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

05/28/2025

EMERITUS CORPORATION
Brookdale Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

RE: Brookdale Olympia East # 2275

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 60151 (Completion Date 05/28/2025) and 56445 (Completion Date 03/27/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/28/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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;

(b) Basic;

WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(l) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

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

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

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

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

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

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

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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

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

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

(e) Chapter 246-888 WAC, Medication assistance.

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

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

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(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;

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

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

WAC 388-78A-2040 Other requirements.

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

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

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

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

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

(d) Provide all resident care and services according to current acceptable standards for infection control;

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

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

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

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

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

The Department staff who did the On Site verification:

Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

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

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 1 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

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 03/17/2025 and 03/27/2025 of:
Brookdale Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

The following sample was selected for review during the unannounced on-site visit: 9 of 68 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 2 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

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

Cory Cisneros
Residential Care Services

04/03/2025
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.

Bob
Administrator (or Representative)

4·13·25
Date

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

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

(a) Orientation and safety;

(b) Basic;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 4 of 4 staff (Staff A, Staff B, Staff F, and Staff G) completed their facility orientation training and 3 of 4 staff (Staff A, Staff F, and Staff G) completed their 5-hour DSHS (Department of Social and Health Services) training. The facility failed to ensure 2 of 2 new staff (Staff F and Staff G) completed their 70-hour basic training. These failures placed 68 of 68 residents at risk of being improperly cared for by untrained staff.

Findings Included...

WAC 388-112A-0200
What is orientation training, who should complete it, and when should it be completed?
There are two types of orientation training: Facility orientation training and long-term care worker orientation training.
"(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials,

or trainers. No test is required for this orientation.
(2) Long-term care worker orientation. Individuals required to complete the 70-hour home care aide basic training must complete long-term care worker orientation, which is two hours of training regarding the long-term care worker's role and applicable terms of employment as described in WAC 388-112A-0210.
(a) All long-term care workers who are not exempt from home care aide certification as described in RCW 18.88B.041 hired on or after January 7, 2012, must complete two hours of long-term care worker orientation training before providing care to residents."

WAC 246-980-030
Working while obtaining certification as a home care aide.
"(1) A long-term care worker may provide care before receiving certification as a home care aide if all the following conditions are met:
(b) The long-term care worker must submit an application for home care aide certification to the department within fourteen calendar days of hire. An application is considered to be submitted on the date it is post-marked or, for applications submitted in person or online, the date it is accepted by the department.
(2) A long-term care worker is no longer eligible to provide care without a credential under the following circumstances:
(a) The long-term care worker does not successfully complete all of the training required by RCW 74.39A.074(1) within one hundred twenty calendar days from their date of hire;
(b) The long-term care worker has not obtained their certification within two hundred calendar days from their date of hire, or two hundred sixty calendar days if granted a provisional certificate under RCW 18.88B.041."

Record review of the" Associate Roster", undated, showed Staff A, Executive Director was hired at the facility on 10/14/2024. Staff B, Health and Wellness Coordinator was hired at the facility on 09/30/2024. Staff F, Care Partner, was hired at the facility on 09/05/2024. Staff G, Medication Technician, was hired at the facility on 10/02/2024.

Record review of the facility, "Washington Training Plan Checklist", undated, showed the top of the document said retain on file once signed and dated. The bottom of the document showed "I attest the items were marked "done" have been reviewed, and I had the opportunity to ask questions about the information." There was a line for the associate name, date, associate signature, and facilitator signature.

Record review of the facility, "Community Tour Checklist", undated, showed the top of the document said retain on file once signed and dated. The bottom of the document showed "I attest that the items marked as done have been covered on the community tour, and I have been provided the opportunity to ask questions about the information provided." There was a line for the associate name and date and the facilitator name and date.

Facility Orientation

Staff A

Record review of Staff A's, "Timecard", dated 12/31/2024 – 01/01/2025, showed they were paid 8 hours of holiday pay on "01/01[/2025]".

Record review of Staff A's, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff A completed the facility orientation in accordance with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

In an interview on 03/20/2025 at 11:27 AM, Staff A stated they did not work at the facility on 01/01/2025.

Staff B

Record review of Staff B's, "Timecard", dated 12/31/2024 – 01/01/2025, showed they were paid 6 hours of holiday pay on Wednesday (01/01/2025) and they worked 2 hours for a total of 8 hours paid for the day.

Record review of Staff Bs, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff B completed the facility orientation in accordance with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

Staff F

Record review of Staff F's, "Timecard", dated 12/31/2024 – 01/01/2025, showed they were paid 8 hours of holiday pay on Wednesday (01/01/2025).

Record review of Staff F's, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff F completed the facility orientation in accordance with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

In an interview on 03/19/2025 at 12:56 PM, Staff F stated, "no don't recall that", when asked if they had attended a five-hour class with Staff C, Business Office Coordinator on 01/01/2025. Staff F stated they had completed all the modules on the computer and only fit testing with Staff C. Staff F stated they did not work on 01/01/2025.

Staff G

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 6 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

completed 53 days after the required timeframe.

Staff G

Record review of Staff G's, Completed 75 hours of DSHS approved Basic Training and Passed the Home Care Aide Certification Exams, dated 02/25/2025 showed it was completed 26 days after the required timeframe.

In an interview on 03/19/2025 at 3:33 PM, Staff C said the facility orientation and 5-hour DSHS orientation and training were completed on the staff's first date of hire. Staff C said the facility orientation takes approximately three to four days to complete. Staff C said facility staff members were required to get their 75-hour basic within 120 days.

In an interview on 03/20/2025 at 11:32 AM, Staff C stated they had made all the employee's five-hour DSHS orientation and safety certificates dated for 01/01/2025. Staff C stated it was not standard of practice to just date employee certificates for the first day of the year. Staff C they were told by the corporation that they needed to be caught up and thought they would start fresh with all employee's five-hour DSHS orientation and safety certificates dated for 01/01/2025. Staff C stated they did not do any actual trainings on 01/01/2025.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob C

Administrator (or Representative)

4.13.25

Date

WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(l) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

This requirement was not met as evidenced by:

Record review of Staff G's, "Timecard", dated 12/31/2024 – 01/01/2025, showed they were paid 0.05 hours of holiday pay on Wednesday (01/01/2025).

Record review of Staff G's, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff G completed the facility orientation in accordance with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

In an interview on 03/18/2025 at 3:55 PM, Staff C said the Washington training plan checklist and the community tour checklist documents showed what topics were reviewed and covered for staff's facility orientation. Staff C said facility staff members also completed Relias (online workforce education for healthcare organizations) trainings during staff's facility orientation. Staff C said the facility staff members did not sign off on the Washington training plan checklist document. Staff C said facility staff received a certificate after they completed the facility orientation.

5 Hour DSHS Orientation

Staff A

Record review of Staff A's, "Orientation and Safety", showed it was completed on 01/01/2025.

Staff F

Record review of Staff F's, "Orientation and Safety", showed it was completed on 01/01/2025.

Staff G

Record review of Staff G's, "Orientation and Safety", showed it was completed on 01/01/2025.

70 Hour Basic

Staff F

Record review of Staff F's, "Completed 75 hours of DSHS approved Basic Training and Passed the Home Care Aide Certification Exams", dated 02/25/2025 showed it was

Based on interview and record review, the facility failed to ensure that the certificate of completion for facility orientation for 4 of 4 sampled staff (Staff A, Staff B, Staff F, and Staff G), and 3 of 3 sampled staff (Staff A, Staff F, and Staff G) five hour Department of Social and Health Services certificates were dated for the date of the completion of course. This failure placed 68 of 68 residents at risk of inaccurate training records and staff at risk of being untrained on the facility.

Findings included...

Record review of the Department of Social and Health Services Aging and Long-Term Support Administration document titled, "Long-Term Care Woker Orientation Training", undated, under the section titled, "appendix 2; Long-Term Care Worker Orientation Checklist", showed "your certificate of completion is the official document of completion".

Record review of the facility's document titled, "Associates Roster", undated, showed Staff A, Executive Director, started employment on 10/14/2024; Staff B, Health and Wellness Coordinator, started employment at the facility on 09/30/2024; Staff F, Care Partner, started employment on 09/05/2024; and Staff G, Medication Technician, started employment on 10/02/2024.

Staff A

Record review of Staff A's, "Timecard", dated 12/31/2024 through 01/01/2025, showed they were paid eight hours of holiday pay on "01/01".

Record review of Staff A's, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff A completed the facility orientation in accordance with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

In an interview on 03/20/2025 at 11:27 AM, Staff A stated they did not work at the facility on 01/01/2025.

Staff B

Record review of Staff B's, "Timecard", dated 12/31/2024 – 01/01/2025, showed they were paid 6 hours of holiday pay on Wednesday (01/01/2025) and they worked 2 hours for a total of 8 hours paid for the day.

Record review of Staff Bs, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff B completed the facility orientation in accordance

with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

Staff F

Record review of Staff F's, "Timecard", dated 12/31/2024 through 01/01/2025, showed they were paid 8 hours of holiday pay on Wednesday (01/01/2025).

