STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Sapphire at Brighton Court LLC
Brighton Court Assisted Living
1308 N Vercler Rd
Spokane Valley, WA 99216

RE: Brighton Court Assisted Living License # 2629

Dear Administrator:

This letter addresses Compliance Determination(s) 47035 (Completion Date 09/11/2024) and 44092 (Completion Date 07/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/11/2024 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-2140-1-a-iii, WAC 388-78A-2140-1-b, WAC 388-78A-2140-2-a

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brighton Court Assisted Living
License/Cert.#: 2629
Compliance Determination #: 44092
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 137021
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 07/12/2024 through 07/29/2024
Complainant Contact Date(s): 07/03/2024, 07/29/2024

Allegation(s):

1 - Care plans not updated to address assistance with meals
2 - Facility doesn't provide medications, as ordered

Investigation Methods:

Sample:	Total residents: 38 Resident sample size: 9 Closed records sample size: 0
Observations:	Residents' safety and well-being Any unmet needs Meal(s) Medication passes Staff's response to residents' needs/concerns
Interviews:	Four residents, including alleged victim (AV) Four resident representatives, including for AV Two facility caregivers Medication Aide Two hospice staff Facility licensed nurse Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, and medication administration records (MARS) Staffing schedules - May, June, and July 2024 Disclosure of Services

Investigation Summary:

1 - Alleged victim was observed needing assistance for oral intake. Interviews with representative, and facility and hospice staff showed the AV's ability to eat had declined. The care plan for the AV showed the facility failed to include instructions regarding the AV's food and fluid intake. Failed facility practice was found and documented in 07/29/2024 Statement of Deficiencies under Washington Administrative Code 388-78a-2140 (1)(a)(iii)(b)(2) Negotiated service agreement contents.

2 - As observed, staff utilized a system to check prescribers' orders prior to providing medications to residents. Resident, representative, and collateral contact interviews did not support allegation. Reviews of sampled residents' MARS showed the facility provided medications, as ordered. The investigation findings did not support violations. No failed facility practices were found related to allegation.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2629	Compliance Determination # 44092
Plan of Correction	Brighton Court Assisted Living	Completion Date
Page 1 of 5	Licensee: Sapphire at Brighton Court LLC	07/29/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 07/12/2024, 07/12/2024 and 07/12/2024 of:

Brighton Court Assisted Living
1308 N Vercler Rd
Spokane Valley, WA 99216

This document references the following complaint number(s): 137021

The following sample was selected for review during the unannounced on-site visit: 9 of 38 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Michelle R. Closner
Residential Care Services

08/05/2024
Date

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

Administrator (or Representative) Date 8-7-24

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to include instructions in the negotiated service agreement related to a resident's food and fluid intake for 1 of 3 residents (Resident 3) who received hospice services. This failure placed the resident at risk for inconsistent feeding assistance and at risk for aspiration of food/fluids into their lungs.

Findings included...

Review of the undated Face Sheet for Resident 3 showed they had diagnoses including [redacted], [redacted], [redacted], and [redacted].

In an interview on 07/03/2024 at 10:10 AM, Collateral Contact 1 (CC1), family member of Resident 3, stated the resident had a stroke that affected the resident's ability to use the right side of their body. CC1 stated Resident 3 was unable to independently use utensils to eat and needed to be fed. CC1 further stated they were concerned that the

facility wasn't providing the resident with enough encouragement and help to eat, and the facility didn't provide the family with a current care plan that included staff's interventions related to Resident 3's nutritional intake.

In an interview on 07/03/2024 at 10:10 AM Collateral Contact 2 (CC2), family member of Resident 3, stated Resident 3 was sometimes able to verbalize they were thirsty and hungry. CC2 stated the facility didn't provide the resident with help to eat and provided minimal amounts of fluids.

Observations on 07/12/2024 at 10:08 AM, showed Resident 3 was in bed, asleep. Staff A, Medication Aide/Caregiver was observed waking the resident and providing them with the resident's medication. Staff A provided the medication in applesauce, which Resident 3 accepted. Collateral Contact 3 (CC3), family member of Resident 3 was observed at the resident's bedside.

