Staff D worked at the facility providing care and services for residents. There was no documentation in Staff D's records that showed Staff D completed the required twelve hours of annual continuing education.

Review of Staff E's undated personnel records showed from 11/04/2019 through 09/27/2023, Staff E worked at the facility providing care and services for residents. There was no documentation in Staff E's records that showed Staff E completed the required twelve hours of annual continuing education.

Review of Staff F's undated personnel records showed from 04/23/2015 through 09/27/2023, Staff F worked at the facility providing care and services for residents. There was no documentation in Staff F's records that showed Staff F completed the required twelve hours of annual continuing education.

HOME CARE AIDE CERTIFICATION

Review of Staff A's undated personnel records showed from 09/12/2022 through 09/27/2023, Staff A worked at the facility providing oversight of the care and services for residents, a total of 381 days. There was no documentation that showed Staff A completed the required Home Care Aide (HCA) certification.

During an interview on 09/20/2023 at 4:15 PM, Staff A stated that they were not a certified HCA. Staff A stated that on 07/28/2022, they completed the 70-hour basic training requirements. Staff A stated "they (the training program) told me that I had up to a year to take the HCA test and so I have not taken it yet." Staff A stated that they had not applied to take the HCA certification test.

Review of the Washington State Department of Health website, Provider Credential Search, on 09/27/2023, showed no documentation of Staff A's HCA certification record.

During an interview on 09/20/2023 at 4:25 PM, Staff A stated that they were unaware of the incomplete staff training records. Staff A stated that they were unaware Staff C and Staff F had not completed first aid training. Staff A stated that they were unaware Staff D, Staff E and Staff F had not completed continuing education requirements. Staff A stated that they (Staff A) were unaware they were required to obtain the HCA certification.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

Gleam Winkoff
Administrator (or Representative)

11/10/2023
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.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 7 staff (Staff A, Administrator, Staff B, Health and Wellness Director/registered nurse [RN], and Staff D, medication technician/nursing assistant registered [NAR]) were tested within three days of employment for tuberculosis, (TB), a serious respiratory disease. This placed all the residents at risk of contracting a contagious and serious illness.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff A on 09/12/2022, Staff B on 01/30/2023, and Staff D on 04/21/2020.

Review of Staff A's undated personnel records showed from 09/12/2022 through 09/27/2023, Staff A worked at the facility. Staff A supervised staff who provided care and services for residents. There was no documentation in Staff A's records that showed the facility screened Staff A for TB within three days of employment.

Review of Staff B's undated personnel records showed from 01/30/2023 through 09/27/2023, Staff B worked at the facility. Staff B provided care and services for residents. The records showed documentation that the facility screen Staff B for TB on 05/03/2023, 94 days after the date of employment.

Review of Staff D's undated personnel records showed from 04/21/2020 through 09/27/2023, Staff D worked at the facility. Staff D provided care and services for residents. There was no documentation in Staff D's records that showed the facility screened Staff D for TB within three days of employment.

During an interview on 09/20/2023 at 4.30 PM, Staff A confirmed that when they were hired, they were not screened for tuberculosis. Staff A confirmed that when Staff B was hired, Staff B was not screened for tuberculosis. Staff A confirmed that when Staff D was hired, Staff D was not screened for tuberculosis. Staff A stated that they were not aware that testing for tuberculosis was required for all facility staff within three days of employment.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/18/2023.

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

Glenn Winkert
Administrator (or Representative)

11/12/2023
Date

WAC 388-78A-2520 Administrator qualifications General.

(1) The licensee must appoint an administrator who is:

(c) Qualified to perform the administrator's duties specified in WAC 388-78A-2560 .

(2) The licensee must only appoint as an assisted living facility administrator an individual who meets the requirements of at least one of the following sections in WAC 388-78A-2522 through 388-78A-2527 .

This requirement was not met as evidenced by:

Based on record review and interview, the licensee failed to ensure 1 of 1 sampled staff (Staff A, Executive Director) met the Washington State qualifications and requirements to be an assisted living facility administrator. This failure placed all 86 facility residents at risk for unmet care needs by an untrained and unqualified staff.

Findings included...

Review of the facility staff records showed that the facility hired Staff A on 09/12/2022. Further review of available documents showed that Staff A did not meet the requirements to be a long-term care facility administrator as outlined in WAC 388-78A-2522 through WAC 388-78A-2527. There was no documentation that showed Staff A was previously employed as an assisted living facility administrator. There was no documentation that showed Staff A obtained certification for completion of administrator training and had three years paid experience providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults. There was no documentation that showed

Staff A obtained an associate degree in a related field of study, completed administrator training, and had two years paid experience providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults. There was no documentation that showed Staff A obtained a bachelor's degree in related field of study, completed administrator training, and had one-year paid experience providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults. There was no documentation that showed Staff A had five years of paid experience providing direct care to vulnerable adults or managing person who provided direct care to vulnerable adults.

During an interview on 09/20/2023 at 4:10 PM, Staff A stated that in their past employment, they had not provided direct care to vulnerable adults. Staff A stated that they had never provided supervision for individuals who provided care to vulnerable adults. Staff A stated that they received an associate degree in science. Staff A stated that they had management certificates as general managers for hotel management. Staff A stated that they did not have any certification or credentials as a Home Care Aide.

During an interview on 09/20/2023, at 4:30 PM, Staff P, District Director of Corporate Operations, stated that the corporation hired Staff A based on the documented experience as a manager in the hotel and hospitality industry. Staff P stated that they were unaware that Staff A did not meet the qualifications for the administrator position.

Plan/Attestation Statement

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Administrator (or Representative)

11/10/2023
Date

WAC 368-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to implement two

facility policies, one on oxygen management for 1 of 1 resident (Resident 23) and one on medication disposal for 8 of 8 sampled residents (Resident 20, Resident 62, Resident 6, Resident 12, Resident 26, Resident 42, Resident 15, and Resident 63). These failures placed all residents in the facility at risk of harm from improper oxygen management and Resident 6, Resident 12, Resident 15, Resident 20, Resident 26, Resident 42, Resident 62, and Resident 63 at risk of compromised health from receiving expired medications.

Findings included...

OXYGEN USE POLICY

Review of the facility's undated oxygen use policy titled, "Oxygen Tanks/Cylinders Safe Handling", showed the facility required posted signs outside any apartment doors where oxygen was used. The policy further required that staff ensure any oxygen cylinders in the facility were properly stored. The policy also showed staff were required to perform continuous equipment safety checks.

Review of Resident 23's Personal Service Plan (PSP), dated 07/16/2023, showed that Resident 23 used an oxygen concentrator (a respiratory equipment that supplies oxygen). The PSP showed that Resident 23 independently managed the oxygen and respiratory equipment.

Observation of Resident 23's apartment on 09/26/2023 at 12:45 PM showed an oxygen concentrator was plugged into the wall with a coil of nasal cannula tubing (a tube that delivers oxygen through the nose) connected to it. Observation showed Resident 23 was not wearing the nasal cannula in their apartment and the oxygen concentrator was running and connected to a coil of nasal cannula. Further observation showed eight oxygen cylinders stored in cardboard carriers were on the floor, by the window inside the apartment. Observation outside the apartment door showed no signs that oxygen was used in the apartment.

During an interview on 09/26/2023 at 12:45 PM, Staff S, Licensed Practical Nurse, stated that the facility's respiratory equipment service included assistance with proper storage of the oxygen tanks, reorder of oxygen supplies and posted signs outside areas in the facility where oxygen was used. Staff S stated that they were unaware Resident 23 used an oxygen concentrator. Staff S stated that they were unaware Resident 23 stored oxygen cylinders in the room. Staff S stated that without knowledge of oxygen used, Staff S did not perform safety checks as stated in the facility policy. Staff S stated they were unaware of any oxygen in use signs posted anywhere in the facility.

During an interview on 09/26/2023 at 12:45 PM, Resident 23 stated that they did not receive staff assistance storing oxygen tanks. Resident 23 further stated that staff did not perform equipment safety checks.

MEDICATION DISPOSAL POLICY

Review of the facility's policy titled "Unused medication disposal", dated 03/01/2003,

showed that staff were required to regularly inspect medication carts for expired medications. The policy further showed that staff were required to remove expired medications from the carts and dispose them per facility disposal guidelines.

Observation on 09/18/2023 at 1:20 PM showed Medication Cart 1 on the first floor contained two expired over the counter medications. The expired medications were prescribed for Resident 20. The Antacid expired on 09/01/2023 and a bottle of Centrum for Men 50 Plus expired on 09/12/2023.

Observation on 09/18/2023 at 1:40 PM showed Medication Cart 2 on the first floor contained expired medications. The expired medications were prescribed for Resident 62. There were two bottles of Furosemide (medication to help reduce water retention and swelling) on the cart. One bottle expired on 05/05/2023 and a second bottle expired on 08/17/2023.

Observation on 09/18/2023 at 3:00PM showed Cart 3 on the second floor contained expired medications. The expired medications were prescribed for Resident 6. Two cards of Senna -time (constipation), for a total of 60 pills, expired on 08/31/2023.

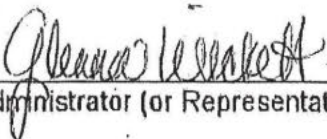
Observation on 09/18/2023 at 3:15 PM showed Cart 4 on the second floor contained expired medications. The expired medications were prescribed for several residents. Resident 12's stool softener expired on 04/22/2023. Resident 26's two full cards of acetaminophen (Tylenol) expired on 08/31/2023. Resident 42's Famotidine (acid reflux) expired on 08/31/2023, Vitamin D3 (supplement) expired on 04/07/2023, and a Dulera Inhaler (asthma) expired on 07/22/2023. Resident 15's Hydrochlorothiazide/Lisinopril (blood pressure medication) expired on 06/28/2023. Resident 63's Ferrous Sulfate (iron) expired on 01/06/2022, Docusate Sodium (stool softener) expired on 01/05/2022, Tizanidine (muscle relaxer) expired on 04/06/2020, Sertraline (antidepressant) expired on 01/08/2023, and Atorvastatin (lowers cholesterol) expired on 07/18/2023.

During an interview on 09/18/2023 at 1:15 PM, Staff J, Medication Technician (unlicensed staff who dispense and under nurse delegation administer medications), stated that there was no system in place to track and monitor the carts for expired medications. Staff J further stated that there were no medication cart inspections completed to dispose of expired medication.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

 Administrator (or Representative)	<u>11/21/2023</u> Date
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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:
- (a) Develop and implement a system to identify and manage infections;
 - (b) Restrict a staff person's contact with residents when the staff person has a known communicable disease in the infectious stage that is likely to be spread in the assisted living facility setting or by casual contact;
 - (c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;
 - (d) Provide all resident care and services according to current acceptable standards for infection control;
 - (e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;
 - (f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement infection control policies and requirements to protect 86 of 86 residents (Resident 1 through Resident 86) in the facility from an infectious illness. This failure placed all 86 residents at risk of contracting and spreading a potentially life-threatening disease.

Findings included...

The Centers for Disease Control and Prevention (CDC) developed guidelines for infection prevention and control practices for healthcare setting in response to respiratory hazards. The Washington State Department of Social and Health Services (DSHS), the Washington State Department of Health (DOH), and the Washington State Department of Labor and Industries (L&I), established the current standards of infection control to prevent and control the spread of respiratory infections, such as COVID-19, in healthcare settings.

Review of the Department's Secure Tracking and Reporting System (STARS) showed that on 08/25/2023, the facility experienced an infectious disease outbreak after one resident tested positive for COVID-19. Further review showed that on 08/30/2023, two additional residents tested positive for COVID-19.

Review of the facility's updated document titled, "Resident Community Outbreak Alert Log", dated 08/25/2023, showed that from 08/31/2023 and 09/21/2023, thirteen more residents tested positive for COVID-19.

During an interview on 09/20/2023 at 9:08 AM, Staff B, Health and Wellness Director, stated that on 08/31/2023 the facility notified the local health department, six days after the first COVID-19 case. Staff B stated that on 09/01/2023, the facility received the DOH guidance and toolkit about "COVID-19 Prevention for Healthcare Settings". Staff B further stated that they were unable to review the content of the DOH guidance.

RESPIRATORY PROTECTION PROGRAM

Review of the Department of Social and Health Services Dear Provider Letter titled "Provider Responsibilities for Provision of Personal Protective Equipment (PPE), Respiratory Protection Program (RPP), and Changes to the Department of Health RPP Resources", dated 09/14/2023, showed the guidelines for long-term care facilities (LTCF) and employer responsibilities for respiratory protection and RPP. The letter showed that Long-term Care (LTC) setting providers were required to supply PPE to staff who provided care to residents with known or suspected communicable disease. The letter also showed that employers were responsible to identify respiratory hazards in the workplace, provided appropriate respiratory protection equipment and follow regulations pertaining to respiratory protection.