Record review of Staff F's, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff F completed the facility orientation in accordance with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

In an interview on 03/19/2025 at 12:56 PM, Staff F stated, "no don't recall that", when asked if they had attended a five-hour class with Staff C, Business Office Coordinator on 01/01/2025. Staff F stated they had completed all the modules on the computer and only fit testing with Staff C. Staff F stated they did not work on 01/01/2025.

Staff G

Record review of Staff G's, "Timecard", dated 12/31/2024 – 01/01/2025, showed they were paid 0.05 hours of holiday pay on Wednesday (01/01/2025).

Record review of Staff G's, "Certificate of Completion", dated 01/01/2025 showed the certificate was to certify that Staff G completed the facility orientation in accordance with WAC 388-112-0200 (1) on 01/01/2025. The certificate did not show what topics were reviewed during the facility orientation.

In an interview on 03/18/2025 at 3:55 PM, Staff C said the Washington training plan checklist and the community tour checklist documents showed what topics were reviewed and covered for staff's facility orientation. Staff C said facility staff members also completed Relias (online workforce education for healthcare organizations) trainings during staff's facility orientation. Staff C said the facility staff members did not sign off on the Washington training plan checklist.

5 Hour DSHS Orientation

Staff A

Record review of Staff A's, "Orientation and Safety", showed it was completed on 01/01/2025.

Staff F

Record review of Staff F's, "Orientation and Safety", showed it was completed on 01/01/2025.

Staff G

Record review of Staff G's, "Orientation and Safety", showed it was completed on 01/01/2025.

In an interview on 03/19/2025 at 3:33 PM, Staff C stated the facility orientation and 5-hour DSHS orientation and training were completed on the staff's first date of hire. Staff C stated the facility orientation takes approximately three to four days to complete.

In an interview on 03/20/2025 at 11:32 AM, Staff C stated they had made all the employee's five-hour DSHS orientation and safety certificates dated for 01/01/2025. Staff C stated it was not standard of practice to just date employee certificates for the first day of the year. Staff C stated they were told by the corporation that they needed to be caught up by the beginning of the year 2025 and thought they would start fresh with all employee's five-hour DSHS orientation and safety certificates dated for 01/01/2025. Staff C stated they did not do the actual training on 01/01/2025 for Staff A, Staff B, Staff F, and Staff G that were reviewed.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob C

Administrator (or Representative)

4.13.25

Date

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether

the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete a character, competence, and suitability for 1 of 1 staff member (Staff F) before they were determined they were cleared to work with vulnerable adults. This placed 68 of 68 residents at risk for potentially being cared for by an unauthorized staff member.

Findings included...

"WAC [Washington Administrative Code] 388-113-0060 How and when must a character, competence, and suitability [CCS] determination be conducted by the department or an authorized entity? (1) The department or an authorized entity must conduct a character, competence, and suitability determination of an employee, prospective employee, or other individual who is required to undergo a background check when the applicant has received a "review required" result as defined in WAC 388-113-0101(b). (3) If an applicant is required to have a character, competence, and suitability determination under this section, the applicant may not have unsupervised access to minors or vulnerable adults unless the character, competence, and suitability determination has: (a) Been completed and documented in writing. applicant may have unsupervised access to minors or vulnerable adults."

Record review of the facility's, "Associate Roster", undated, showed Staff F's, Care Partner, hire date was on 09/05/2024.

Record review of Staff F's interim Washington state name and date of birth and fingerprint background check, dated 08/28/2024, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review". There was no CCS completed for Staff F's interim fingerprint background check results for review.

Review of Staff F's final Washington state name and date of birth and fingerprint background check, dated 09/10/2024, showed there were "information reported by one or more background check sources that requires a character, competency, and suitability (CCS) review".

Review of Staff F's CCS, dated 09/10/2024, showed it was completed when the final Washington state name and date of birth and fingerprint background check was completed.

In an interview and record review on 03/18/2025 at 3:37 PM, Staff C, Business Office Coordinator, stated if any employees background check results showed the employee had a finding and required a CCS review, they would complete it with that background result. Staff C stated the do it for all background check results that show a CCS was required. Staff C stated all employee CCS forms were in the background check binder in their office. At 3:50 PM, Staff C reviewed the background check binder in their office for a CCS for Staff F's interim Washington state name and date of birth and fingerprint background check, dated 08/28/2024. There was no CCS completed in the binder for Staff F's interim Washington state name and date of birth and fingerprint background

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 11 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

check, dated 08/28/2024 for review. Staff C stated they were responsible to ensure that employees had a CCS when their background check results required one and then have the executive director sign off on it.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob Cobbs 4.13.25

Administrator (or Representative) Date

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 2 sampled staff (Staff E and Staff H) received their fingerprint background check. This failure placed 68 of 68 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

WAC (Washington Administrative Code) 388-78A-24681
"Background checks—Employment—Provisional hire—Pending results of national fingerprint background check.
The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:
(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and
(2) The results of the national fingerprint background check are pending."

Record review of the" Associate Roster", undated, showed Staff E, Resident Care

Coordinator, was hired at the facility on 05/23/2022. Staff H, Resident Engagement, was hired at the facility on 05/06/2022. Staff C, Business Office Coordinator, was hired on 02/07/2024.

Staff E

Record review of Staff E's, "Notification of Background Check Result", dated 10/01/2024 showed it was a final fingerprint completed on 10/01/2024 which was 742 days past the 120-day timeframe.

Staff H

Record review of Staff H's, "Notification of Background Check Result", dated 06/21/2024 showed it was an interim fingerprint completed on 06/21/2024 which was 657 days past the 120-day timeframe.

In an interview on 03/18/2025 at 4:30 PM, Staff C said they were responsible to complete facility staff background checks. Staff C said after they completed an audit, they realized Staff H's final fingerprint background check had not been completed and they started the process to complete it.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5-11-25 .

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

Administrator (or Representative) Date 4-13-25

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

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 2 sampled staff (Staff E and Staff H) had submitted a new Washington state name and background check every two years. This failure placed 68 of 68 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Record review of the" Associate Roster", undated, showed Staff E, Resident Care Coordinator was hired at the facility on 05/23/2022. Staff H, Resident Engagement was hired at the facility on 05/06/2022.

Staff E

Record review of Staff E's, "Notification of Background Check Result", dated 05/17/2024 showed it was an interim fingerprint completed on 05/17/2024.

Staff H

Record review of Staff H's, "Notification of Background Check Result", dated 05/22/2024 showed it was an interim fingerprint completed on 05/22/2024.

In an interview on 03/18/2025 at 4:30 PM, Staff C, Business Office Coordinator, said they could not provide Staff E or Staff H's initial background checks to review of when they were first hired at the facility. Staff C acknowledged that without the initial staff background checks to review Staff E and Staff H's two year background check renewal could not be verified.

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 14 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Administrator (or Representative) Date 4.13.25

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

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

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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

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

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

(e) Chapter 246-888 WAC, Medication assistance.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 2 medication technicians (Staff L) observed provided medication assistance within their scope of practice. This failure placed Resident 9 [R9] at risk of receiving nursing services unsupervised by unqualified and untrained medication technicians.

Findings included...

Revised Code of Washington 18.79.260 "Registered nurse—Activities allowed—Delegation of tasks. (Effective June 30, 2027.) ...(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient... (c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) or (f) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated... (e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants under

chapter 18.88A RCW or home care aides certified under chapter 18.88B RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the board are exempted from this requirement... (f) The delegation of nursing care tasks only to registered or certified nursing assistants under chapter 18.88A RCW or to home care aides certified under chapter 18.88B RCW may include glucose monitoring and testing."

Record review of the facility's Disclosure of Services, undated, under section titled "intermittent nursing services", showed the facility did not use nursing assistants under the delegation of a registered nurse to provide some authorized nursing services.

Record review of the Washington State Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2025", undated, under the section titled, "what is not covered under medication assistance", showed injectable medications were not covered under medication assistance.

Record review of R9's Admission Record, dated 09/25/2024, showed R9 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted].

Record review of R9's Care Profile, dated 03/04/2025, showed R9 had diabetes. Staff were to prepare R9's medications. R9 required insulin assistances as R9 injected them self.

In an observation on 03/18/2025 at 4:35 PM, in R9's living room area, Staff L, Care Partner, came into R9's living room area to check R9's blood sugar and provide R9 their insulin prior to dinner. Staff L put disposable gloves on both hands. Staff L cleaned R9's left hand pinky finger with an alcohol wipe. Staff L waited for the area to be dried. Staff L then placed a stick onto R9's left hand pinky finger and pushed down. Once the stick device was pushed down, you could hear a click. When Staff L lifted up the stick device up off of R9's pinky finger there was a drop of blood. Staff L put the strip that was in the machine into the blood until it beeped. Staff L was not observed or heard to ask or have R9 poke their own finger to draw their blood for their blood sugar check.