In an interview on 07/12/2024 at 10:08 AM, CC3 stated Resident 3 was hospitalized on [redacted]/2024 for urinary tract infection and hallucinations. CC3 stated the resident was diagnosed at the hospital with [redacted], received rehabilitation services, and at the time was able to independently use utensils and eat. CC3 stated Resident 3 returned to the facility on [redacted]/2024. CC3 stated the resident's physical function declined after returning to the facility and the resident was placed on hospice services on 07/02/2024. CC3 further stated that hospice staff and Staff B, Director of Nursing, believed Resident 3 should not be fed. CC3 stated they disagreed with this, and they frequently visited Resident 3 and fed the resident applesauce, small amounts of fruit, and Cream of Wheat. They stated the resident ate scrambled eggs that morning. CC3 stated they themselves or the facility provided food for the resident. When the department investigator asked CC3 what the facility and resident/family negotiated related to the resident's food/fluid intake, CC3 could not specify.

In an interview on 07/12/2024 at 12:10 PM, Staff C, Caregiver, stated Resident 3 currently took meals in their apartment. Regarding the staff's responsibility related to Resident 3's meals, Staff C stated staff should check on and remind the resident to eat, in case the resident fell asleep. Staff C also stated Resident 3 had problems with swallowing.

In an interview on 07/23/2024 at 11:15 AM, Staff A stated Resident 3 required assistance with feeding. Staff A stated the resident's acceptance of medications and food varied, and staff did not force the resident to take them. Staff A was unsure about how facility staff received instructions about Resident 3's food and fluid needs.

In an interview on 07/23/2024 at 11:40 AM, CC3 stated they gave Resident 3 some Cream of Wheat and sips of water. CC3 stated they sometimes brought foods, such as chili for Resident 3 to have at lunch. CC3 stated staff were currently offering the resident food at times, adding that the resident sometimes eagerly accepted the food and at other times did not because the resident was unable to exercise the thought process to eat. CC3 stated the facility provided the family with an updated negotiated

service agreement (NSA). The department investigator asked CC3 to provide the department investigator with a copy of the NSA they received from the facility.

In an interview on 07/23/2024 at 11:40 AM, CC4, Resident 3's family member stated the resident sometimes eagerly accepted their favorite foods, such as ice cream with chocolate sauce. CC4 stated Staff B did not provide verbal or written details to the family related to Resident 3's food and fluid needs. CC4 stated, "We're not expecting (facility) to force feed (Resident 3), but they should provide information about what to do when (Resident 3) wants/is willing to take food and fluids."

In an interview on 07/23/2024 at 1:23 PM, CC5, Hospice Nurse, stated hospital staff initiated a request for hospice services for Resident 3, which were started on 07/02/2024. CC5 stated Resident 3 experienced a change in nutritional needs and decreased intake after returning to the facility from the hospital. CC5 stated hospice notes showed a plan to frequently offer small amounts of food, increase protein intake, and encourage but not push the resident's intake. CC5 stated concern that during the prior week, the resident's lungs sounded filled with fluid, a symptom that could indicate food/fluid consumed by the resident was going into the lungs rather than the stomach, and placed the resident at risk of pneumonia, a potentially fatal lung infection. CC5 further stated they were concerned about the safety related to Resident 3's impaired ability to swallow and planned to meet with the resident's family and facility on 07/26/2024.

In an interview on 07/23/2024 at 1:35 PM, Staff B stated they incorporated into residents' NSA any instructions from hospice. Staff B further stated they did not write instructions from hospice in Resident 3's NSA regarding issues such as food/fluid intake and assistance to eat.

At the request of the department investigator, the facility provided a copy of the current NSA for Resident 3. The NSA, that was updated on 07/02/2024, showed the resident was at risk of dehydration and did not include specific instructions for staff and family related to the resident's fluid and food intake. The NSA only included instructions for staff to obtain monthly weights.

Review of a copy of the 07/02/2024 NSA that the facility provided to CC3 showed the information about Resident 3's nutritional needs was identical to the information listed in the previous paragraph.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2629	Compliance Determination # 44092
Plan of Correction	Brighton Court Assisted Living	Completion Date
Page 5 of 5	Licensee: Sapphire at Brighton Court LLC	07/29/2024

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, Brighton Court Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8-1-24 .

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

Administrator (or Representative) Date 8-7-24