Review of the facility's document titled "Respiratory Protection Program- 57", dated 01/15/2021, showed that the Executive Director or designee was the Respiratory Program Administrator. The document showed that the program administrator was responsible for the program that monitored respiratory hazards and conducted the program evaluations annually.

Observation on 09/19/2023 between 8:15 AM and 1:00 PM, showed Staff Y, Caregiver wore a surgical mask and delivered breakfast trays to two residents, both positive for COVID-19. Further observation showed Staff Y provided care to these two residents. Staff Y provided care without wearing a fit tested respirator.

During an interview on 09/18/2023 at 3:20 PM, Resident 11 stated that they were infected with COVID-19 from 08/30/2023 to 09/10/2023. Resident 11 stated that during this time, staff entered their apartment to provide care and services. Resident 11 stated when staff entered the apartment, the staff did not wear any respirator and inconsistently wore gowns.

During an interview on 09/19/2023 at 10:04 AM, Staff A, Executive Director, stated that they were unaware if the staff identified as at risk for exposure to a respiratory hazard were fit-tested for a respirator, as required. Staff A confirmed that the annual respirator fit tests were not completed for staff who previously completed the fit test.

During an interview on 09/18/2023 at 3:20 PM, Resident 11 stated that facility staff did not inform the residents about the outbreak. Resident 11 stated that they became aware of the outbreak when they saw the isolation cart outside another resident's room.

During an interview on 09/18/2023 at 3:45 PM, an unidentified resident stated that they learned about the facility's COVID-19 outbreak from other residents.

During an interview on 09/19/2023 at 10:04 AM, Staff A stated that the facility only notified the resident's family through phone calls for those residents who tested positive for COVID-19. Staff A stated that they did not communicate the outbreak to all residents or resident representatives.

SCREENING

Review of the facility's policy titled "COVID-19 Screening Policy- IC-11", revised date 10/05/2022, showed that all COVID-19 screening logs for the residents, visitors, and essential healthcare providers were kept in the Executive Director administrative files or in the medical records. The COVID-19 screening consisted of questions for individuals that entered the facility which included any signs and symptoms of COVID, any exposure to COVID, and any infection prevention practices completed by the person.

Observation on 09/18/2023 between 9:00 AM and 3:00 PM showed several individuals visited the community. Further observation showed the facility did not conduct any screening when visitors entered the building.

During an interview on 09/19/2023 at 10:04 AM, Staff A stated that the facility did not have COVID-19 screening logs. Staff A confirmed they did not initiate any COVID-19 screenings for residents, visitors, and outside health care providers.

DINING

Review of the facility's policy titled "Infection Control Policy- VA-12", revised date 05/20/2023, showed that the facility has procedures to sanitize, clean, and disinfect surfaces and equipment.

Observation of the main dining room on 09/18/2023 at 1:45 PM showed that an unidentified facility server removed the dirty plates from the tables and stacked them on the cart. The server emptied the cups and glasses in a green bucket on top of the same cart. The server wiped the table under the placemat, then wiped the placemat and reset the table for the next meal. Observation showed that after the server removed the dirty plates, silverware, and cups from the next two tables, the server used the same cloth to wipe down the tables. Observation showed the server did not rinse and sanitize the cloth between tables.

During an interview on 09/18/2023 at 2:00 PM, Staff O, Chef, stated that the facility

During an interview on 09/19/2023 at 12:16 PM, Staff K, Caregiver, stated that the facility did not fit test Staff K for a respirator. Staff J, Medication Technician stated that the facility did not fit test Staff J for a respirator.

TESTING

Review of the facility's document titled "COVID-19 Playbook", dated 09/05/2023, showed that the facility performed COVID-19 testing when required by the local health department.

Review of the Washington State Department of Health (DOH) toolkit titled "SARS-CoV-2 Infection Prevention and Control in Health Care Settings", dated 2023, received by the facility from DOH, showed that symptomatic residents should be tested immediately regardless of vaccination status. DOH further stated that a robust testing program identifies cases earlier, allowing early isolation, identification of people exposed and early source control interventions when indicated.

During an interview on 09/19/2023 at 2:08 PM, Resident 2 stated that on 08/23/2023, Resident 2 reported to facility evening staff about a sore throat and tiredness. Resident 2 stated that on 08/24/2023, Resident 2 still did not feel well. Resident 2 stated that they only left their room for meals in the dining room. Resident 2 stated that on 08/24/2023, they requested to be tested for COVID-19. Resident 2 stated that the facility did not complete the test, as requested. Resident 2 stated that on 08/25/2023, Resident 2's symptoms worsened with fever and shortness of breath. Resident 2 stated that they again requested a COVID test. Resident 2 stated that the facility complied with the second request. Resident 2 stated that they tested positive for COVID. Resident 2 stated that they were concerned that the delay of testing contributed to late medical treatment and isolation for Resident 2 which would have reduced the spread of the infection.

During an interview on 09/20/2023 at 9:20 AM, Resident 6 stated that in September 2023, they tested positive for COVID-19. Resident 6 stated that the facility did not test them for COVID-19 infection until they requested it. Resident 6 stated that on 09/07/2023, they felt sick while they visited a friend. Resident 6 stated that their friend tested them for COVID-19, which showed a positive result. Resident 6 stated that they returned to the facility and notified the facility the positive result. Resident 6 stated that the facility placed them in isolation. Resident 6 stated that while on isolation, the facility staff did not check on them to monitor for any change in condition. Resident 6 also stated that the facility did not re-test them for COVID-19 status until they requested it on 09/17/2023. Resident 6 stated that the facility then tested them, with negative results. Resident 6 stated that staff then informed them they could end their isolation.

NOTIFICATION AND COMMUNICATION

Review of the facility's COVID-19 Playbook showed that the facility used optional tools to communicate new positive cases to residents and families. The tools included a "24-hour letter" or a "Weekly Report" that summarized the positive cases. Further review of the document showed that the facility also used an option of "Talking Points" to notify associates, residents, and families.

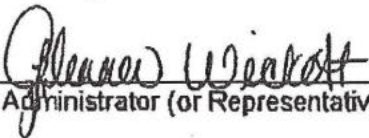
expected the dining staff to keep a sanitation bucket with sanitizing solution available when they cleaned the tables. Staff O further stated that the procedure included the dining staff sanitized wiping cloths during the in-between use and each time they wiped down a different table.

HOUSEKEEPING

Review of the facility's document titled "Fresh Impressions – Cleaning for Infection Prevention and Infection Control/Illness Outbreak", dated March 2023, showed that during outbreak the facility increased cleaning of high-touch surface areas to three times daily, each shift.

Observation on 09/19/2023 at 1:35 PM showed several residents moved about the activity room as they participated in activities. Observation showed the Activity Room was littered with used disposable cups and dessert plates that sat on top of a table and couch. During an interview at the same time, Resident 9 stated that the used cups and plates were from yesterday's card games. Resident 9 stated that the residents usually tidied up the activity room.

During an interview on 09/19/2023 at 10:04 AM, Staff A stated that housekeeping cleaned and sanitized the common areas twice daily, once at night and once in the morning. Staff A further stated that the housekeeping cleaned highly touched surface, as needed.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>12/15/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>11/10/2023</u> Date

WAC 388-76A-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 maintain current veterinarian pet records for 7 of 8 pets (Pet 1, cat, Pet 2, dog, Pet 3, dog, Pet 4, cat, Pet 5, cat, Pet 7, cat, and Pet 8, dog) that resided in the facility. This failure placed the residents at risk of contracting illnesses from unvaccinated or unhealthy pets living in the facility.

Findings included...

Observation on 09/18/2023 at 2:00 PM, showed several residents seated in the in the facility's common area. Observation showed the residents petted another resident's dog that resided in the facility.

Observation on 09/19/2023 at 9:20 AM, in the apartment where Pet 7 lived, showed Pet 7 rubbed against the legs of their owners and visitors. Observation showed a cat litter box was in the main area of the apartment. The room had a faint smell of waste and cat food. During an interview at this time, Resident 32, Pet 7's owner, stated that they scooped the waste in a plastic bag and threw in their garbage. Resident 32 stated that the facility's housekeeper emptied their garbage as needed.

Observation on 09/27/2023 at 7:56 AM, showed animal feces on the carpet, at the corner outside the main dining room. Observation showed the residents who walked by the feces avoided the mess as they walked towards the dining room. During an interview at this time, an unidentified resident stated that the feces was from the dog whose owner received their medication earlier that morning.

Review of the facility's undated document titled, "Disclosure of Services", showed the facility permitted pets with the condition stated in their pet policy. Review of the facility's document titled "Pet policy – OM 5", dated 05/2021, outlined that pets must maintain a regular veterinary examination and immunizations. The pet policy also showed that pets must be free of diseases transmittable to humans.

Review of the facility's pet binder showed there were eight pets that lived in the facility: five cats and three dogs. Review of the records showed no documentation that Pet 1, Pet 7, and Pet 8 received a veterinarian certificate that verified they were free of diseases transmittable to humans. Review of the records showed that Pet 2, Pet 4, and Pet 5 were due for a health examination. Further review of the records showed that Pet 3's rabies vaccine was due on 02/09/2023.

During an interview on 09/20/2023 at 11:40 AM, Staff I, Business Office Coordinator, stated that they were recently designated to maintain the pet records. Staff I stated that they were unaware of the pets who needed updated records.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

Jenna Wiakett
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(a) Maintain the premises free of hazards;

(c) Provide, and tell staff persons of a means of emergency access to resident-occupied bedrooms, toilet rooms, bathing rooms, and other rooms;

(d) Provide emergency lighting or flashlights in all areas accessible to residents of the assisted living facility.

(e) Make sure first-aid supplies are:

(i) Readily available and not locked,

(ii) Clearly marked;

(iii) Able to be moved to the location where needed; and

(iv) Stored in containers that protect them from damage, deterioration or contamination.

(f) Make sure first-aid supplies are appropriate for:

(i) The size of the assisted living facility;

(ii) The services provided,

(iii) The residents served; and

(iv) The response time of emergency medical services

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters including, but not limited to:

(i) On-duty staff persons' responsibilities,

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications, and

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on observation, record review, and interview the facility failed to maintain an emergency and disaster plan that provided information, operating procedures for internal and external disasters and essential supplies as required to provide care and services for 86 of 86 (Resident 1 to Resident 86) residents in the event of an emergency. This failure placed facility residents at risk for illness, injury, and potential loss of life in the event of a disaster.

Findings included...

DISASTER PLAN

Review of the unlabeled and undated red three ring binder, identified as the facility's "Disaster Manual", found: no information that instructed staff of their responsibilities in an emergency; no instructions on how to contact emergency personnel; no instructions on the procedure for evacuation of residents; no details that outline alternative resident accommodations, when needed; and no instructions that outlined the facility's emergency communication plan. The facility stored the binder on a shelf in Staff A, Executive Director's, office.

During an interview on 09/20/2023 at 2:30 PM, Staff A confirmed that the only copy of the emergency binder was kept in the Administrator's Office. Staff A stated that the office was kept locked unless Staff A was present at the facility. Staff A stated that staff only had access to the binder when Staff A worked.

During a second interview on 09/20/2023 at 3:19 PM, Staff A acknowledged that the facility did not have a facility specific emergency manual. Staff A stated that when they were hired, the current disaster manual was in the facility. Staff A stated that they thought the corporation-wide policies and procedures inserted in the emergency manual were all that was needed. When Staff A stated that they did not know the local First Responder's contact information for emergency services (gas, electric, elevator, water companies). Staff A stated there was another facility down the street run by the same company that this facility used in emergencies. Staff A stated that at the moment, the facility did not have a van driver. Staff A stated that the emergency manual did not have the following information: 1) a current resident roster with room numbers and evacuation status and instructions; 2) staff roles and responsibilities during emergencies, 3) utilities shut off instructions; and 4) a current list of facility employees and corporate contacts with phone/contact information.