In an interview on 03/17/2025 at 2:14 PM, Staff A, Executive Director, stated the facility did not provide nurse delegation services and did not have a nurse delegation policy for review.

In an interview on 03/19/2025 at 7:34 AM, Staff N, Medication Technician, stated all medication technicians were trained to assist residents with blood sugar checks for R9. Staff N stated R9 was to injection their own insulin and poke their own finger for their blood sugar checks. Staff N stated the facility was assisted living and did not have nurse delegation. Staff N stated medication technicians were not nurse delegated to poke a resident's finger for blood sugar check or inject insulin administration.

In an interview on 03/19/2025 at 11:18 AM, Staff B, Health and Wellness Coordinator, stated medication technicians were not to poke a resident's finger to get blood to check their blood sugar. Staff B stated that task required nurse delegation and the facility did not have nurse delegation. Staff B stated the medication technicians were able to assist the resident with setting up the supplies, but the resident would have to poke their finger or insert the insulin needle for administration and not the medication technician.

Staff B stated all medication technicians completed an electronic training that reviewed they were not allowed to poke a resident's finger to obtain blood for their blood sugar check.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob Clay — 4.13.25

Administrator (or Representative) — Date

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all medications were stored and locked in a secure manner in 1 of 2 sampled resident rooms (Resident 6 [R6]). The failure to secure medications placed 68 of 68 residents at risk of access to and potential ingestion of potentially harmful substances and presented risk for tampering with or misuse of medications by residents, staff, or visitors in the facility.

Findings included...

Record review of the facility policy titled, "Medication & Treatment – Storage Policy", dated "10/18", showed medications and treatments stored by the community were to be stored in designated locations that must be locked when not in use or when attended. Medication carts could be used as storage containers to deliver medications and treatments throughout the community.

Record review of R6's, "Admission Record", dated [redacted]/2025, showed R6 had diagnoses of [redacted] and [redacted].

Record review of R6's, "Personal Service Plan", dated 02/27/2025, showed the facility ordered and coordinated medications between residents' family, health care providers, and pharmacy. The Facility provided assistance with R6's self-administration of their

medications as needed, and they stored R6's medications in the community's medication storage area.

In an observation and interview on 03/19/2025 at 2:46 PM, R6 said the facility staff provided them their medications for them to take. On R6's kitchen counter showed a container of Tylenol (medication that reduces pain and fever) with 50 gel caps at 500 milligrams each. On R6's coffee table next to their couch there were three containers of Flonase (nasal spray) 50 milligrams per spray.

In an interview on 03/19/2025 at 3:43 PM, Staff J, Medication Technician, said the facility staff provided R6 their medications to them. Staff J said if facility staff managed a resident's medications and had knowledge the resident had medications inside of their room they would retrieve the medication from the resident's room. Staff J was notified R6 had Tylenol and Flonase inside of their room. Staff J said that they would follow up.

In an observation on 03/20/2025 at 10:56 AM, R6's kitchen counter showed a container of Tylenol with 50 gel caps at 500 milligrams each and on R6's coffee table next to their couch there were three containers of Flonase 50 milligrams per spray.

In an interview on 03/20/2025 at 11:12 AM, Staff B, Health and Wellness Coordinator, said R6 did not have an order for them to self-administer Tylenol or Flonase. Staff B said if the facility managed a resident's medication and found medication inside of their room, they would retrieve the medication and put it inside of the medication cart. Staff B said they did not have knowledge that R6 had Tylenol or Flonase inside of their room.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5·11·25 .

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

Administrator (or Representative) 4·13·25 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 8 sampled

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 18 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

residents (Resident 1 [R1] and Resident 6 [R6]) medications were available to be administered. This failure resulted in the residents not receiving their medications as ordered and placed the residents at risk for unmet care needs and medical complications associated with not receiving medications as ordered.

Findings included...

Record review of the facility policy titled, "Medications & Treatments – Availability", dated "8/2022", showed it was the facility policy that all current ordered medications would be available to the resident. The facility was responsible to obtain new medications or refills for medications and treatment orders. In the event the resident or the legally responsible party had the responsibility to obtain new ordered medications or reordering medications, and medications were not delivered within two days prior to the depletion of the medication stock, the facility nurse would do the following, order and reorder the medication with the preferred pharmacy provider, so there was no interruption of medication administration takes place, and the family would be responsible to pay for the medications as well as any associated emergency delivery services charges.

R1

Record review of R1's "Admission Record", dated 11/18/2024, showed R1 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted] and [redacted].

Review of R1's Personal Service Plan, dated 02/12/2025, showed R1 required the facility staff prepare and store R1's medications in the wellness room. Staff were to notify R1 and their daughter when R1's medication was getting low to reorder.

Record review of the R1's Medication Administration Record (MAR), dated 01/01/2025 through 01/31/2025, showed R1 had an order for senna laxative (a medication to help treat constipation or lack of ability to pass bowel movements) take one tablet every day. The medications indications were for constipation (a condition when a person has a difficult time passing bowel movements). Review of administration showed on 01/10/2025, 01/11/2025, 01/14/2025 through 01/17/2025, R1's doses of senna laxative were not administered related to the medication not available.

Record review of R1's progress note, dated 01/10/2025 at 5:22 PM, showed the type of note was "general noted from the electronic MAR". There was no documentation other than the senna laxative order.

Record review of R1's progress note, dated 01/11/2025 at 7:26 AM, showed the type of note was "general noted from the electronic MAR". The progress note had the order for the senna laxative and "will inform resident on needing to reorder the medication" documented.

Record review of R1's progress note, dated 01/14/2025 at 9:15 AM, showed the type of note was "general noted from the electronic MAR". The progress note showed the order for the senna laxative and "medication not on hand calling family to see when they can bring this in" documented.

Record review of R1's progress note, dated 01/15/2025 at 8:43 AM, showed the type of

note was "general noted from the electronic MAR". The progress note showed the order for the senna laxative and "medication not on hand the resident is going to get it" documented.

Record review of R1's progress note, dated 01/16/2025 at 9:36 AM, showed the type of note was "general noted from the electronic MAR". The progress note showed the order for the senna laxative and "medication ordered and will be delivered soon" documented.

R6

Record review of R6's, "Admission Record", dated [redacted]/2025, showed R6 had diagnoses of [redacted] and [redacted].

Record review of R6's, "Personal Service Plan", dated 02/27/2025, showed the facility ordered and coordinated medications between residents' family, health care providers, and the pharmacy. The facility provided assistance with R6's self-administration of their medications as needed.

Record review of R6's MAR, dated 03/01/2025 – 03/17/2025, showed R6 had an order for potassium (treats or prevents low amounts of potassium in the blood) and did not receive their medication on 03/06/2025, 03/07/2025, 03/09/2025, 03/10/2025, and 03/11/2025. R6 had an order for Sertraline (medication used to treat mood disorders) and did not receive their medication on 03/09/2025, 03/10/2025, and 03/11/2025. R6 had an order to receive Alvesco (medication to prevent and control asthma) twice a day and did not receive one dosage on 03/07/2025, one dosage on 03/08/2025, two dosages on 03/09/2025, two dosages on 03/10/2025, and one dosage on 03/11/2025. The chart codes indicated R6 did not receive their medications because 20 "medication/treatment not available/pharmacy action" and 18 "other/see med (medication) note".

Record review of R6's, "Progress Notes", dated 03/06/2025, showed R6's potassium medication had been ordered and Staff B, Health and Wellness Coordinator, would go pick it up.

Record review of R6's, "Progress Notes", dated 03/06/2025 – 03/11/2025, showed there were no progress notes to review as to why R6 did not receive their potassium medication.

Record review of R6's, "Progress Notes", dated 03/09/2025, showed "medication not on hand will call residents preferred pharmacy to reorder". The progress note did not specify what medication was not on hand to administer.

Record review of R6's, "Progress Notes", dated 03/10/2025, showed R6's sertraline medication "out of medication".

Record review of R6's, "Progress Notes", dated 03/11/2025, showed there were no notes to review as to why R6 did not receive their sertraline medication.

Record review of R6's, "Progress Notes", dated 03/07/2025, showed there were no notes to review as to why R6 did not receive their Alvesco medication.

Record review of R6's, "Progress Notes", dated 03/08/2025, showed R6's Alvesco medication needed to be reordered.

Record review of R6's, "Progress Notes", dated 03/09/2025, showed R6's Alvesco medication "medication not on hand reordering".

Record review of R6's, "Progress Notes", dated 03/10/2025 – 03/11/2025, showed there were no notes to review as to why R6 did not receive their Alvesco medication.

In an interview on 03/19/2025 at 2:46 PM, R6 said the facility staff provided them their medications for them to take.

In an interview on 03/19/2025 at 11:18 AM, Staff B stated if the resident used the house preferred pharmacy, the medication technicians were to reorder the resident's medications three days before the medication was out. Staff B stated if the resident received medication from an outside preferred pharmacy, the mediation technicians were to order the medication seven to five days before the medication ran out.

In an interview on 03/18/2025 at 11:49 AM, Staff B said if a resident missed a medication, then a progress note should be created to indicate what facility staff did to resolve the issue, for example, the facility staff would notate if they reordered the medication. Staff B said if a medication had been missed for multiple days, there should be multiple progress notes related to different interventions the facility staff completed. Staff B said interventions included faxing and calling the provider and inquiring if the facility could pay for the medication out of pocket if needed.

In an interview on 03/19/2025 at 3:43 PM, Staff J, Medication Technician, said the facility provided R6 their medications. Staff J said for residents who used the in-house pharmacy their medications were reordered in the system before the resident ran out of their medications. Staff J said if a resident missed their medication, they would create a progress note in the resident's record as to why.

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 21 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5·11·25 .

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

Administrator (or Representative) Date 4·13·25

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(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, interview, and record review, the facility failed to keep 6 of 6 sampled resident's (Resident 10 [R10], Resident 11 [R11], Resident 12 [R12], Resident 13 [R13], Resident 14 [R14], and Resident 15 [R15]) information were kept confidential. This failure allowed the public, visitors, and other residents to review private medical information without the resident's consent and a breach of confidentiality.

Findings included...

Revised Code of Washington (RCW) 70.129.050 "Privacy and confidentiality of personal and medical records. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records."

Record review of the facility policy titled, "HIPPA [Health Insurance Portability and Accountability Act]: Use and Disclosure of Protected Health Information (PHI) (General)", dated 01/01/2023, showed prior to disclosing any PHI, workforce members must verify the identify of the recipient of the PHI. The company would limit the use or disclosure of PHI to the minimum amount necessary to accomplish it's intended purpose. The company would work with privacy officers to identify, and monitor uses and disclosures of PHI potential HIPPA infractions. The company would obtain an authorization prior to releasing PHI.

In an interview on 03/17/2025 at 1:13 PM, Staff D, Maintenance Manager, stated all closet and storage room doors were to be always locked.

In an observation on 03/17/2025 at 1:39 PM, on the second floor at the end of the hallway closest to the elevator, Staff D opened the last door on the right without the use of a key to the closet. Inside of the closet there were multiple white filing boxes. On the

door frame where the hole for the doorknob to latch was blue tape that covered the hole.

In an observation on 03/17/2025 at 1:39 PM, on the second floor at the end of the hallway closest to the elevator, the closet door was able to be opened without a key and the blue tape remained over the hole on the door frame. Inside the closet were 28 white cardboard boxes with resident records inside. On the outside of the white boxes that were on the top shelf written in black marker, showed "resident files 2022 destroy 2019". Inside one of the white boxes that was labeled on the outside of the box in black marker, showed "files 2019 resident", had multiple bundles of paper records that were rubber banded together. Review of one of the packets showed, there was a sheet of paper on the top of the packet that had R10's first and last name, date of birth, and move out date of [redacted]/2018 listed. Inside the packet of records for R10 included billing statements and emails related to R10. Review of another packet showed R11 and R12's, first and last name, date of births, move out date of [redacted]/2019 and that they resided in room [redacted]. Inside the packet was R11 and R12's rental agreement, list of their medications that included amlodipine (a prescribed medication to help treat high blood pressure) 2.5 milligrams daily. Review of another packet had R13's first and last name, date of birth with move out date of [redacted]/2020. Inside the packet showed there were physician orders for R13, residential agreement, and other documents for review. There were no staff in the closet or around the closet observed during review of the documents.

In an observation on 03/18/2025 at 10:46 AM, on the second floor at the end of the hallway closest to the elevator, the closet door was able to be opened without a key and the blue tape remained over the hole on the door frame. Inside the closet were the 28 white cardboard boxes with resident records inside. On the ground inside one of the white cardboard boxes were multiple blue file folders that obtained resident records inside them. Review of one of the blue file folders showed, there was a drivers license with R14's first and last name, address, date of birth, hair color, weight, and height with an expiration date of [redacted]/2022. On the same paper of the copied driver license photo were three copies of Medicare prescription cards that had R14's first and last name and identification numbers listed. The file showed R14 had resided in room [redacted].

Review of another blue file folders showed R15's first and last name, date of birth, and move out date of [redacted]/2018. Inside the folder was R15's rental agreement, face sheet with emergency contacts listed with their first and last name, phone numbers, and addresses. There were no employees in the room during the entire time the files were reviewed.

In an observation on 03/19/2025 at 7:34 AM, on the second floor at the end of the hallway closest to the elevator, the closet door was able to be opened without a key and the blue tape remained over the hole on the door frame. Inside the closet were the 28 white cardboard boxes with resident records inside. On the ground inside one of the white cardboard boxes were multiple blue file folders that continued to include resident file folders for R14 and R15.

In an observation on 03/19/2025 at 2:17 PM, on the second floor at the end of the hallway closest to the elevator, the closet door continued to be opened without a key with access to the 28 white cardboard boxes with resident records inside for review.

In an observation and interview on 03/19/2025 at 2:42 PM, Staff A, Executive Director,

was showed the second-floor closet door that was not locked and able to access the resident's records in the 28 white cardboard boxes that were stored inside all three days of the inspection. Staff A acknowledged that the closet door should have been locked and unable to access the resident records without the use of the key.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Administrator (or Representative) 4.13.25 Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature did not go below 105 degrees Fahrenheit (F) and above 120 degrees F for 6 of 6 resident accessible (activity room, public resident bathrooms, Resident 2 [R2] room, Resident 8 [R8] room, Resident 9 [R9] room, and Resident 5 [R5] room) sinks in the facility. This failure placed 68 of 68 residents and staff at risk for potential skin burns.

Findings included...

Record review of the facility's policy titled, "water temperature", dated "12/2024", showed water temperature levels in resident areas would be maintained between 105 through 120 degrees F. The maintenance director would monitor the temperature of water from randomly selected resident bathroom faucets. The temperature gauge would be adjusted, when necessary, to verify that the proper water temperature was maintained.

Record review of the facility provided document titled, "Logbook Documentation", dated 02/17/2025, showed the bathroom faucet water temperature in room [redacted] was 103 degrees F, in room [redacted] it was 102 degrees F, and in room [redacted] the shower water temperature was 100 degrees F.
In an observation on 03/17/2025 at 1:03 PM, on the first floor, inside the public resident

bathroom that was to the left upon walking into the wellness room, the hot water temperature was 120.7 degrees F.

In an observation on 03/17/2025 at 1:06 PM, on the first floor, inside the activity room at the resident accessible sink, the hot water temperature was 120.4 degrees F.

In an interview and observation on 03/17/2025 at 1:10 PM, Staff D, Maintenance Manager, stated they checked the facility's water temperatures weekly. Staff D stated the water temperature range was supposed to be between 105 degrees to 115 degrees. The facility had three hot water tanks that were lined up in a row, in a room by the laundry room. The middle hot water tank that had written on the outside "installed 12/18/2014", temperature gauge showed, the dial pointed to 123 degrees F. Staff D stated the gauge on the hot water tank's showed what temperature the hot water tanks were set at.

In an observation on 03/17/2025 at 4:20 PM, in the resident public bathroom that was to the right before entering into the wellness room, the hot water temperatures was 120.5 degrees F.

In an observation on 03/18/2025 at 10:42 AM, in the public resident bathroom to the right before entering the wellness room, the hot water temperature was 123.1 degrees F. The water was hot to touch and there was steam rising from the running hot water.

In an observation on 03/18/2025 at 10:51 AM, the first-floor resident public restroom located out of the wellness center that was closest to the resident laundry room showed a water temperature of 123.3 degrees F.

In an observation on 03/18/2025 at 10:56 AM, the first-floor resident public restroom located out of the wellness center that was closest to the dining room showed a water temperature of 122.9 degrees.

In an observation on 03/18/2025 at 11:22 AM, inside the first-floor activity room resident accessible sink, the hot water temperature was 126.9 degrees F.

In an observation on 03/18/2025 at 12:23 PM, in R8's bathroom sink, the hot water temperature was 123.6 degrees F. In R8's kitchen area sink the hot water temperature was 121.8 degrees F.

In an observation on 03/18/2025 at 1:29 PM, in R5's kitchen area sink, the hot water temperature was 124.4 degrees F. The hot water temperature in R5's bathroom sink was 124.2 degrees F.

In an observation on 03/18/2025 at 1:44 PM, on the first floor inside the public resident bathroom that was to the right before entering the wellness room, the hot water temperature was 122.9 degrees F.