Observation on 09/21/2023 at 12:33 PM showed the facility fire alarm sounded as staff

served lunch to the residents. The state Licensors were seated in the private facility dining room where the licensors observed the facility staff response. Facility dining staff continued to deliver food to residents seated in the dining room, continued to take resident orders, and continued to clear tables. Licensors observed the facility sous chef and chef continued with meal preparation and plated the prepared food. Observation of staff actions during the alarm, from 12:33 PM until 12:38 PM, showed the facility staff and administrative staff did not enter the dining room at any time to check on residents and provide emotional support, if needed. During this time, observation showed facility staff did not check on other areas of the facility and did not direct the state Licensors in the facility's evacuation process. Observation of three unidentified care staff and three administrative staff (Staff A; Staff I, Business Office Manager; and Staff S, Clinical Specialist, Corporate) showed no recognition of what to do. The Licensors overheard one unidentified staff ask Staff I what happened. At 12:38 PM, Staff U, Regional Maintenance Technician, silenced the alarm.

During an interview on 09/21/2023 at 12:40 PM, Staff U informed the Licensors that when an alarm sounded, facility staff notified residents of the status of the alarm if a resident asked. Staff U stated that staff have radios to be notified of the reason for the alarm. Staff U stated that this alarm resulted from burnt toast. Staff U stated that the facility would just use this incident as a drill.

EMERGENCY FOOD/WATER PROVISION

Observation of the facility environment on 09/26/2023 at 10:25 AM showed that the facility had no food and water supplies that were designated for emergency use.

During an interview, on 09/26/2023 at 10:35 AM, Staff A confirmed that the dry and canned food items located in the dietary supply room were the supplies for both routine daily meals and the emergency food reserves for the facility. Staff A stated that the facility emergency manual had no information for how emergency water would be obtained if needed.

FIRST AID SUPPLIES AND FIRST AID KITS

Observation during the entrance tour on 09/19/2023 at 10:55 AM showed that the facility had no first aid kits visible and readily accessible in the facility. There were no signs visible that indicated where any first aid kit was located.

During an interview on 09/19/2023 at 1:40 PM, Staff A stated that the facility stored one first aid kit in the administrator's office and a second first aid kit in the first-floor medication room. Staff A stated that they were unaware that first aid kits were required to be readily available to residents, visitors, and staff.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

J. Leana Winkett
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the Department of a change in the assisted living facility administrator within 10 days of hire for 1 of 1 staff (Staff A, Executive Director), as required. This failure placed all the residents at risk of receiving care from an unqualified staff member.

Findings included...

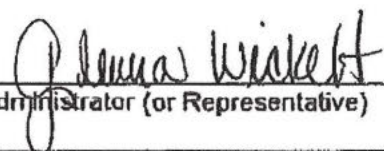
Review of the Department's Facilities Management System (FMS) on 09/14/2023 showed that Staff T, Previous Administrator, was the Administrator of record. Review of the undated facility staff records showed that the facility hired Staff A on 09/12/2022, as the current facility Administrator. There was no documentation that showed the facility reported the change of administrator, as required.

During an interview on 09/21/2023 at 4:34 PM, Staff A stated that they were unaware of the requirement to notify the Department of the change in administrators.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

 _____ Administrator (or Representative)	<u>11</u> / <u>10</u> / <u>2023</u> _____ Date
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WAC 388-70A-2970 Garbage and refuse disposal. The assisted living facility must:

(1) Provide an adequate number of garbage containers to store refuse generated by the assisted living facility:

(c) Cleaned and maintained to prevent:

(i) Entrance of insects, rodents, birds, or other pests;

(iii) Other nuisances.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to maintain 1 out of 1 outdoor garbage containers. This failure placed all residents at risk for potential pest infestations.

Findings included...

Observation during the environmental tour on 09/20/2023 at 12:15 PM, showed one garbage dumpster and one recycling dumpster, located behind the facility, accessible through the parking lot. The garbage container lid was bent, which left a gap between the lid and container. The recycling container lid was damaged by a large hole in the middle. The size of the hole was estimated to be three feet in diameter. The damaged lids on both containers were large enough for rodents or other pest easy access to the garbage inside.

During an interview on 09/20/2023 at 12:30 PM, Staff V, Brookdale Foundation House Maintenance Director, stated that the damaged containers were not of concern. Staff U, Regional Maintenance Technician, stated that they were unaware of the condition of the containers.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) <u>12/15/2023</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>11</u> / <u>10</u> / <u>2023</u> _____ Date

WAC 368-78A-2980 Lighting.

(3) The assisted living facility must provide enough lighting in each resident's room to meet the resident's needs, preferences and choices.

WAC 368-78A-2980 Lighting.

(2) The assisted living facility must maintain electric light fixtures and lighting necessary for the comfort and safety of residents and for the activities of residents and staff.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to fully maintain the lighting fixtures in 1 of 3 stairwells (Northeast Stairwell) and the facility dining room. The facility also failed to meet the lighting needs of 1 of 45 sampled residents (Resident 1). This failure placed all residents at risk for potential injury.

Findings included...

During the facility environmental tour with Staff U, Regional Maintenance Technician, and Staff V, Brookdale Foundation House Maintenance Director, on 09/20/2023 starting at 12:15 PM, observation showed a flickering ceiling light fixture in the facility's dining room. The light was above the dining tables, near the right corner window of the room. Review of the facility work orders showed a work order was placed for repair of this lighting fixture. The work order showed the task was assigned to Staff AA, Previous Maintenance Director.

During an interview on 09/20/2023 at 12:15 PM, Staff U stated that the previous maintenance director left the facility a month ago. Staff U stated that the work order was never completed.

During the environmental tour on 09/20/2023, observation showed there were three stairways in the facility: one to the North, one in the center of the building, and one to the South. The stairs were used for emergency evacuation by residents and staff who were on the second floor of the facility. Observation of the North stairwell showed there were two light fixtures, side by side on the ceiling. The ceiling fixtures were over the stairwell landing, between the first and second floor flight of stairs. Observation showed only one of the two fixtures worked, which allowed only one set of stairs to be properly lit. Review of the facility work orders showed no documentation a request was submitted for repair.

During an interview on 09/20/2023 at 12:20 PM, Staff V stated they were aware of the nonoperational light fixture. Staff V stated that repair was not a priority since one light fixture was operational. Staff V stated that was sufficient to light the stairwell.

On 09/20/2023 at 3:05 PM, observation of Resident 1's apartment showed a ceiling light fixture in the entryway hall of the apartment. The fixture emitted a dim light that consistently flickered.

During an interview on 09/20/2023 at 3:05 PM, Resident 1 stated that over a month ago, they submitted a work order with the previous maintenance director. Resident 1 stated that there was no follow up. Resident 1 stated that they were unable to see clearly in the entryway of their apartment. Resident 1 also stated that staff were aware of the flickering light. Resident 1 stated that staff observed the lighting whenever they entered the apartment.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

[Signature]
Administrator (or Representative)

11/10/2023
Date

WAC 366-78A-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;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 13 of 90 residents (Resident 3, Resident 9, Resident 25, Resident 27, Resident 35, Resident 37, Resident 40, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51) with cognitive deficits, did not have access to hazardous chemicals and equipment. This failure placed the residents at risk for harm and injury if they ingested the toxic chemicals.

Findings included...

Review of the undated characteristics roster showed that the facility provided care and services to 13 residents (Resident 3, Resident 9, Resident 25, Resident 27, Resident 35, Resident 37, Resident 40, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51) with diagnosis of [REDACTED] or another [REDACTED].

[REDACTED]. During an interview on 09/18/2023 at 9:55 AM Staff A, Executive Director,

stated that the facility also cared for residents who presented with behaviors related to dementia, such as wandering.

Observation on 09/21/2023 at 11:30 AM showed an unlocked housekeeping cart in the first-floor hallway, across from apartment 102. The cart contained: one 32 fluid ounces (fl oz) bottle of Formula Q&A Acid Disinfectant Cleaner and one 32 fl oz bottle of Ecolab Medallion stainless steel cleaner. Observation showed there was no staff member present in the hall during this time.

Review of the Formula Q&A Acid Disinfectant Cleaner warning label showed "Corrosive. Harmful if swallowed. Inhalation of vapors or mist may cause respiratory irritation". The Ecolab Medallion Stainless Steel Cleaner warning label showed "Causes serious eye irritation".

Observation on 09/25/2023 at 1:21 PM showed an unlocked storage room on the second floor, across from apartment 293. On 09/26/2023 at 1:21 PM, observation showed the same room unlocked. Further observation showed the room contained several boxes of Monoject 1 milliliter (mL) insulin syringes. The unlocked room also contained a pile of damaged doors with sharp edges.

Observation on 09/20/2023 at 12:45 PM showed an unlocked common use bathroom on the second floor of the facility. The bathroom contained broken light fixtures, paint cans and broken door fixtures. During an interview at this time, Staff U, Regional Maintenance Technician, stated that the facility used the bathroom as a storage room. Staff U stated that the door should always be locked.

Throughout the licensing visit from 09/18/2023 to 09/27/2023, multiple observations showed the first-floor housekeeping supply room, across from apartment 104, frequently remained unlocked. Further observation showed the room contained: multiple one-gallon containers of Ecolab Peroxide Multi-Surface Cleaner Disinfectant and multiple 22 fl. oz bottles of Whittaker Crystal Carpet Spotting Agent.

Review of the Ecolab Peroxide Multi-Surface Cleaner and Disinfectant warning label showed "Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage. May cause an allergic skin reaction. Toxic if inhaled". The Whittaker Crystal Carpet Spotting Agent warning label showed "Contact poison treatment specialist immediately if large quantities have been ingested or inhaled".

During an interview on 09/20/2023 at 1:00 PM, Staff U stated that the doors to housekeeping closets, housekeeping carts, and storage rooms should always be locked. Staff U stated that some of the employee keys to the closets, carts, and storage rooms did not work. Staff U stated that the locks needed to be updated to provide staff access without leaving the doors and carts unlocked.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

Gloria Wakefield

Administrator (or Representative)

11/10/2023

Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

- (3) Be provided to prospective residents, before they are admitted to the home;
- (4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;
- (5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and
- (6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to provide 11 of 15 sampled residents (Resident 1, Resident 2, Resident 4, Resident 7, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 15) a copy of the facility's Medicaid acceptance policy when admitted. The facility also failed to properly format the policy, obtain the resident's signature and date, and maintain a copy of the policy in the resident's record. These failures placed Resident 1, Resident 2, Resident 4, Resident 7, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 15 at risk of being discharged and unable to reside in the facility on State assistance.

Findings included...

Review of the facility's undated document titled, "Disclosure of Services," showed that the facility accepted Medicaid as a payment source. Further review of the document showed that the facility accepted Medicaid based on availability.

Review of the facility's undated document titled, "Washington Medicaid Disclosure Form," showed a two-page document that explained the private pay circumstances expected before a resident converted to Medicaid. The document also showed that a move to a

Medicaid apartment or double occupancy apartment was required at the time of conversion. The document was typed with a font size less than fourteen point.

Review of Resident 1's admission paperwork showed that the facility admitted Resident 1 on [REDACTED]/2023. Further review of the paperwork showed that on 09/22/2023, Resident 1 signed and dated the facility's [REDACTED] policy, 87 days after admission. Review of the facility [REDACTED] policy signed by Resident 1 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 2's admission paperwork showed that the facility admitted Resident 2 on [REDACTED] 2023. Further review of the paperwork showed that Resident 2 signed the facility's [REDACTED] policy. There was no date on the signed document. Review of the facility [REDACTED] policy signed by Resident 2 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 11's admission paperwork showed that the facility admitted Resident 11 on [REDACTED]/2023. Further review of the paperwork showed that Resident 11 signed the facility's [REDACTED] policy. There was no date on the signed document. Review of the facility [REDACTED] policy signed by Resident 11 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 12's admission paperwork showed that the facility admitted Resident on [REDACTED] 2023. Further review of the paperwork showed that on 09/22/2023, Resident 12 signed and dated the facility's [REDACTED] policy, 53 days after admission. Review of the facility [REDACTED] policy signed by Resident 12 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 4, Resident 7, Resident 9, Resident 10, Resident 13, Resident 14, and Resident 15's admission paperwork showed no documentation that the residents or their representatives received the facility's [REDACTED] policy.

During an interview on 09/20/2023 at 1:40 PM, Staff A, Executive Director, stated that they were unaware that all residents, both private pay and Medicaid funded residents, who admitted to an assisted living facility must be given a copy of the facility's policy for accepting Medicaid. Staff A stated that they thought only residents who admitted on Medicaid were provided the policy. Staff A stated that they were unaware that all residents or the resident representative must sign and date the Medicaid policy. Staff A stated that they were unaware if all current residents or their representatives received the facility's Medicaid policy prior to their admission to the facility.

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

Medicaid apartment or double occupancy apartment was required at the time of conversion. The document was typed with a font size less than fourteen point.