In an interview and observation on 03/18/2025 at 2:44 PM, Staff D said they used the system Tels (a web-based platform and service used to help senior living communities track and complete tasks). Staff D said the Tels system would tell them what daily tasks needed to be completed. Staff D pulled up Tels on their cell phone and showed the Department that through the Tels system they had been informed the water temperature in the facility was supposed to be between 100 degrees F to 115 degrees

F. Staff D was notified the Tels system had been inaccurate, and the water temperature was supposed to be between 105 degrees to 120 degrees. Staff D acknowledged when the Department informed them multiple resident accessible areas were above 120 degrees. At 2:48 PM, Staff D used their own thermometer in the first-floor resident public restroom located out of the wellness center that was closest to the resident laundry room, and it showed the water temperature was 121.2 degrees F. At 2:50 PM, the first-floor resident public restroom located out of the wellness center that was closest to the dining room showed a water temperature of 120.9 degrees F. Staff D acknowledged the water temperatures had been above the regulation.

In an observation on 03/18/2025 at 4:47 PM, in R9's bathroom sink, the hot water temperature was 125.2 degrees F. The hot water was hot to touch. R9 stated that the hot water gets very hot.

In an observation on 03/19/2025 at 8:06 AM, inside the resident's public bathroom that was on the left before entering the wellness room, the hot water temperature in the sink was 120.5 degrees F.

In an observation on 03/19/2025 at 8:09 AM, on the first floor in the resident activity room in the resident accessible sink, the hot water temperature was 124.3 degrees F.

In an observation and interview on 03/19/2025 at 10:53 AM, in R2's bathroom the hot water temperature in the sink was 120.2 degrees F.

In an interview on 03/19/2025 at 9:42 PM, Staff D said when they checked the water temperatures in the facility that morning they were within range. Staff D acknowledged that the activity room water temperature had been above 124 degrees F and the resident public bathrooms were above 120 degrees F.

In an interview on 03/19/2025 at 10:00 AM, Staff A, Executive Director, acknowledged that the activity room water temperature had been above 124 degrees F and the resident public bathrooms were above 120 degrees F.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25

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

Administrator (or Representative) Date 4.13.25

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 4 of 4 areas (Resident Laundry Room, Living Room, Kitchen, and Dining Room). This failure placed 68 of 68 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Resident Laundry Room

In an observation and interview on 03/17/2025 at 1:20 PM, on the second floor, in the resident laundry room, behind the washing machine there was a large hole that measured two feet seven inches long and two feet one inch wide. Inside the hole there was exposed dry wall material, copper pipes that were connected to the hot and cold-water hoses attached to the washing machine, and yellow fuzzy material that resembled wall insulation. Staff D, Maintenance Manager, stated they were unaware that the hole was there in the wall when asked where the hole came from.

In an observation on 03/19/2025 at 8:14 AM, on the second floor, in the resident laundry room behind the washing machine, the hole in the wall remained with exposed copper pipes.

Dinning Room

In an observation on 03/18/2025 at 2:23 PM, in the dining room behind the large two pot coffee maker and pots, the double electrical outlets plate protruded off from the wall. The hole behind the outlet plate was able to be observed with fuzzy brown matter on the electrical wires that was in the hole.

Kitchen

In an observation on 03/18/2025 at 2:30 PM, inside the kitchen in the closet with the hot water tank and stored kitchen chemicals in the far-right corner on the back wall halfway up was a hole in the wall. There was exposed dry wall, copper pipes, and yellow fuzzy matter that resembled insulation. The hole was two feet wide and nine inches long.

In an observation and interview on 03/18/2025 at 2:35 PM, inside the office area of the kitchen, on the wall to the right upon entering the office, there was a large, damaged area in the wall that was two feet nine inches wide, nine inches long and five inches

deep. There was exposed white powder dry wall, fuzzy yellow matter that resembled insulation, and two gray and rusted nails that protruded out from the dry wall material exposing the entire head of the nail and part of the stick. Staff K, Dining Service Manager, stated they were unsure if there was a plan to have the holes in the walls in the kitchen repaired. At 2:45 PM when leaving the kitchen directors office, on the ceiling at the end of the kitchen's hood there was a fire alarm sprinkler that had fuzzy brown and black matter on it. Staff K stated they cleaned the sprinkles every month and needed to be cleaned and would that night 03/18/2025.

In an observation on 03/19/2025 at 8:16 AM, inside the kitchen on the ceiling at the end of the kitchen hood closest to the kitchen director's office door, the fire alarm sprinkler had a fuzzy black and brown substance.

Living Room

In an observation on 03/17/2025 at 1:54 PM, in the lobby living room area under the window closest to the front doors, the electrical outlet was protruding out away from the wall that exposed a hole in the wall.

In an interview on 03/17/2025 at 1:20 PM, Staff D stated that all employees of the facility had access to the TELS (a web-based platform and service used to help senior living communities track and complete tasks) program to make a work order for maintenance to know what something needs to be fixed or addressed within the facility. Staff D stated if staff did not access the TELS system then they could tell the receptionist at the front lobby desk and they could make a maintenance work order. Staff D stated they get notified immediately with the priority level when a work order was made. Staff D stated it was hard to fix the problems when there were no work orders made by the employees.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Administrator (or Representative) Date 4.13.25

WAC 388-78A-2040 Other requirements.

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to maintain fire safety per the state fire marshal regulations related to obstruction of fire doors in 2 of 3 floors (first floor and second floor) and securing oxygen cylinders in 1 of 2 (Resident 1 [R1] room) areas reviewed. These failures placed all 68 of 68 residents, staff and visitors' life and safety at risk.

Findings included...

"Code IFC [International Fire Code] 705.2 2018: Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NDPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified."

"Code IFC 5303.5.3 2018: compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. Securing of compressed gas containers, cylinders and tanks shall be by one of the following methods: 1. Securing containers, cylinders and tanks to a fixed object with one or more restraints. 2. Securing containers, cylinders and tanks on a cart or other mobile device designed for the movement of compressed gas containers, cylinders or tanks. 3. Nesting of compressed gas containers, cylinders and tanks at container filling or servicing facilities or in sellers' warehouses not open to the public. Nesting shall be allowed provided that the nested containers, cylinders or tanks, if dislodged, do not obstruct the required means of egress. 4. Securing of compressed gas containers, cylinders and tanks to or within a rack, framework, cabinet or similar assembly designed for such use. Exception: Compressed gas containers, cylinders and tanks in the process of examination, filling, transport or servicing. "

Record review of the facility policy titled, "Oxygen Cylinders/Tanks Safe Handling", dated "12/2022" showed the facility should follow the policy guidelines for receiving, safe handling, use, storage, and transport of oxygen cylinders/tanks. The facility management team should check that the oxygen cylinders/tanks were used properly and were stored in a safe location. Oxygen cylinders should be provided with chains, sturdy portable carts, or approved stands to prevent tipping exposure. Storage of oxygen cylinder/tanks should be in a secured area where they could not be knocked over or damaged by passing facility staff members, residents, or visitors.

Oxygen Cylinders

In an observation on 03/19/2025 at 11:42 AM, inside R1's kitchen and living area near R1's oxygen concentrator machine, was a small green and silver oxygen cylinder that

was standing upright without being secured in a stand, chain, or device to prevent the oxygen cylinder from being knocked over.
In an interview on 03/17/2025 at 1:11 PM, Staff D, Maintenance Manager, stated all oxygen cylinders in the facility were to be stored in a storage caddy or chained to the wall to prevent them from falling over.

Propped Doors

In an observation on 03/17/2025 at 1:12 PM, the first-floor laundry room located next to the maintenance room showed the door had been propped open with a green and wooden chair.

In an observation on 03/18/2025 at 1:18 PM, the first-floor laundry room located next to the maintenance room showed the door had been propped open with a green and wooden chair.

In an observation on 03/19/2025 at 10:56 AM, the second-floor laundry room closest to room 215 showed the door had been propped open with a green and wooden chair.

In an observation on 03/19/2025 at 11:10 AM, the second-floor laundry room closest to room 221 showed the door had been propped open with a green and wooden chair.

In an interview and observation on 03/19/2025 at 1:56 PM, the second-floor laundry room closest to room 221 showed the door had been propped open with a green and wooden chair. Staff D said the facility laundry room doors were fire doors and they were not supposed to be propped open. Staff D had been observed to take the green and wooden chair outside of the doorway to allow the door to fully close.

In an observation on 03/20/2025 at 10:52 AM, the first-floor laundry room located next to the oxygen storage room showed the door had been propped open with a green and wooden chair.

In an observation on 03/20/2025 at 10:55 AM, the second-floor laundry room closest to room 221 showed the door had been propped open with a green and wooden chair.

In an interview on 03/19/2025 at 3:25 PM, Staff A, Executive Director, said fire doors in the facility should not be propped open. Staff A said oxygen tanks in residents' rooms should be secured. Staff A had been unable to inform the Department how oxygen tanks were secured and stated they would follow up.

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 30 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob C

Administrator (or Representative) Date 4.13.25

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

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

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to have the most recent survey or inspection results publicly posted and easily available for 1 of 1 inspection binders. This failure effected all 68 residents and visitors right to be able to have knowledge of the facility's inspection results.

Findings included...

In an observation on 03/17/2025 at 12:56 PM, in the front lobby area of the facility, there were no signs or binders with the facility's prior annual inspection results available for review.

In an observation on 03/17/2025 at 1:00 PM – 1:35 PM, the Department completed a tour of the facility premises. The Department had been unable to locate the facility inspection binder to review.

In an interview on 03/18/2025 at 10:43 AM, Staff I, Receptionist, sat behind the front desk in the facility lobby. Staff I said they had been unaware where the facility inspection binder had been located. Staff I then proceeded to make a phone call and stated to an unknown individual that the Department had inquired about the inspection binder.

There was no annual survey inspection binder observed around the receptionist desk or lobby area for review.

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 31 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

In an interview and observation on 03/19/2025 at 9:51 AM, Staff I sat behind the front desk in the facility lobby. Staff I said the inspection binder had been located behind the front desk amongst other facility binders. Staff I said yesterday the binder had been present, they just did not see it amongst all the other binders. Staff I had been observed to retrieve the inspection binder that was behind the front desk and in between other binders. Staff I said when residents and their families admitted into the facility, they were provided a copy of the facility handbook that explained if the resident or family had any questions related to the state that they could come to the front desk.

In an interview and observation on 03/19/2025 at 10:30 AM, Staff H, Resident Engagement sat behind the front desk in the facility lobby. Staff H said they knew the inspection binder had been located at the front desk. Staff H verbally said "where is it" as they started the process to look for the inspection binder. Staff I had been behind Staff H and pointed to the location of the inspection binder. Staff H then retrieved the inspection binder and provided it to the Department to review.

In an interview on 03/20/2025 at 11:27 AM Staff A, Executive Director, stated the survey binder was always available at the front lobby desk, but the sign was not posted. Staff A stated if there was no staff member at the front lobby desk, any staff member could get the survey binder visitors and residents for review.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob C — 4.13.25

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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

(2) The assisted living facility must:

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

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide necessary handwashing supplies in 8 of 8 resident (Resident 2 [R2], Resident 4 [R4], Resident 6 [R6], Resident 7 [R7], Resident 5 [R5], Resident 8 [R8], Resident 9 [R9], and Resident 1 [R1]) care areas. Additionally, the facility failed to implement proper infection control hand washing measures when job tasks were changed for 2 of 3 observed staff (Staff L and Staff M) during resident care. These failures resulted in a break in hand hygiene practices, staff not having access to hand hygiene supplies in resident care areas, and placed all 68 of 68 residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

Record review of the Center of Disease Control and Prevention (CDC) website document titled, "clinical safety: Hand Hygiene for Healthcare Workers", dated 02/27/2024, showed hand hygiene protected both healthcare personnel and patients. A common challenge was to keep the skin on the healthcare personnel hands healthy and clean. Under the section titled, "when to use an alcohol-based hand sanitizer (ABHS)", showed unless hands were visibly soiled, ABHS was preferred over soap and water in most clinical settings. Under the section titled, "when to wash with soap and water", showed when hands were visibly soiled, before eating, after using the restroom, and during care of patients with suspected or confirmed infection during outbreaks of Clostridioides difficile (a contagious virus that was easily transmitted through a person stool) and norovirus (an infectious virus that is easily transmitted that cause stomach upset, nausea, vomiting, and diarrhea). Under the section titled, "Healthcare Facilities: Make hand Hygiene a priority", showed they were to require healthcare personnel to perform hand hygiene based on CDC recommendations, ensure that healthcare providers perform hand hygiene with soap and water when hands were visibly soiled, and ensure supplies for adhering to hand hygiene were accessible when delivering patient care.

Record review of the CDC's website document titled, "Hand sanitizer Guidelines and Recommendations", dated 03/12/2024, showed hand sanitizers can quickly reduce the number of germs on hands in many situations. However sanitizers do not get rid of all types of germs, may not be effective when hands were visibly dirty or greasy, might not remove harmful chemicals, such as pesticides, and heavy metals like lead, and soap and water were more effective than hand sanitizer at removing certain kinds of germs like norovirus, cryptosporidium (an infection that causes a person to have loose stools), Clostridioides difficile, as well as chemicals. Under the section titled, "tips", showed Do not use hand sanitizers if a person's hands were visibly dirty or greasy.

Record review of CDC's fact sheet titled, "About Hand Hygiene at Work", dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to prevent the spread of germs and keep employees healthy. Hand hygiene was one of the best ways to prevent employees from getting sick and spreading germs to others in the workplace. Good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It can also mean using alcohol-based hand sanitizer with at least 60% alcohol if soap and water were not readily available. Employees were to wash their hands use soap and water instead of hand sanitizer when their hands were visibly dirty. Under the section titled, "tips for protecting employee health", showed provide soap, water, and way to dry hands (for example paper towels or a hand dryer) so employees can wash and dry hands properly. An alcohol-based hand

sanitizer was the preferred method for cleaning your hands when they were not visibly dirty.

Record review of the Washington State Department of Health's (DOH) document DOH 505-144 titled, "hand hygiene policy and procedure", dated "May 2018", showed effective hand hygiene reduces the incidence of healthcare-associated infections. All members of the healthcare team would comply with current CDC hand hygiene guidelines. Under the section titled, "indications for handwashing and hand rubbing", showed handwashing was to be conducted when hands were visibly dirty or contaminated with proteinaceous material or were visibly soiled with blood or other body fluids, wash hands with either non-antimicrobial soap and water or an antimicrobial soap and water. Handwashing may also be used routinely decontaminating hands (reduce bacterial count on hands by performing hand hygiene) in the clinical situations that included after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, ever if hands were not visibly soiled. Indications for use of hand rubbing included if hands were not visibly soiled. When gloves were used and removed the healthcare personnel were to decontaminate hands after removing gloves.

Record review of the facility policy titled, "Handwashing/Hand Hygiene", dated "10/2021", showed that regular hand washing was the primary means to prevent the spread of infections. The CDC promoted regular handwashing as one of the best ways to remove germs, avoid getting sick, and prevent the spread of germs to others. Hand hygiene products and supplies such as sinks, soap, towels, and alcohol-based hand rub should be readily accessible for staff to use and encourage compliance with hand hygiene policies. Hands should be washed with soap and water when they were visibly soiled. The CDC recommended using alcohol based hand sanitizer unless hands were visibly soiled before or after direct contact with residents, before handling medications, before putting on gloves, before moving from a contaminated body site to a clean body site during resident care, after contact with a residents intact skin, after handling contaminated equipment, after contact with objects such as medical equipment in the immediate vicinity of the resident, and after removing gloves. The use of gloves did not replace hand washing. The procedure of how to wash hands included vigorously lather hands with soap and rub together to create friction for at least 20 seconds, rinse hands under running water, dry hands thoroughly with paper towels and then turn off faucets with a clean dry paper towel and discard the paper towel in the trash.

R2

Record review of R2's, "Admission Record", dated 02/04/2025, showed R2 moved into the facility on [redacted]/2025.

In an observation and interview on 03/19/2025 at 10:39 AM, R2's apartment showed the kitchen counter had a bottle of A Jax liquid dish soap and roll of paper towels. The bathroom had bar soap next to the bathroom sink and a reusable hand towel that hung on a rack. R2 said they provided their own soap and paper towels. R2 said the facility did not provide soap or paper towels for the staff to use if they needed it.

R4

Record review of R4's, "Admission Record", dated 02/04/2025, showed R4 moved into the facility on [redacted]/2023.

In an observation and interview on 03/19/2025 at 11:00 AM, R4's apartment showed the kitchen counter had a bottle of dawn dish soap and roll of paper towels. The bathroom had bar soap next to the sink. R4 said they bought and supplied their own soap and paper towels. R4 said if the facility staff needed to wash their hands inside of their room would use their supply.

R6

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", dated 03/05/2025, showed R6 moved into the facility on [redacted]/2025.

In an observation and interview on 03/19/2025 at 2:46 PM, R6's apartment showed the kitchen counter had a bottle of liquid Essenza hand soap and a roll of paper towels. The bathroom had liquid hand soap next to the sink. R6 said they bought and supplied their own hand soap and paper towels for their room.

R7

Record review of R7's, "Admission Record", dated 02/04/2025, showed R7 moved into the facility on [redacted]/2022.

Record review of R7's, "Personal Service Plan", dated 03/17/2025, showed R7 was incontinent of bowel and bladder and always wore briefs. The facility staff were to help toilet R7 every two to four hours with one facility staff member who helped manage incontinence products, put on and took off R7's pants, and helped transfer them to the
toilet.

In an observation on 03/18/2025 at 1:22 PM, R7's apartment showed the kitchen counter had a container of liquid Dove soap, a container of Dawn dish soap, and a roll of paper towels. The bathroom had a container of liquid Dove soap. There were no paper towels or hand towels observed in R7's bathroom.

R5

Record review of R5's Admission Record, dated 02/04/2025, showed R5 moved into the facility on [redacted]/2023.

Record review of R5's Personal Service Plan, dated 01/27/2025, showed staff were to physically assist R5 with washing their lower body for their showers two times a week. R5 was incontinent of urine and bowels. Staff were to provide R5 with peri care and change R5's incontinence pull up products when soiled.