Review of Resident 1's admission paperwork showed that the facility admitted Resident 1 on [REDACTED]/2023. Further review of the paperwork showed that on 09/22/2023, Resident 1 signed and dated the facility's [REDACTED] policy, 87 days after admission. Review of the facility [REDACTED] policy signed by Resident 1 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 2's admission paperwork showed that the facility admitted Resident 2 on [REDACTED]/2023. Further review of the paperwork showed that Resident 2 signed the facility's [REDACTED] policy. There was no date on the signed document. Review of the facility [REDACTED] policy signed by Resident 2 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 11's admission paperwork showed that the facility admitted Resident 11 on [REDACTED]/2023. Further review of the paperwork showed that Resident 11 signed the facility's Medicaid policy. There was no date on the signed document. Review of the facility Medicaid policy signed by Resident 11 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 12's admission paperwork showed that the facility admitted Resident on 08/01/2023. Further review of the paperwork showed that on 09/22/2023, Resident 12 signed and dated the facility's Medicaid policy, 53 days after admission. Review of the facility Medicaid policy signed by Resident 12 showed the written policy did not meet all the Washington Administrative Code requirements: one page typed in at least fourteen-point font.

Review of Resident 4, Resident 7, Resident 9, Resident 10, Resident 13, Resident 14, and Resident 15's admission paperwork showed no documentation that the residents or their representatives received the facility's [REDACTED] policy.

During an interview on 09/20/2023 at 1:40 PM, Staff A, Executive Director, stated that they were unaware that all residents, both private pay and Medicaid funded residents, who admitted to an assisted living facility must be given a copy of the facility's policy for accepting Medicaid. Staff A stated that they thought only residents who admitted on Medicaid were provided the policy. Staff A stated that they were unaware that all residents or the resident representative must sign and date the Medicaid policy. Staff A stated that they were unaware if all current residents or their representatives received the facility's Medicaid policy prior to their admission to the facility.

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

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

Glen Winkett
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure window screens were appropriately placed on 12 of 218 (screen 1 to screen 12) operable, exterior windows throughout the facility. This failure placed all residents at potential risk of illness from unnecessary airborne contamination or insect and rodent borne diseases.

Findings included...

Observation during the environmental tour on 09/20/2023 at 12:15 PM with Staff U, Regional Maintenance Technician, and Staff V, Maintenance Director Brookdale Foundation House, showed there were 12 screens missing on operable, exterior windows. The missing screens were on both the first and second floors of the facility. Observation showed screens were missing from windows of residents' rooms.

During an interview on 09/20/2023 at 12:15 PM, Staff U confirmed that there were several windows with missing screens. Staff U stated that they were unaware there were screens missing from so many of the windows.

Plan/Attestation Statement

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Administrator (or Representative)

Date

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(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure window screens were appropriately placed on 12 of 218 (screen 1 to screen 12) operable, exterior windows throughout the facility. This failure placed all residents at potential risk of illness from unnecessary airborne contamination or insect and rodent borne diseases.

Findings included...

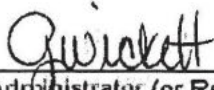
Observation during the environmental tour on 09/20/2023 at 12:15 PM with Staff U, Regional Maintenance Technician, and Staff V, Maintenance Director Brookdale Foundation House, showed there were 12 screens missing on operable, exterior windows. The missing screens were on both the first and second floors of the facility. Observation showed screens were missing from windows of residents' rooms.

During an interview on 09/20/2023 at 12:15 PM, Staff U confirmed that there were several windows with missing screens. Staff U stated that they were unaware there were screens missing from so many of the windows.

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)

11/10/2023

Date

WAC 388-78A-2190 Activities of daily living. Assistance with activities of daily living is a service that the assisted living facility may provide.

(3) When an assisted living facility chooses to provide, either directly or indirectly, assistance with activities of daily living, the assisted living facility must provide to each resident, consistent with the resident's assessed needs, minimal assistance with the following activities of daily living:

(h) Medication assistance: As defined in RCW 69.41.010 .

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide prescribed medication assistance services as agreed upon in the Personal Service Plan (PSP) for 8 of 8 sampled residents (Residents 2, 11, 13, 14, 15, 18, 20, and 21). This placed the Residents 2, 11, 13, 14, 15, 18, 20, and 21 at risk for pain and discomfort and compromised health.

Findings included...

Review of the ALF's policy, titled "Medication Administrative Services," dated 11/2018, stated that all appropriately trained or licensed ALF Staff administering medication were to follow the "Rights of Medication Administration." The policy defines these rights as the right medication, the right dose, the right time, the right route, the right resident, the right documentation, and the right to refuse. The policy directs ALF Staff administering medications that if a resident chooses to not take a medication or the medication is not given for any reason, the ALF Staff should document the reason in the Electronic Medication Administration Record (eMAR).

RESIDENT 2

Review of Resident 2's PSP, dated 03/17/2023, showed the ALF was to dispense Resident 2's medications which included narcotic medications (medications used to manage pain).

Review of Resident 2's eMAR, for August 2023 and September 2023, showed an order for a narcotic medication to be given by mouth twice daily at noon and 8:00 PM. The eMAR showed that the medication was initiated as given without any missing entries.

Review of the narcotic control log for Resident 2's prescribed narcotic medication showed the medication was not given, as ordered, on 08/25/2023, 09/23/2023, and 09/30/2023.

Administrator (or Representative)

Date

WAC 388-78A-2190 Activities of daily living. Assistance with activities of daily living is a service that the assisted living facility may provide.

(3) When an assisted living facility chooses to provide, either directly or indirectly, assistance with activities of daily living, the assisted living facility must provide to each resident, consistent with the resident's assessed needs, minimal assistance with the following activities of daily living:

(h) Medication assistance: As defined in RCW 69.41.010 .

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide prescribed medication assistance services as agreed upon in the Personal Service Plan (PSP) for 8 of 8 sampled residents (Residents 2, 11, 13, 14, 15, 18, 20, and 21). This placed the Residents 2, 11, 13, 14, 15, 18, 20, and 21 at risk for pain and discomfort and compromised health.

Findings included...

Review of the ALF's policy, titled "Medication Administrative Services," dated 11/2018, stated that all appropriately trained or licensed ALF Staff administering medication were to follow the "Rights of Medication Administration." The policy defines these rights as the right medication, the right dose, the right time, the right route, the right resident, the right documentation, and the right to refuse. The policy directs ALF Staff administering medications that if a resident chooses to not take a medication or the medication is not given for any reason, the ALF Staff should document the reason in the Electronic Medication Administration Record (eMAR).

RESIDENT 2

Review of Resident 2's PSP, dated 03/17/2023, showed the ALF was to dispense Resident 2's medications which included narcotic medications (medications used to manage pain).

Review of Resident 2's eMAR, for August 2023 and September 2023, showed an order for a narcotic medication to be given by mouth twice daily at noon and 8:00 PM. The eMAR showed that the medication was initialed as given without any missing entries.

Review of the narcotic control log for Resident 2's prescribed narcotic medication showed the medication was not given, as ordered, on 08/25/2023, 09/23/2023, and 09/30/2023.

RESIDENT 11

Review of Resident 11's PSP, dated 03/10/2023, showed the ALF was to dispense Resident 11's medications which included narcotic medications for neck and knee pain. The PSP showed that the ALF Staff assisted with administration of medications as needed.

Review of Resident 11's eMAR, for August 2023 and September 2023, showed an order for narcotic medication to be given by mouth every six hours (a total of four times given in 24 hours) for unspecified abnormalities of gait and mobility and chronic pain syndrome. The August 2023 eMAR showed the medication was given without any missing entries. The September 2023 eMAR showed there were seven times the medication was not given:
twice on 09/03/2023 the reason documented was Resident 11 was sleeping,
three times on 09/08/2023 with the documented reason as, "pharmacy action required,"
twice on 09/18/2023 with the documented reason being, "sleeping and other."

Review of the ALF's narcotic control log for Resident 11's narcotic medication showed that the medication was only given:
three times on 08/04/2023 08/17/2023, 08/25/2023, 09/16/2023, 09/19/2023, 09/23/2023, and 09/24/2023
five times on 08/18/2023
once on 09/18/2023 with two exceptions documented as to why it was not given.

RESIDENT 13

Review of Resident 13's PSP, dated 02/10/2023, showed that the ALF was responsible for dispensing Resident 13's medications which included narcotic medications. The PSP showed Resident 13 was, "Able to take medication whole with thin liquids, oral medications are prepared by staff and handed to resident."

Review of Resident 13's Medication Administration Audit Report, dated August 2023, showed an order for a narcotic medication to be given by mouth four times a day for pain. Review of the audit showed three doses were given:
08/07/2023, 08/18/2023, and 08/19/2023
two doses were given on 08/11/2023, and 08/17/2023.
Further review of the audit record showed additional discrepancies after 08/17/2023 to the end of August.

Review of the September eMAR showed Resident 13 received all the prescribed narcotic medication on 09/01/2023 through 09/18/2023, with one exception for the noon dose on 09/09/2023. Review of the eMAR for September showed it was not aligned with Resident 13's narcotic record.

Review of the ALF's narcotic control log for Resident 13's narcotic medication, the narcotic was given:
twice on 08/05/2023, 08/14/2023, 09/13/2023, and 09/14/2023
three times on 08/06/2023, 08/12/2023, 09/08/2023, 09/09/2023
once on 08/07/2023, 08/11/2023, and 08/13/2023

RESIDENT 11

Review of Resident 11's PSP, dated 03/10/2023, showed the ALF was to dispense Resident 11's medications which included narcotic medications for neck and knee pain. The PSP showed that the ALF Staff assisted with administration of medications as needed.

Review of Resident 11's eMAR, for August 2023 and September 2023, showed an order for narcotic medication to be given by mouth every six hours (a total of four times given in 24 hours) for unspecified abnormalities of gait and mobility and chronic pain syndrome. The August 2023 eMAR showed the medication was given without any missing entries. The September 2023 eMAR showed there were seven times the medication was not given:

twice on 09/03/2023 the reason documented was Resident 11 was sleeping,
three times on 09/08/2023 with the documented reason as, "pharmacy action required,"
twice on 09/18/2023 with the documented reason being, "sleeping and other."

Review of the ALF's narcotic control log for Resident 11's narcotic medication showed that the medication was only given:

three times on 08/04/2023 08/17/2023, 08/25/2023, 09/16/2023, 09/19/2023, 09/23/2023, and 09/24/2023

five times on 08/18/2023

once on 09/18/2023 with two exceptions documented as to why it was not given.

RESIDENT 13

Review of Resident 13's PSP, dated 02/10/2023, showed that the ALF was responsible for dispensing Resident 13's medications which included narcotic medications. The PSP showed Resident 13 was, "Able to take medication whole with thin liquids, oral medications are prepared by staff and handed to resident."

Review of Resident 13's Medication Administration Audit Report, dated August 2023, showed an order for a narcotic medication to be given by mouth four times a day for pain. Review of the audit showed three doses were given:

08/07/2023, 08/18/2023, and 08/19/2023

two doses were given on 08/11/2023, and 08/17/2023.

Further review of the audit record showed additional discrepancies after 08/17/2023 to the end of August.

Review of the September eMAR showed Resident 13 received all the prescribed narcotic medication on 09/01/2023 through 09/18/2023, with one exception for the noon dose on 09/09/2023. Review of the eMAR for September showed it was not aligned with Resident 13's narcotic record.

Review of the ALF's narcotic control log for Resident 13's narcotic medication, the narcotic was given:

twice on 08/05/2023, 08/14/2023, 09/13/2023, and 09/14/2023

three times on 08/06/2023, 08/12/2023, 09/08/2023, 09/09/2023

once on 08/07/2023, 08/11/2023, and 08/13/2023

RESIDENT 14

Review of Resident 14's PSP, dated 08/09/2023, showed that the ALF was responsible for dispensing Resident 14's medications which included an anti-anxiety medication. The PSP showed Resident 14 can take their medication whole with thin liquids. The PSP showed that staff were to get the medication ready and hand them to Resident 14. Resident 14's eMAR for September 2023 showed an anti-anxiety medication to be given twice a day for post-traumatic stress disorder (a disorder that develops after experiencing shocking, scary, or dangerous event with anxiety as a possible symptom).

Review of Resident 14's eMAR for September 2023 showed the anti-anxiety medication was given as ordered with one exception, on 09/16/2023 with the documented reason of Resident 14 was absent.

Review of the ALF's narcotic control log for Resident 14's anti-anxiety medication was given once on 09/01/2023, 09/05/2023, 09/07/2023, 09/08/2023, 09/12/2023, 09/14/2023, 09/15/2023, 09/16/2023, and 09/18/2023 instead of twice a day.