In an observation and interview on 03/18/2025 at 1:05 PM, inside R5's apartment, Staff M, Care Partner, was gathering supplies with a new pull up in their bare hands to take R5 to the bathroom. At 1:06 PM, Staff M put on a new pair of disposable gloves on both hands. There was no observed hand hygiene completed prior to putting the gloves on. Staff M assisted R5 stand up from the lounge chair into R5's manual wheelchair. Staff M pushed R5 in the manual wheelchair into R5's bathroom. R5 stood up with the use of the grab bar on the wall by the toilet. Staff M pulled R5's pants and soiled brief that had a strong odor that resembled urine down and R5 sat down on the toilet. Staff M

removed both of their gloves and provided R5 privacy to use the toilet. Staff M exited the bathroom and went to the kitchen sink. Staff M turned the kitchen sink's water on and put both their hands in the water. It was observed that there was a bottle of blue liquid that had a label "dawn" dish soap and no facility provided soap or paper towels available for Staff M to use at the sink. Staff M was observed to look around the area and then turned the water off, shook their hands, and then wiped their hands on the back of their pants over their buttocks area that left wet finger marks on their pants. At 1:10 PM Staff M entered the bathroom to assist R5 off the toilet. Staff M put a new pair of disposable gloves on both hands. Staff M removed the urine soiled pull up R5 had worn and threw it in the trash. Staff M put the new pull up on R5's leg and their pants with the same gloves the soiled pull up were removed with. R5 stood up with the use of the grab bar on the wall and stood there while Staff M cleansed R5's front and back peri area with wet wipes. Staff M threw the used wet wipes in the trash, pulled up R5's clean pull up and pants with the same gloves that were used to clean R5's peri area and removed the soiled pull up. Staff M assisted R5 back into the wheelchair. Staff M removed their disposable gloves threw them into the trash. Staff M pushed R8 in the manual wheelchair back into the living room and assist with the transfer into R5's lounge chair. Staff M was not observed to use hand sanitizer that was hanging from their black pack they wore around their waste after the gloves were removed. Staff M removed the trash back with the soiled pull up and the disposed gloves, tied it closed, put a new trash bag in, and exited R5's room with the trash bag. No hand hygiene was observed. At 1:29 PM in R5's bathroom sink, there was a large bottle of antimicrobial hand wash lavender "pearlessence" brand at the sink. R5 stated the dawn soap at the sink and the lavender soap in the bathroom were both their personal supply of soap.

R8

Record review of R8's "Admission Record", dated 02/01/2024, showed R8 moved into the facility on [redacted]/2025, with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R8's Personal Service Plan, dated 09/19/2024, showed R8 required one person physical assistance to help them with dressing, hygiene, and showering. R8 was incontinent of bowel and bladder that required staff to toilet R8 two to three times a shift. Staff were to cleans R8's peri area and change their incontinence brief products when soiled.

In an observation and interview on 03/18/2025 at 12:41 PM, inside R8's kitchen area sink, it was observed there was no soap and two rolls of white paper towels with one roll that hand been used and was half the size of the other. R5 stated the two rolls of white paper towels at the sink were their own supply that their sister had bought for them. At 12:43 PM in R8's bathroom at the sink, there was a bottle that was a quarter full of creamy yellow liquid, that had a white pump top with a label that showed "honey citrus and shea butter" and a gray cloth towel. R5 stated the soap and cloth towel in the bathroom were their own, that they used to wash their hands. There was no facility provided soap in the bathroom or the sink care areas of R5's room observed. At 12:50 PM, Staff M came into R8's room to provide care for them. Staff M gathered all the

supplies out of R8's closet that was beside the left side of their bed and shut the blinds on R8's window and sliding glass door windows. Staff M put on disposable gloves on both hands. There was no hand hygiene completed prior to Staff M putting the new gloves on their hands. Staff M had removed R8's brief and cleansed R8's peri area with wet wipes. Staff M had R8 roll over on their side with the use of their side rail on the bed and Staff M then cleaned R8's buttocks area with wet wipes and removed the soiled brief and placed into the trash bag. Staff M grabbed the new brief with the same gloves that they had removed the soiled brief with and cleaned R8 with, opened the brief up, and placed the new brief under R8's buttocks area. Staff M had R8 roll onto their back and onto their other side to help straighten out the brief. Staff M pulled and readjusted the brief to R8's preference and secured the brief on R8 with the sticky tabs. Staff M removed their gloves and threw them in the trash bag with the soiled brief, tied the bag up. Staff M went to the kitchen sink turned the water on, rinsed their hand with water, turned the water off, grabbed a few of the white paper towels and dried their hands off and threw the used paper towels away. Staff M grabbed the bag of trash and left R8's room. During the entire observation there was no use of hand sanitizer in between tasks and no use of soap at the kitchen sink as there was no soap available for use.

R9

Record review of R9's Admission Record, dated 09/25/2024, showed R9 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R9's Care Profile, dated 03/04/2025, showed R9 was incontinent of urine and bowels. Staff were to monitor R9 for any urine-soaked clothing, smell, or request for assistance with toileting.

In an observation on 03/18/2025 at 4:35 PM, in R9's living room area, Staff L, Care Partner, came into R9's living room area to check R9's blood sugar prior to dinner. Staff L put disposable gloves on both hands. Staff L did not use hand sanitizer or perform hand hygiene prior to putting the gloves on. Staff L then poked R9's left hand pinky finger that resulted a drop of blood. Staff L put the strip that was in the machine into the blood until it beeped. Staff L wiped R9's pinky finger with the alcohol wipe to stop it from bleeding. Staff L handed R9 their insulin pen after Staff L dialed up the number of insulin units R9 needed to inject. R9 injected the insulin themselves. Staff L grabbed the insulin pen. Staff L removed both disposable gloves off their hands and held them in their hand. Staff L grabbed the doorknob opened the door and exited that room. During the entire observation Staff L did not use any hand sanitizer or hand hygiene prior or after the use of gloves or contact with R9. At 4:48 PM, observation of R9's kitchen sink area there was a small 221 milliliter bottle with blue liquid inside labeled, "dawn" dish soap. There was no facility provided paper towels or soap at the kitchen sink available for staff to use. In R9's bathroom at the sink there was no facility provided soap or paper towels available for staff to use. There was a bottle of Meyer's soap that had a purple label. R9 stated the Meyer's soap was their own supply.

R1

Record review of R1's Admission Record, dated 11/18/2024, showed R1 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted] and [redacted]

Record review of R1's Personal Service Plan, dated 02/12/2025, showed R1 was incontinent of urine with leakage. Staff were to observe R1 for any urine-soaked clothing, smelling or request for assistance. R1 wore a pull up for their urine incontinence leakage.

In an observation on 03/19/2025 at 11:43 AM, inside R1's apartment in the bathroom and in the kitchen at both the sink there were a bottle of blue liquid both labeled "dawn" dish soap. There was no facility provided soap or paper towels available for staff to use to wash their hands with observed.

In an interview on 03/19/2025 at 7:47 AM, Staff N, Medication Technician, stated they were to wash their hand prior to and after providing care to a resident. Staff N stated they would have to ask the resident to use their soap and paper towels if they needed to wash their hands with soap and water as the only supplies in the resident's room was their own and facility did not provide supplies as it was an assisted living facility. Staff N was observed to not have any hand sanitizer, soap, or other hand hygiene supplies on them during the interview. Staff N stated they were to perform hand hygiene after the use of gloves, in between resident during a medication pass, if they were soiled, and change in task.

In an interview on 03/19/2025 at 11:18 AM, Staff B, Health and Wellness Coordinator, stated if their hands were visibly soiled while in a resident apartment care area, they would use the residents supply of soap and paper towels to wash their hands, in one of the sinks in the residents apartment.

In an interview on 03/19/2025 at 3:25 PM, Staff A, Executive Director said if a facility staff member needed to perform hand hygiene in a resident's room, then they would use the resident supplies to do so.

In an interview on 03/19/2025 at 3:43 PM, Staff J, Medication Technician, said if they were in a resident's room and their hands were visibly soiled sometimes the residents did not have soap or paper towels for them to be able to perform hand hygiene. Staff J said they did not like to use the residents supply of soap or paper towels because the residents bought the items themselves. Staff J said they try not to use the resident supply of soap or paper towels but if they had to they would. Staff J said at times they had rinsed their hands in the resident's sink, exited the room, and would go to a nearby facility sink to perform hand hygiene.

This is a recurring deficiency previously cited on 12/21/2022 under WAC 388 78A 2610 (1)(2)(a)(f)(d)

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 38 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob Cl
Administrator (or Representative) Date 4.13.25

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 2 of 2 residents (Resident 5 [R5] and Resident 7 [R7]) reviewed were provided care in a dignified manner and resolve their grievances. These failures resulted in R5 and R7 having unresolved concerns and placed the residents at risk for decreased quality of life.

Findings included...