RESIDENT 15

Review of Resident 15's PSP, dated 03/13/2023, showed that the ALF was responsible for dispensing Resident 15's medications. The PSP showed that ALF Staff were to get Resident 15's medications ready and hand them to Resident 15.

Review of Resident 15's eMAR, dated July 2023, showed an order for a narcotic medication to be given by mouth twice a day for pain management. The MAR showed the medication was documented as given without missing any doses from 07/01/2023 through 07/18/2023.

Review of the ALF's narcotic control log for Resident 15's narcotic medication showed it was only given once on 07/01/2023, 07/04/2023, 07/07/2023, and 07/10/2023.

RESIDENT 20

Review of Resident 20's PSP, dated 02/10/2023, showed that facility was responsible for dispensing Resident 20's medications. The PSP showed that staff were to get Resident 20's medications ready and hand them to Resident 20.

Review of Resident 20's eMAR, dated September 2023, showed an order for an anti-anxiety medication to be given by mouth twice a day. The eMAR showed that it was documented as given without missing any doses through 09/15/2023.

Review of the ALF's narcotic control log for Resident 20's anti-anxiety medication showed it was only given once on 09/05/2023, 09/06/2023, 09/07/2023, 09/08/2023, 09/12/2023, 09/13/2023, and 09/14/2023.

RESIDENT 14

Review of Resident 14's PSP, dated 08/09/2023, showed that the ALF was responsible for dispensing Resident 14's medications which included an anti-anxiety medication. The PSP showed Resident 14 can take their medication whole with thin liquids. The PSP showed that staff were to get the medication ready and hand them to Resident 14. Resident 14's eMAR for September 2023 showed an anti-anxiety medication to be given twice a day for post-traumatic stress disorder (a disorder that develops after experiencing shocking, scary, or dangerous event with anxiety as a possible symptom).

Review of Resident 14's eMAR for September 2023 showed the anti-anxiety medication was given as ordered with one exception, on 09/16/2023 with the documented reason of Resident 14 was absent.

Review of the ALF's narcotic control log for Resident 14's anti-anxiety medication was given once on 09/01/2023, 09/05/2023, 09/07/2023, 09/08/2023, 09/12/2023, 09/14/2023, 09/15/2023, 09/16/2023, and 09/18/2023 instead of twice a day.

RESIDENT 15

Review of Resident 15's PSP, dated 03/13/2023, showed that the ALF was responsible for dispensing Resident 15's medications. The PSP showed that ALF Staff were to get Resident 15's medications ready and hand them to Resident 15.

Review of Resident 15's eMAR, dated July 2023, showed an order for a narcotic medication to be given by mouth twice a day for pain management. The MAR showed the medication was documented as given without missing any doses from 07/01/2023 through 07/18/2023.

Review of the ALF's narcotic control log for Resident 15's narcotic medication showed it was only given once on 07/01/2023, 07/04/2023, 07/07/2023, and 07/10/2023.

RESIDENT 20

Review of Resident 20's PSP, dated 02/10/2023, showed that facility was responsible for dispensing Resident 20's medications. The PSP showed that staff were to get Resident 20's medications ready and hand them to Resident 20.

Review of Resident 20's eMAR, dated September 2023, showed an order for an anti-anxiety medication to be given by mouth twice a day. The eMAR showed that it was documented as given without missing any doses through 09/15/2023.

Review of the ALF's narcotic control log for Resident 20's anti-anxiety medication showed it was only given once on 09/05/2023, 09/06/2023, 09/07/2023, 09/08/2023, 09/12/2023, 09/13/2023, and 09/14/2023.

During an interview on 09/20/2023 at 3:30 PM, Staff S, Licensed Practical Nurse, Clinical Specialist, stated that they reviewed the discrepancies and tried to reconcile the eMAR signatures with the narcotic control logs and were unable to make sense out of the documentation. Staff S stated it appeared narcotics and anti-anxiety medications were not given as ordered. Staff S stated that the eMARs showed narcotics were signed as given. When Staff S compared the eMARs to the narcotics control log the two documents did not match. Staff S stated they interviewed several Medication Technicians (also known as Med Techs, unlicensed staff who dispense and administer medications under nurse delegation) and were told that the eMAR showed the narcotics and anti-anxiety medication as given when in fact they had not been dispensed as ordered. Staff S stated that the Med Techs informed them that the reason for the discrepancies was due to a lack of staff.

MEDICATIONS NOT RECEIVED ON TIME

RESIDENT 35

During an interview, on 09/19/2023 at 5:20 PM, during dinner Resident 35 stated that they did not receive their antacid medication (medications used to manage stomach acid before or after eating) that was due the night before on 09/18/2023 at 9:00 PM.

Review of Resident 35's eMAR, dated September 2023, showed an order for an antacid medication to be given by mouth four times a day for ulcer (a condition where the stomach can be damaged by an excess of stomach acid) prevention. The eMAR showed the medication was to be dispensed at 8:00 AM, 12:00 PM, 6:00 PM, and 10:00 PM. The eMAR showed that on 09/18/2023, the 10:00 PM dose was not given.

Review of Resident 35's Medication Administration Audit Report, dated September 2023, showed the medication was signed as given on 09/29/2023 at 11:14 AM by Staff C, Med Tech, Resident Care Coordinator. The Report showed that on 09/17/2023 and 09/18/2023, medications were scheduled for 7:00 AM and 8:00 AM were not given until 11:28 AM, and on 09/19/2023, the 7:00 AM medication not given until 10:56 AM, and the 8:00 AM medication not given until 2:53 PM. The Report showed that on 09/23/2023, the 8:00 AM meds were not given until 2:43 PM and 5:43 PM.

RESIDENT 44

During an interview, on 09/19/2023 at 5:21 PM, at dinner, Resident 44 stated that they did not receive their morning medications until 3:00 PM on 09/19/2023.

Review of Resident 44's eMAR, for September 2023, showed an order for a medication to be given every evening was not given from 09/03/2023 thru 09/20/2023. The eMAR showed the reason as a pharmacy action was required.

Review of Resident 44's Medication Administration Audit Report dated September 2023, showed that on 09/18/2023 through 09/24/2023 medications schedule for 7:00 AM and 8:00 AM were given over three hours late.

During an interview on 09/20/2023 at 3:30 PM, Staff S, Licensed Practical Nurse, Clinical Specialist, stated that they reviewed the discrepancies and tried to reconcile the eMAR signatures with the narcotic control logs and were unable to make sense out of the documentation. Staff S stated it appeared narcotics and anti-anxiety medications were not given as ordered. Staff S stated that the eMARs showed narcotics were signed as given. When Staff S compared the eMARs to the narcotic control log the two documents did not match. Staff S stated they interviewed several Medication Technicians (also known as Med Techs, unlicensed staff who dispense and administer medications under nurse delegation) and were told that the eMAR showed the narcotics and anti-anxiety medication as given when in fact they had not been dispensed as ordered. Staff S stated that the Med Techs informed them that the reason for the discrepancies was due to a lack of staff.

MEDICATIONS NOT RECEIVED ON TIME RESIDENT 35

During an interview, on 09/19/2023 at 5:20 PM, during dinner, Resident 35 stated that they did not receive their antacid medication (medications used to manage stomach acid before or after eating) that was due the night before on 09/18/2023 at 9:00 PM.

Review of Resident 35's eMAR, dated September 2023, showed an order for an antacid medication to be given by mouth four times a day for ulcer (a condition where the stomach can be damaged by an excess of stomach acid) prevention. The eMAR showed the medication was to be dispensed at 6:00 AM, 12:00 PM, 6:00 PM, and 10:00 PM. The eMAR showed that on 09/18/2023, the 10:00 PM dose was not given.

Review of Resident 35's Medication Administration Audit Report, dated September 2023, showed the medication was signed as given on 09/29/2023 at 11:14 AM by Staff C, Med Tech, Resident Care Coordinator. The Report showed that on 09/17/2023 and 09/18/2023, medications were scheduled for 7:00 AM and 8:00 AM were not given until 11:26 AM, and on 09/19/2023, the 7:00 AM medication not given until 10:56 AM, and the 8:00 AM, medication not given until 2:53 PM. The Report showed that on 09/23/2023, the 8:00 AM meds were not given until 2:43 PM and 5:43 PM.

RESIDENT 44

During an interview, on 09/19/2023 at 5:21 PM, at dinner, Resident 44 stated that they did not receive their morning medications until 3:00 PM on 09/19/2023.

Review of Resident 44's eMAR, for September 2023, showed an order for a medication to be given every evening was not given from 09/03/2023 thru 09/20/2023. The eMAR showed the reason as a pharmacy action was required.

Review of Resident 44's Medication Administration Audit Report dated September 2023, showed that on 09/18/2023 through 09/24/2023 medications schedule for 7:00 AM and 8:00 AM were given over three hours late.

During an interview on 09/20/2023 at 8:58 AM, Staff C, Resident Care Coordinator, Med Tech, stated that there often were days when there was not enough staff available to meet the needs of the residents such as care and medication assistance. Staff C stated she was not surprised narcotics were signed for on the eMAR but were not signed out on the narcotic record which showed they were not given. Staff C stated that there have been day and evening shifts where there has only been one caregiver and one Med Tech to care for over 80 residents. Staff C stated that on 09/14/2023 they addressed staff shortages with Staff A, Executive Director. Staff C stated that Staff A's response was to instruct them to call Staff B, RN, Health Wellness Director, who was at home ill from COVID. Staff C stated that Staff A was aware Staff A had tested positive for COVID and was ill at home. Staff C also stated that when staff agreed to work vacant shifts, Staff A would send them home to avoid the overtime expense which would leave the facility with not enough staff to meet resident needs.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

Glenna Wickett
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

- (1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;
- (2) Complete an assessment specifically focused on a resident's identified problems and related issues:
 - (a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;
 - (b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete the required full assessment to evaluate the capabilities, care needs and preferences for 4 of 4 sampled residents (Resident 3, Resident 8, Resident 24, and Resident 45) at admission and with a change of condition. This failure placed Resident 3, Resident 8, Resident 24, and Resident 45 at risk of unmet care needs and a decreased quality of life.

Findings included...

During an interview on 09/20/2023 at 8:56 AM, Staff C, Resident Care Coordinator, Med Tech, stated that there often were days when there was not enough staff available to meet the needs of the residents such as care and medication assistance. Staff C stated she was not surprised narcotics were signed for on the eMAR but were not signed out on the narcotic record which showed they were not given. Staff C stated that there have been day and evening shifts where there has only been one caregiver and one Med Tech to care for over 80 residents. Staff C stated that on 09/14/2023 they addressed staff shortages with Staff A, Executive Director. Staff C stated ~~that~~ Staff A's response was to instruct them to call Staff B, RN, Health Wellness Director, who was at home ill from COVID. Staff C stated that Staff A was aware Staff A had tested positive for COVID and was ill at home. Staff C also stated that when staff agreed to work vacant shifts, Staff A would send them home to avoid the overtime expense which would leave the facility with not enough staff to meet resident needs.

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Administrator (or Representative)

Date

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- (2) Complete an assessment specifically focused on a resident's identified problems and related issues:
 - (a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;
 - (b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete the required full assessment to evaluate the capabilities, care needs and preferences for 4 of 4 sampled residents (Resident 3, Resident 8, Resident 24, and Resident 45) at admission and with a change of condition. This failure placed Resident 3, Resident 8, Resident 24, and Resident 45 at risk of unmet care needs and a decreased quality of life.

Findings included...

INDWELLING CATHETER ASSESSMENT

Review of the facility document titled "How To: Indwelling Catheter Care", updated June 2020, showed the facility's guidelines for indwelling catheter care. The document listed the catheter care procedures and documentation instructions.

RESIDENT 3

Review of the facility's "Admission Record", dated 09/18/2023, showed that the facility admitted Resident 3 in [REDACTED] 2022.

Review of Resident 3's "Personal Service Plan", dated 05/22/2023, showed that Resident 3 was bladder continent and independent with bathroom use. Review of Resident 3's "Progress Notes", between 06/01/2023 and 09/18/2023, showed no documentation of any change in Resident 3's bladder function. There was no documentation that Resident 3 used a urinary catheter (a small flexible tube that drains urine from the bladder).

Review of the "TriMed Ambulance Report" showed that on 09/14/2023, the emergency medical service provider assessed Resident 3 in response to Resident 3's 911 call. The report showed that the emergency medical service provider identified Resident 3 used a urinary catheter. The report showed that Resident 3 emptied their own catheter bag.

During an interview on 10/03/2023 at 4:07 PM, Collateral Contact 2 (CC 2), Resident 3's representative, stated that after Resident 3's spinal surgery in June 2023, Resident 3 received and used an indwelling urinary catheter. The catheter was connected to a collection bag. CC 2 stated that they were unaware the facility did not list Resident 3's use of the indwelling catheter on Resident 3's assessment. CC 2 stated that Resident 3 required assistance with wheelchair transfers. CC 2 stated that when Resident 3 was seated in the wheelchair, Resident 3 was able to drain the collection bag by themselves. CC2 stated that the staff sometimes assisted Resident 3 with emptying the collection bag.

During an interview on 10/05/2023 at 3:22 PM, Staff B confirmed that Resident 3 used an indwelling urinary catheter with a collection bag. Staff B stated that they became aware Resident 3 used a catheter after the former nurse resigned in late July 2023. Staff B stated that they did not assess Resident 3 for catheter use, and there was no documentation of catheter care in Resident 3's record. Staff B stated that they were unaware of any updated assessment when Resident 3's condition changed. Staff B also stated that the facility did not have the physician's order for the catheter. Staff B stated that they did not know the catheter care plan required by the physician. Staff B stated that they did not know who changed the catheter for the resident, or whether the catheter was ever changed since it was inserted.

CONTINUOUS POSITIVE AIRWAY PRESSURE ASSESSMENT

Review of the facility document titled "Continuous Positive Airway Pressure (CPAP)/Bi-level Positive Airway Pressure (BiPAP) Policy", dated October 2023, showed that the facility required the Health and Wellness Director (HWD)/nurse/designee to evaluate residents that used the CPAP/BiPAP (a machine that uses mild air pressure to keep breathing airways

INDWELLING CATHETER ASSESSMENT

Review of the facility document titled "How To: Indwelling Catheter Care", updated June 2020, showed the facility's guidelines for indwelling catheter care. The document listed the catheter care procedures and documentation instructions.

RESIDENT 3

Review of the facility's "Admission Record", dated 09/18/2023, showed that the facility admitted Resident 3 in [REDACTED] 2022.

Review of Resident 3's "Personal Service Plan", dated 05/22/2023, showed that Resident 3 was bladder continent and independent with bathroom use. Review of Resident 3's "Progress Notes", between 06/01/2023 and 09/18/2023, showed no documentation of any change in Resident 3's bladder function. There was no documentation that Resident 3 used a urinary catheter (a small flexible tube that drains urine from the bladder).

Review of the "TriMed Ambulance Report" showed that on 09/14/2023, the emergency medical service provider assessed Resident 3 in response to Resident 3's 911 call. The report showed that the emergency medical service provider identified Resident 3 used a urinary catheter. The report showed that Resident 3 emptied their own catheter bag.

During an interview on 10/03/2023 at 4:07 PM, Collateral Contact 2 (CC 2), Resident 3's representative, stated that after Resident 3's spinal surgery in June 2023, Resident 3 received and used an indwelling urinary catheter. The catheter was connected to a collection bag. CC 2 stated that they were unaware the facility did not list Resident 3's use of the indwelling catheter on Resident 3's assessment. CC 2 stated that Resident 3 required assistance with wheelchair transfers. CC 2 stated that when Resident 3 was seated in the wheelchair, Resident 3 was able to drain the collection bag by themselves. CC2 stated that the staff sometimes assisted Resident 3 with emptying the collection bag.

During an interview on 10/05/2023 at 3:22 PM, Staff B confirmed that Resident 3 used an indwelling urinary catheter with a collection bag. Staff B stated that they became aware Resident 3 used a catheter after the former nurse resigned in late July 2023. Staff B stated that they did not assess Resident 3 for catheter use, and there was no documentation of catheter care in Resident 3's record. Staff B stated that they were unaware of any updated assessment when Resident 3's condition changed. Staff B also stated that the facility did not have the physician's order for the catheter. Staff B stated that they did not know the catheter care plan required by the physician. Staff B stated that they did not know who changed the catheter for the resident, or whether the catheter was ever changed since it was inserted.

CONTINUOUS POSITIVE AIRWAY PRESSURE ASSESSMENT

Review of the facility document titled "Continuous Positive Airway Pressure (CPAP)/Bi-level Positive Airway Pressure (BiPAP) Policy", dated October 2023, showed that the facility required the Health and Wellness Director (HWD)/nurse/designee to evaluate residents that used the CPAP/BiPAP (a machine that uses mild air pressure to keep breathing airways

open while the person sleeps) when admitted to the facility and upon initiation of use. The document showed that the facility was responsible to obtain the physician order and complete the "Resident Self-Administration of Medication Review" for CPAP use. The document also listed the procedures and instructions for equipment setup, maintenance and cleaning, and documentation.

RESIDENT 8

Review of Resident 8's "Admission Record", dated 09/18/2023, showed that the facility admitted Resident 8 in [REDACTED] 2019. Resident 8 admitted with medical diagnoses which included [REDACTED] ([REDACTED]).

Review of Resident 8's facility records showed that on 07/16/2023, the facility completed an annual assessment for Resident 8. The record showed no documentation of "Resident Self-Administration of Medication Review" for CPAP use, per the facility's policy. The record showed no documentation in Resident 8's assessment for CPAP usage.

Observation in Resident 8's apartment on 09/20/2023 at 10:42 AM showed that Resident 8 laid in bed and used a CPAP machine. Observation showed Resident 8 wore a facial mask with an air tube connected to the machine which was placed at the left side of the bed.

During an interview on 09/20/2023 at 10:42 AM, Resident 8 stated that they used the CPAP machine for breathing while asleep. Resident 8 stated that they independently set up the CPAP, applied the mask, and operated the CPAP machine. Resident 8 stated that the facility staff did not assist them with the CPAP.

During an interview on 10/05/2023 at 3:22 PM, Staff B stated that when they completed an annual assessment in July 2023, they did not assess to determine Resident 8 was safe and capable of using CPAP on their own. Staff B stated that they were unaware Resident 8 used a CPAP.

SELF-MEDICATION ADMINISTRATION ASSESSMENT

Review of the facility's document titled "Medications and Treatment – Self-Administration of Medication Policy", dated March 2006, showed that the facility required a nurse complete an evaluation of the resident's cognitive, physical, and visual ability to self-administer their own medications. The document showed that the facility required completion of the evaluation initially, quarterly, or as per state regulation and with any change in a resident's condition.

RESIDENT 24

Review of Resident 24's facility records showed that the facility admitted Resident 24 in [REDACTED] 2020. Review of Resident 24's "Personal Service Assessment", dated 09/21/2020, showed that when Resident 24 admitted to the facility, the facility completed an initial assessment. The document showed that at admission, Resident 24 did not have diabetes and did not use insulin. The document showed Resident 24 was independent with medications. The document showed no cognitive/psychosocial assessment for Resident 24.

open while the person sleeps) when admitted to the facility and upon initiation of use. The document showed that the facility was responsible to obtain the physician order and complete the "Resident Self-Administration of Medication Review" for CPAP use. The document also listed the procedures and instructions for equipment setup, maintenance and cleaning, and documentation.

RESIDENT 8

Review of Resident 8's "Admission Record", dated 09/18/2023, showed that the facility admitted Resident 8 in [REDACTED] 2019. Resident 8 admitted with medical diagnoses which included [REDACTED].

Review of Resident 8's facility records showed that on 07/16/2023, the facility completed an annual assessment for Resident 8. The record showed no documentation of "Resident Self-Administration of Medication Review" for CPAP use, per the facility's policy. The record showed no documentation in Resident 8's assessment for CPAP usage.

Observation in Resident 8's apartment on 09/20/2023 at 10:42 AM showed that Resident 8 laid in bed and used a CPAP machine. Observation showed Resident 8 wore a facial mask with an air tube connected to the machine which was placed at the left side of the bed.

During an interview on 09/20/2023 at 10:42 AM, Resident 8 stated that they used the CPAP machine for breathing while asleep. Resident 8 stated that they independently set up the CPAP, applied the mask, and operated the CPAP machine. Resident 8 stated that the facility staff did not assist them with the CPAP.

During an interview on 10/05/2023 at 3:22 PM, Staff B stated that when they completed an annual assessment in July 2023, they did not assess to determine Resident 8 was safe and capable of using CPAP on their own. Staff B stated that they were unaware Resident 8 used a CPAP.

SELF-MEDICATION ADMINISTRATION ASSESSMENT

Review of the facility's document titled "Medications and Treatment – Self-Administration of Medication Policy", dated March 2006, showed that the facility required a nurse complete an evaluation of the resident's cognitive, physical, and visual ability to self-administer their own medications. The document showed that the facility required completion of the evaluation initially, quarterly, or as per state regulation and with any change in a resident's condition.

RESIDENT 24

Review of Resident 24's facility records showed that the facility admitted Resident 24 in October 2020. Review of Resident 24's "Personal Service Assessment", dated 09/21/2020, showed that when Resident 24 admitted to the facility, the facility completed an initial assessment. The document showed that at admission, Resident 24 did not have diabetes and did not use insulin. The document showed Resident 24 was independent with medications. The document showed no cognitive/psychosocial assessment for Resident 24.

Further review of Resident 24's records showed that on 08/02/2021, the facility completed an annual self-medication administration assessment for Resident 24. The record showed that in August 2021, Resident 24 did not require subcutaneous (inject under the skin) injections for any reason. Further review showed no documentation that showed the facility reassessed Resident 24's ability to administer their own medications for over one year. There was no documentation of Resident 24's updated medications.

Observation of Resident 24's apartment on 09/19/2023 at 1:24 PM showed Resident 24 kept their medications in their room. Observation showed several vials of insulin (a medication that lowers blood glucose levels) stored in the apartment refrigerator.

During an interview on 09/19/2024 at 1:24 PM, Resident 24 stated that they were diagnosed with [REDACTED] for many years. Resident 24 stated their blood glucose levels increased that they required insulin injections in recent year. Resident 24 stated they independently monitored their own blood glucose, filled their pill box every week, and administered their own daily medications. Resident 24 also stated that they self-administered their own insulin injections every day.

During an interview on 10/05/2023 at 3:22 PM, Staff B, Registered Nurse, Health and Wellness Director, confirmed Resident 24 self-administered their own medications. Staff B stated that they were hired in January 2023, long after the facility admitted Resident 24. Staff B stated that they did not review and update Resident 24's self-medication administration assessment as a part of the annual assessment in July 2023.

RESIDENT 45

Review of Resident 45's facility records showed that the facility admitted Resident 45 in [REDACTED] 2023 with medical diagnoses which included [REDACTED]. The record showed that on [REDACTED] 2023, the facility assessed Resident 45. The record showed that Resident 45 self-managed their medications. Further review of the record showed no documentation the facility completed a self-medication administration assessment.

During an interview on 09/25/2023 at 10:23 AM, Resident 45 stated that in [REDACTED] 2023, they required assistance with ordering the Phosphate-binder medication (a drug that lowers phosphate level in the body) for their kidney disease. Resident 45 stated that they requested assistance from the facility. Resident 45 stated that in [REDACTED] 2023, the facility did not assess them, and the facility did not assist them to refill the medication. Resident 45 stated that they were unable to take their medication for 11 days. Resident 45 stated they were very concerned that this medication error furthered their medical condition.

During an interview on 10/05/2023 at 4:50 PM, Staff Q, Assistant Executive Director, Brookdale Foundation House, stated that there was no record the facility completed Resident 45's self-medication assessment, as required per facility policy. Staff Q stated that they were unaware of Resident 45's request for assistance with medication refill order.

Further review of Resident 24's records showed that on 08/02/2021, the facility completed an annual self-medication administration assessment for Resident 24. The record showed that in August 2021, Resident 24 did not require subcutaneous (inject under the skin) injections for any reason. Further review showed no documentation that showed the facility reassessed Resident 24's ability to administer their own medications for over one year. There was no documentation of Resident 24's updated medications.

Observation of Resident 24's apartment on 09/19/2023 at 1:24 PM showed Resident 24 kept their medications in their room. Observation showed several vials of insulin (a medication that lowers blood glucose levels) stored in the apartment refrigerator.

During an interview on 09/19/2024 at 1:24 PM, Resident 24 stated that they were diagnosed with [REDACTED] for many years. Resident 24 stated their blood glucose levels increased that they required insulin injections in recent year. Resident 24 stated they independently monitored their own blood glucose, filled their pill box every week, and administered their own daily medications. Resident 24 also stated that they self-administered their own insulin injections every day.