RCW 70.129.140
"Quality of life—Rights.
(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:
(a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;"

Record review of the facility policy, "Service Plan Process Policy", dated "3/2020", showed resident service plans were developed through the evaluation process to provide information about resident needs to the facility staff. Service plans were implemented and maintained for each resident to address their needs.

In an interview and observation on 03/19/2025 at 9:42 AM, Staff B, Health and Wellness Coordinator, said the facility had been unable to print or email the Department any call light reports to review. Staff B said usually facility staff could upload call light reports

onto a flash drive, but the computer had not accepted the flash drive. Staff B said they could show the Department the call light reports on the computer. At 12:02 PM, Staff B inquired with Staff E, Resident Care Coordinator, to pull up the facility call light reports up on the computer. Staff E pulled up the call light reports from 02/17/2025 – 03/19/2025 to review. Per Staff E the reports went by floor number and then by resident room numbers. Staff E said the expectation for a call light to be answered was within 20 minutes. Staff E said that R7 had on going complaints of long call wait times. Staff E said that every time they went into R7's room they complained that they had to wait an hour and a half. Staff E said they thought R7 had been confused when it came to time. The Department reviewed R7's call light report times and saw on 03/16/2025 at 8:05 PM it took 29 minutes and 19 seconds for the call light to be answered, on 03/15/2025 at 9:17 PM it took 45 minutes and 16 seconds, at 7:03 PM it took 39 minutes and 51 seconds, at 4:21 PM it took 31 minutes and 14 seconds, and at 8:19 AM it took 35 minutes and 44 seconds. On 03/14/2025 at 5:49 PM it took 34 minutes and 8 seconds, on 03/13/2025 at 7:22 PM it took 38 minutes and 49 seconds, on 03/12/2025 at 7:33 PM it took 2 hours 41 minutes and 59 seconds, at 6:59 PM, it took 54 minutes and 48 seconds, at 5:25 PM it took 55 minutes and 47 seconds, at 4:33 PM it took 1 hour 19 minutes and 59 seconds. On 03/11/2025 at 8:31 PM, it took 44 minutes and 34 seconds, at 5:23 PM it took 57 minutes and 57 seconds, and at 2:38 PM it took 51 minutes and 22 seconds. On 03/10/2025 at 5:14 PM it took 39 minutes and 4 seconds and on 03/07/2025 at 7:59 AM it took 49 minutes and 35 seconds for the call light to be answered. The Department reviewed R5's call light report times and saw on 03/17/2025 at 7:11 PM it took 37 minutes and 10 seconds, on 03/16/2025 at 6:31 PM it took 1 hour 7 minutes and 42 seconds, on 03/15/2025 at 6:46 PM, it took 53 minutes and 38 seconds, at 5:06 PM it took 1 hour 25 minutes and 48 seconds, on 03/14/2025 at 4:37 PM, it took 1 hour 43 minutes and 9 seconds, on 03/13/2028 at 7:10 PM it took 30 minutes and 29 seconds at 8:08 AM it took 33 minutes and 11 seconds, on 03/12/2025 at 4:25 PM it took 30 minutes and 11 seconds, and on 03/11/2025 at 6:03 PM it took 1 hour 13 minutes and 10 seconds for the call light to be answered. Staff E said if a resident or a family member expressed a concern regarding long call wait times that they could look into the system to determine how long the individual had to wait. Staff E said sometimes the call light report showed that a resident did not have to wait as long as they thought they did.

R7

Record review of R7's, "Admission Record", dated 02/04/2025, showed R7 moved into the facility on [redacted]/2022.

Record review of R7's, "Personal Service Plan", dated 03/17/2025 showed R7 had been on hospice services (specialized care focused on comfort, dignity, and quality of lie for individuals with life limiting illnesses). R7 required one-person physical assistance with transfers. R7 had fallen in the last 12 months. R7's physical impairment had been one of the reasons they needed escort assistance to the dining room and community activities. R7 was not always oriented to time. R7 needed assistance with toileting. R7 was incontinent and facility staff would toilet them every two to four hours during the day and as needed at night. R7 required physical assistance related to their inability to stand independently during bathroom tasks. R7 became frustrated when they felt as though their needs were not being met in a timely manner or if they became lonely.

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 40 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

In an interview on 03/18/2025 at 1:22 PM, R7 expressed concern that the facility did not have enough staff to help them. R7 said when they pushed their pendant (a small wearable device that allows an individual to call for help) the staff were not in their room to help them within 15 minutes. R7 said it regularly took over an hour and a half before staff arrived to help.

In an interview on 03/27/2025 at 9:28 AM, Collateral Contact 1 (CC1), R7's Power of Attorney, said that R7 complained of long call wait times often.

R5

Record review of R5's Admission Record, dated 02/04/2025, showed R5 moved into the facility on [redacted]/2023.

Record review of R5's Personal Service Plan, dated 01/27/2025, showed staff were to physically assist R5 with washing their lower body for their showers two times a week. R5 was incontinent of urine and bowels. Staff were to provide R5 with peri care and change R5's incontinence pull up products when soiled.

In an interview and observation on 03/18/2025 at 1:10 PM, R5 stated it took the facility a long time to answer the pendants after it was pushed. R5 stated they had to call in advance to use the bathroom as it often took a long time for them to come. R5 wore a push button pendant around their neck.

In an interview on 03/17/2025 at 1:04 PM, Staff D, Maintenance Manager, said every resident at the facility had a pendant. Staff D said when residents pushed the pendant, they received help between five to ten minutes.

In an interview on 03/19/2025 at 12:12 PM, Staff B said the expectation for a call light to be answered was within 20 minutes. Staff B said facility staff had not reported to them any resident concerns related to long call wait times.

In an interview on 03/19/2025 at 3:43 PM, Staff J, Medication Technician, stated R7 expressed concerns about long call wait times multiple times a day. Staff J said at times R7 would forget that the facility staff had been in their room and as soon as they left R7 would repush their call light. Staff J said R7's concern was sometimes valid whereas other times it was not.

This is a recurring deficiency previously cited on 04/04/2024 under WAC 388 78A (2660)(1).

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 41 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Bob Cpz
Administrator (or Representative)

4.13.25
Date

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure 2 of 3 sampled pets (Resident 3's [R3] pet and Resident 4's [R4] pet) had regular examinations and were certified by a veterinarian to be free of disease transmittable to humans. This failure placed 68 of 68 assisted living residents and all staff at risk of being exposed to diseases which could impact their health.

Findings included...

Record review of the facility policy titled, "Pet Policy", dated "10/2021", showed pets that were accessible to residents should be in good health. Any living animal in the community must have regular examinations and vaccinations by a licensed veterinarian and be certified by the veterinarian to be free of disease transmittable to humans.

R3

Record review of R3's Admission Record, dated 02/04/2025, showed R3 moved into the facility on [redacted]/2024.

Record review of the facility's pet record binder showed there was an orange post it note with R3's name with their room number and a name listed. The posted note was attached to a document that showed all residents who resided at the facility were required to have a pet agreement in place. That all pets were required to be current on their vaccinations and licenses as required by the state, city, or county requirements. In review of the facility records, the facility did not have any veterinary records on file for

the pet. Review of the entire pet record binder showed, there were no veterinary pet records for R3's pet for review.

In an observation and interview on 03/19/2025 at 7:47 AM, Staff N, Medication Technician, stated the medication technicians were responsible to feed R3's dog every morning and evening that they documented on their treatment administration record. Staff N stated R3 has had the dog since they moved into the facility. At 7:53 AM, Staff N knocked on R3's apartment door, and a dog bark came from the other side of the door. Upon Staff N opening the door, there was a large brown curly haired dog. Staff N stated R3's dog was a standard poodle.

R4

Record review of the facility's pet record binder showed there was an orange post it note with R4's name with their room number and cat listed. The posted note was attached to a document that showed all residents who resided at the facility were required to have a pet agreement in place. That all pets were required to be current on their vaccinations and licenses as required by the state, city, or county requirements. In review of the facility records, the facility did not have any veterinary records on file for the pet. Review of the entire pet record binder showed, there were no veterinary pet records for R4's pet for review.

In an interview and observation on 03/19/2025 at 11:00 AM, R4's cat was inside of their apartment. R4 confirmed that the cat was their pet who resided with them in their residence.

In an interview on 03/19/2025 at 10:31 AM, Staff A, Executive Director, said the facility could not provide R3 or R4's pet records to review.

In an interview on 03/20/2025 at 11:40 AM, Staff C, Business Office Coordinator, stated they were responsible to ensure that all pets that resided in the facility had current and updated vaccination and veterinary records available for review. Staff C stated they had delegated the receptionists to get the records from the residents or their responsibly parties. Staff C stated they should have provided oversight to the receptionist to ensure the pet records were received.

Statement of Deficiencies	License #: 2275	Compliance Determination # 56445
Plan of Correction	Brookdale Olympia East	Completion Date
Page 43 of 43	Licensee: EMERITUS CORPORATION	03/27/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 5.11.25 .

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

Administrator (or Representative) 4.13.25 Date