During an interview on 10/05/2023 at 3:22 PM, Staff B, Registered Nurse, Health and Wellness Director, confirmed Resident 24 self-administered their own medications. Staff B stated that they were hired in January 2023, long after the facility admitted Resident 24. Staff B stated that they did not review and update Resident 24's self-medication administration assessment as a part of the annual assessment in July 2023.

RESIDENT 45

Review of Resident 45's facility records showed that the facility admitted Resident 45 in [REDACTED] 2023 with medical diagnoses which included [REDACTED]. The record showed that on [REDACTED]/2023, the facility assessed Resident 45. The record showed that Resident 45 self-managed their medications. Further review of the record showed no documentation the facility completed a self-medication administration assessment.

During an interview on 09/25/2023 at 10:23 AM, Resident 45 stated that in [REDACTED] 2023, they required assistance with ordering the Phosphate-binder medication (a drug that lowers phosphate level in the body) for their kidney disease. Resident 45 stated that they requested assistance from the facility. Resident 45 stated that in [REDACTED] 2023, the facility did not assess them, and the facility did not assist them to refill the medication. Resident 45 stated that they were unable to take their medication for 11 days. Resident 45 stated they were very concerned that this medication error furthered their medical condition.

During an interview on 10/05/2023 at 4:50 PM, Staff Q, Assistant Executive Director, Brookdale Foundation House, stated that there was no record the facility completed Resident 45's self-medication assessment, as required per facility policy. Staff Q stated that they were unaware of Resident 45's request for assistance with medication refill order.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 10/15/2023

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

Glenna Wiskett
Administrator (or Representative)

11/10/2023
Date

WAC 366-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (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 observation and interview the facility failed to provide a clean, safe, and well-maintained environment. This failure placed 86 of 86 residents at risk of injury and a diminished quality of life.

Findings included...**INDOOR COMMON AREAS**

Observations on 09/18/2023 at 12:15 PM showed the common areas and hallways throughout the facility were carpeted. Observations showed the carpets were significantly stained with multiple dark brown and black areas that varied in size. There were multiple ceiling tiles broken with visible insulation protruding down from the ceiling. Multiple ventilation screens covered with dust, grime, and water stains. Observation of the northeast second-floor stairwell showed a loose handrail. Observations in the main dining room showed a table in disrepair with loose leg supports. Observation in the first-floor activity room showed worktables held piles of used clothing, dirty dishware, and food debris. The activity room furniture was stained and dirty. The activity room floors were sticky.

During an interview on 09/18/2023 at 12:15 PM, Staff U, Regional Maintenance Technician, stated that there was no maintenance director at the facility. Staff U stated that as a result, carpet cleaning was not done, and the ventilation screens were not cleaned. Staff U also acknowledged that the broken ceiling tiles needed to be replaced.

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 Federal Way 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.

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Findings included...

INDOOR COMMON AREAS

Observations on 09/18/2023 at 12:15 PM showed the common areas and hallways throughout the facility were carpeted. Observations showed the carpets were significantly stained with multiple dark brown and black areas that varied in size. There were multiple ceiling tiles broken with visible insulation protruding down from the ceiling. Multiple ventilation screens covered with dust, grime, and water stains. Observation of the northeast second-floor stairwell showed a loose handrail. Observations in the main dining room showed a table in disrepair with loose leg supports. Observation in the first-floor activity room showed worktables held piles of used clothing, dirty dishware, and food debris. The activity room furniture was stained and dirty. The activity room floors were sticky.

During an interview on 09/18/2023 at 12:15 PM, Staff U, Regional Maintenance Technician, stated that there was no maintenance director at the facility. Staff U stated that as a result, carpet cleaning was not done, and the ventilation screens were not cleaned. Staff U also acknowledged that the broken ceiling tiles needed to be replaced.

During an interview on 09/26/2023 at 10:58 AM, Staff O, Chef, acknowledged that the dining table was in disrepair. Staff O further stated that they attempted to repair the dining table. Staff O stated that there were things in the facility that needed repairs and the repairs were not addressed.

During an interview on 09/26/2023 at 11:04 AM, Resident 42 stated that the clothing on activity room tables were used clothes dropped off several days ago as a donation to residents. Resident 42 further stated that the former activity director organized and distributed the clothing to residents. Resident 42 stated that without an activity director, the clothes sit on the tables for weeks at a time. Resident 42 stated that there were no other staff available to maintain the donations and activity area.

RESIDENT APARTMENTS

Observation of Resident 21's apartment on 09/18/2023 at 12:15 PM showed one clothes closet with two sliding doors. Further observation showed one of the closet doors was detached from its sliding track at the top and the door leaned against the residents' clothes. Observation during the licensing visit showed the same safety concerns for unsecured closet doors in Resident 7's apartment.

During an interview on 09/18/2023 at 12:15 PM, Staff U stated that the closet door design throughout the facility was the same in all resident rooms. Staff U stated the closet doors easily detached from the sliding tracks, at the top and bottom of the doors. Staff U stated that care staff and/or residents were expected to reattach the doors to the sliding tracks.

On 09/20/2023 at 2:10 PM, observation in Resident 5's apartment showed a missing drawer in the kitchenette cabinet. Observation showed a three-foot by one-foot piece of plywood nailed to the cabinet that covered the missing drawer space.

During an interview on 09/20/2023 at 12:40 PM, Collateral Contact 3 (CC3), Resident 5's representative, stated that there used to be a large drawer in the kitchenette cabinet which held Resident 5's personal items. CC3 stated that several weeks ago, they noticed the broken drawer. CC3 stated that they notified the facility. CC3 stated that the facility told them the drawer was thrown away. CC3 stated that Resident 5 needed the cabinet drawer. Without the drawer, Resident 5's storage space was limited. CC3 further stated that rather than fix the drawer, the facility covered the missing drawer with a piece of plywood.

During an interview on 09/21/2023 at 4:00 PM, Staff A, Executive Director, stated that they were unaware of the maintenance repair request submitted by Resident 5's representative. Staff A stated that they were unaware that the cabinet drawer was not replaced. Staff A further stated that since the former Maintenance Director resigned, the facility did not have a maintenance person to work on residents' maintenance requests.

During an interview on 09/26/2023 at 10:58 AM, Staff O, Chef, acknowledged that the dining table was in disrepair. Staff O further stated that they attempted to repair the dining table. Staff O stated that there were things in the facility that needed repairs and the repairs were not addressed.

During an interview on 09/26/2023 at 11:04 AM, Resident 42 stated that the clothing on activity room tables were used clothes dropped off several days ago as a donation to residents. Resident 42 further stated that the former activity director organized and distributed the clothing to residents. Resident 42 stated that without an activity director, the clothes sit on the tables for weeks at a time. Resident 42 stated that there were no other staff available to maintain the donations and activity area.

RESIDENT APARTMENTS

Observation of Resident 21's apartment on 09/18/2023 at 12: 15 PM showed one clothes closet with two sliding doors. Further observation showed one of the closet doors was detached from its sliding track at the top and the door leaned against the residents' clothes. Observation during the licensing visit showed the same safety concerns for unsecured closet doors in Resident 7's apartment.

During an interview on 09/18/2023 at 12:15 PM, Staff U stated that the closet door design throughout the facility was the same in all resident rooms. Staff U stated the closet doors easily detached from the sliding tracks, at the top and bottom of the doors. Staff U stated that care staff and/or residents were expected to reattach the doors to the sliding tracks.

On 09/20/2023 at 2:10 PM, observation in Resident 5's apartment showed a missing drawer in the kitchenette cabinet. Observation showed a three-foot by one-foot piece of plywood nailed to the cabinet that covered the missing drawer space.

During an interview on 09/20/2023 at 12: 40 PM, Collateral Contact 3 (CC3), Resident 5's representative, stated that there used to be a large drawer in the kitchenette cabinet which held Resident 5's personal items. CC3 stated that several weeks ago, they noticed the broken drawer. CC3 stated that they notified the facility. CC3 stated that the facility told them the drawer was thrown away. CC3 stated that Resident 5 needed the cabinet drawer. Without the drawer, Resident 5's storage space was limited. CC3 further stated that rather than fix the drawer, the facility covered the missing drawer with a piece of plywood.

During an interview on 09/21/2023 at 4:00 PM, Staff A, Executive Director, stated that they were unaware of the maintenance repair request submitted by Resident 5's representative. Staff A stated that they were unaware that the cabinet drawer was not replaced. Staff A further stated that since the former Maintenance Director resigned, the facility did not have a maintenance person to work on residents' maintenance requests.

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

Glenn Winkett
Administrator (or Representative)

11/10/2023
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:

- (1) Comply with chapter 70.129 RCW, Long-term care resident rights;
- (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 observation, interview and record review, the facility failed to ensure 3 of 3 sampled residents (Resident 2, Resident 9, and Resident 19) were treated respectfully and in a dignified manner. These failures placed the residents at risk of emotional distress and a diminished quality of life.

Findings included...

RESIDENT 2

Review of the facility's undated document titled "Admission Record" showed that the facility admitted Resident 2 in [REDACTED] 2023. Resident 2 admitted with multiple medical diagnoses which included [REDACTED].

Review of Resident 2's September 2023 "Medication Administration Record" (MAR) showed an order for insulin injection (a medication that lower blood sugar levels). The MAR showed Resident 2 received insulin three times daily, before meals.

Observation on 09/19/2023 at 11:45 AM and on 09/20/2023 at 11:45 AM, showed that Staff C, Resident Care Coordinator, Medication Technician, administered Resident 2's medications in the resident dining room. Observation showed that when Staff C

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 Federal Way 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 70.129.140 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:

- (1) Comply with chapter 70.129 RCW, Long-term care resident rights;
- (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 observation, interview and record review, the facility failed to ensure 3 of 3 sampled residents (Resident 2, Resident 9, and Resident 19) were treated respectfully and in a dignified manner. These failures placed the residents at risk of emotional distress and a diminished quality of life.

Findings included...

RESIDENT 2

Review of the facility's undated document titled "Admission Record" showed that the facility admitted Resident 2 in [REDACTED] 2023. Resident 2 admitted with multiple medical diagnoses which included [REDACTED] ([REDACTED]).

Review of Resident 2's September 2023 "Medication Administration Record" (MAR) showed an order for insulin injection (a medication that lower blood sugar levels). The MAR showed Resident 2 received insulin three times daily, before meals.

Observation on 09/19/2023 at 11:45 AM and on 09/20/2023 at 11:45 AM, showed that Staff C, Resident Care Coordinator, Medication Technician, administered Resident 2's medications in the resident dining room. Observation showed that when Staff C

approached Resident 2 with the insulin, Resident 2 pulled their sweatpants down to expose their lower abdomen. Observation showed Staff C administered the injection on Resident 2's lower abdomen. Observation showed that during the insulin administration, there were three unidentified residents seated with Resident 2. The three other residents watched Staff C administer Resident 2's insulin injection. Observation showed Staff C did not offer Resident 2 a private area to receive the injection.

During an interview on 09/19/2023 at 11:45 AM, Resident 2 stated that they did not choose to receive their medication in the dining room.

During an interview on 09/19/2023 at 11:50 AM, Staff C stated that the facility management allowed the medication technicians to administer residents' medications in the dining room.

RESIDENT 9

Observation on 09/19/2023 at 5:20 PM, showed Staff C administered Resident 9's insulin injection in the resident dining room. Observation showed that during this insulin administration, there were three unidentified residents seated with Resident 9 at the dining table. Observation showed Staff C injected the insulin into Resident 9's right shoulder, while the three unidentified residents watched. Observation showed Staff C did not offer Resident 9 a private area to receive the injection.

During a telephone interview on 10/05/2023 at 3:22 PM, Staff B, Health and Wellness Director, stated that they were aware the staff administered medications and insulin injections in the dining room. Staff B stated that they did not know when this medication practice first started. Staff B stated that no resident expressed any concern when they received their medications in the dining room. Staff B also stated that no resident complained about other residents receiving medications or injections in the dining room. Staff B stated that they were unaware the practice potentially violated residents' privacy and rights.

RESIDENT 19

Review of the facility's undated document titled "Admission Record" showed that the facility admitted Resident 19 in January 2023. Resident 19 admitted with multiple medical diagnoses which included Multiple Sclerosis (a potentially disabling disease that affects the central nervous system made up of the brain and spinal cord).

Review of Resident 19's "Personal Service Plan," (PSP), dated 02/10/2023, showed that Resident 19 was independent with transfers. The PSP showed Resident 19 had a history of falls in the past 12 months. The PSP showed the facility's fall prevention plan included the use of a scoop mattress (a special type of mattress with raised sides). The plan also showed defined bed boundaries were used to reduce the risk of Resident 19 sliding from bed.

Observation of Resident 19's apartment on 09/27/2023 at 1:49 PM showed Resident 19's

approached Resident 2 with the insulin, Resident 2 pulled their sweatpants down to expose their lower abdomen. Observation showed Staff C administered the injection on Resident 2's lower abdomen. Observation showed that during the insulin administration, there were three unidentified residents seated with Resident 2. The three other residents watched Staff C administer Resident 2's insulin injection. Observation showed Staff C did not offer Resident 2 a private area to receive the injection.

During an interview on 09/19/2023 at 11:45 AM, Resident 2 stated that they did not choose to receive their medication in the dining room.

During an interview on 09/19/2023 at 11:50 AM, Staff C stated that the facility management allowed the medication technicians to administer residents' medications in the dining room.

RESIDENT 9

Observation on 09/19/2023 at 5:20 PM, showed Staff C administered Resident 9's insulin injection in the resident dining room. Observation showed that during this insulin administration, there were three unidentified residents seated with Resident 9 at the dining table. Observation showed Staff C injected the insulin into Resident 9's right shoulder, while the three unidentified residents watched. Observation showed Staff C did not offer Resident 9 a private area to receive the injection.

During a telephone interview on 10/05/2023 at 3:22 PM, Staff B, Health and Wellness Director, stated that they were aware the staff administered medications and insulin injections in the dining room. Staff B stated that they did not know when this medication practice first started. Staff B stated that no resident expressed any concern when they received their medications in the dining room. Staff B also stated that no resident complained about other residents receiving medications or injections in the dining room. Staff B stated that they were unaware the practice potentially violated residents' privacy and rights.

RESIDENT 19

Review of the facility's undated document titled "Admission Record" showed ~~that~~ the facility admitted Resident 19 in January 2023. Resident 19 admitted with multiple medical diagnoses which included Multiple Sclerosis (a potentially disabling disease that affects the central nervous system made up of the brain and spinal cord).

Review of Resident 19's "Personal Service Plan," (PSP), dated 02/10/2023, showed that Resident 19 was independent with transfers. The PSP showed Resident 19 had a history of falls in the past 12 months. The PSP showed the facility's fall prevention plan included the use of a scoop mattress (a special type of mattress with raised sides). The plan also showed defined bed boundaries were used to reduce the risk of Resident 19 sliding from bed.

Observation of Resident 19's apartment on 09/27/2023 at 1:49 PM showed Resident 19's

bed contained two different sized mattresses, a twin-sized mattress placed on the top of a queen-sized mattress. The two mattresses were stacked up on an adjustable metal bed frame. Observation showed the bed did not contain a box spring that supported the mattresses. Further observation showed, a recliner chair across from the bed. The recliner was in a reclined position with a pillow, a blanket and sheets left unfolded in the recliner.

During an interview on 09/27/2023 at 1:55 PM, Resident 19 stated that when they moved into the facility, no bed was provided to them. Resident 19 stated that a friend gave them the bed seen in the apartment. Resident 19 stated the mattresses sagged in the middle, was uncomfortable, and caused them to have disrupted sleep. Resident 19 further stated that at night, they constantly transferred from the bed to the recliner to sleep. Resident 19 stated that there were days they experienced fatigue and would sleep in the recliner. Resident 19 said when fatigued, the bed was too high up to climb into for sleep. Resident 19 stated that eight months ago, they reported the condition of the bed to the facility staff. Resident 19 stated that they made multiple requests for a decent bed. Resident 19 stated "Nothing was done about it."

During an interview on 09/27/2023 at 2:00 PM, Staff A, Executive Director, stated that the facility provided standard beds to all the residents. Staff A stated they were unaware of Resident 19's concern with their bed.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023.

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

Denise Wiskeff
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2730 Licensee's responsibilities.

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to post 1 of 1 assisted living facility license (License 1) in a publicly noticeable location within the facility. This failure placed all 86 residents at risk of being uninformed about facility licensure status and any conditions.

bed contained two different sized mattresses, a twin-sized mattress placed on the top of a queen-sized mattress. The two mattresses were stacked up on an adjustable metal bed frame. Observation showed the bed did not contain a box spring that supported the mattresses. Further observation showed, a recliner chair across from the bed. The recliner was in a reclined position with a pillow, a blanket and sheets left unfolded in the recliner.

During an interview on 09/27/2023 at 1:55 PM, Resident 19 stated that when they moved into the facility, no bed was provided to them. Resident 19 stated that a friend gave them the bed seen in the apartment. Resident 19 stated the mattresses sagged in the middle, was uncomfortable, and caused them to have disrupted sleep. Resident 19 further stated that at night, they constantly transferred from the bed to the recliner to sleep. Resident 19 stated that there were days they experienced fatigue and would sleep in the recliner. Resident 19 said when fatigued, the bed was too high up to climb into for sleep. Resident 19 stated that eight months ago, they reported the condition of the bed to the facility staff. Resident 19 stated that they made multiple requests for a decent bed. Resident 19 stated "Nothing was done about it."

During an interview on 09/27/2023 at 2:00 PM, Staff A, Executive Director, stated that the facility provided standard beds to all the residents. Staff A stated they were unaware of Resident 19's concern with their bed.

Plan/Attestation Statement

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Administrator (or Representative)

Date

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Based on observation and interview, the facility failed to post 1 of 1 assisted living facility license (License 1) in a publicly noticeable location within the facility. This failure placed all 86 residents at risk of being uninformed about facility licensure status and any conditions.

Findings included...

Observations on 09/18/2023 at 12:40 PM showed the facility assisted living license posted in the locked administrative office. The license was not posted in a visible location available to residents, representatives, or public visitors.

During an interview on 09/18/2023 at 12:41 PM, Staff A, Executive Director, stated that they were not aware of the requirements to post the facility assisted living license in a conspicuous location within the facility.

Observation on 09/27/2023 at 4:55 PM, showed the facility license remained posted in Staff A's office. The facility continued to post the facility license in a location inaccessible to residents, representatives, or public visitors.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) 12/15/2023

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

Glenore Sinkett
Administrator (or Representative)

11/10/2023
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(i) Bathrooms and toilet rooms;

(ii) Resident living rooms and resident sleeping rooms; and

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

(ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

Findings included...

Observations on 09/18/2023 at 12:40 PM showed the facility assisted living license posted in the locked administrative office. The license was not posted in a visible location available to residents, representatives, or public visitors.

During an interview on 09/18/2023 at 12:41 PM, Staff A, Executive Director, stated that they were not aware of the requirements to post the facility assisted living license in a conspicuous location within the facility.

Observation on 09/27/2023 at 4:55 PM, showed the facility license remained posted in Staff A's office. The facility continued to post the facility license in a location inaccessible to residents, representatives, or public visitors.

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 Federal Way 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

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(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

(ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide all residents with a system to call staff for assistance with care and services. This failure placed all facility residents at risk of unmet care needs and not receiving assistance in an emergency.

Findings included...

Review of the undated facility emergency manual showed there was no policy and procedure with instructions for staff in the event the facility's communication system was not operational.

On 09/18/2023 at 2:45 PM, Resident 9 reported that the facility had ongoing problems with Residents' pendants and the call system. Resident 9 stated that the facility had informed residents that the system would be upgraded. Resident 9 stated that after months of residents being told the same thing that the call system continued to malfunction frequently.

During an observation and interview, on 09/27/2023 at 10:35 AM, Resident 12 stated that they wanted to demonstrate the communication system by pushing the button at their bedside. There was no audible alarm when the communication system was activated. Resident 12 stated that the facility staff does not answer when the button is pressed. Resident 12 stated that when staff do come to the room, they enter, turn off the button, and then leave. Resident 12 stated the ALF Staff do not ask what they need. Resident 12 stated that they did not expect to get assistance during an emergency. By 11:25 AM, no facility staff were observed responding to the communication system being activated.

During an interview and observation, on 09/19/2023 at 10:15 AM, Resident 21 stated that when they press the call button, no one comes. Resident 21 pressed the button to activate the communication system. After 15 minutes, there was no response from any staff member. At 11:06 AM, Staff J, Medication technician/Caregiver, was observed in the medication room. Staff J stated that they heard the communication system activate. Staff J stated that residents, "just have to wait... there's only 2 of us".

During an interview, on 09/27/2023 at 12:45 PM, Staff A, Executive Director, stated that the call bell system and resident pendant call devices often, "had ongoing issues and needed to be reset." Staff A stated that the call system, "stopped working yesterday (09/26/2023) just after lunch but the staff have been doing hourly checks on each resident since then." When Staff A was asked for the facility's policy and procedure for the communication system during times when the system was non-operational, Staff A replied that the facility did not have a policy with instructions for staff.

During an interview, on 09/27/2023 at 1:45 PM, Staff I, Business Office Manager, stated that the communication system and resident pendant call devices did not work.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide all residents with a system to call staff for assistance with care and services. This failure placed all facility residents at risk of unmet care needs and not receiving assistance in an emergency.

Findings included...

Review of the undated facility emergency manual showed there was no policy and procedure with instructions for staff in the event the facility's communication system was not operational.

On 09/18/2023 at 2:45 PM, Resident 9 reported that the facility had ongoing problems with Residents' pendants and the call system. Resident 9 stated that the facility had informed residents that the system would be upgraded. Resident 9 stated that after months of residents being told the same thing that the call system continued to malfunction frequently.

During an observation and interview, on 09/27/2023 at 10:35 AM, Resident 12 stated ~~that~~ they wanted to demonstrate the communication system by pushing the button at their bedside. There was no audible alarm when the communication system was activated. Resident 12 stated that the facility staff does not answer when the button is pressed. Resident 12 stated that when staff do come to the room, they enter, turn off the button, and then leave. Resident 12 stated the ALF Staff do not ask what they need. Resident 12 stated that they did not expect to get assistance during an emergency. By 11:25 AM, no facility staff were observed responding to the communication system being activated.

During an interview and observation, on 09/19/2023 at 10:15 AM, Resident 21 stated ~~that~~ when they press the call button, no one comes. Resident 21 pressed the button to activate the communication system. After 15 minutes, there was no response from any staff member. At 11:06 AM, Staff J, Medication technician/Caregiver, was observed ~~in~~ the medication room. Staff J stated ~~that~~ they heard the communication system activate. Staff J stated that residents, "just have to wait... there's only 2 of us".

During an interview, on ~~09~~ 09/27/2023 at 12:45 PM, Staff A, Executive Director, stated that the call bell system and resident pendant call devices often, "had ongoing issues and needed to be reset." Staff A stated ~~that~~ the call system, "stopped working yesterday (09/26/2023) just after lunch but the staff have been doing hourly checks on each resident since then." When Staff A was asked for the facility's policy and procedure for the communication system during times when the system was non-operational, Staff A replied ~~that~~ the facility did not have a policy with instructions for staff.

During an interview, on 09/27/2023 at 1:45 PM, Staff I, Business Office Manager, stated that the communication system and resident pendant call devices did not work

consistently. Staff I stated that when the call system was not operational, the facility staff would do visual checks on the residents' hourly. Staff I stated that the facility staff notified the residents when the call system was not working, and the medication technicians posted a sign on the doorway to the medication room.

Plan/Attestation Statement

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

Glenora Wickert
Administrator (or Representative)

11/10/2023
Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

AMENDED
11/01/2023

Emerital Evergreen Lodge LLC
Brookdale Federal Way
31002 14th Ave S
Federal Way, WA 98003

RE: Brookdale Federal Way # 2526

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/19/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

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 Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

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

Kent, WA 98032

- 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.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

- (1) Cooperate with the department during any on-site inspection or complaint investigation;
- (2) Provide requested records to the representatives of the department; and

During the entrance interview, the Executive Director was provided the list of required inspection documents. The Executive Director stated all current information related to residents' care was readily available in the residents' records. The Executive Director stated all current facility information and staff records were available and would be provided within the timeframes as shown on the required documents list. On 09/21/2023, the facility's Interim Executive Director was notified that the department Licensors had not received all the documentation requested for the licensing inspection process. The Interim Executive Director and the District Director of Operations informed Licensors that the facility was currently implementing processes to ensure that all required resident information, staff records and facility documentation would be up to date and readily available for future Department inspections and complaint visits.

You Are Not:

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

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.
- Send your request to:

IDR Program Manager
Department of Social and Health Services

Brookdale Federal Way #2526

10/19/2023

Page 3 of 3

Aging and Long-Term Support Administration

Residential Care Services

PO Box 45800

Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager

Region 2, Unit D

Residential Care Services

Enclosure

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