



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

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

RE: Brookdale Olympia East License # 2275

Dear Administrator:

This letter addresses Compliance Determination(s) 30382 (Completion Date 09/20/2023) and 23894 (Completion Date 07/25/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/20/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
RCW 70.129.030, RCW 70.129.030.4, WAC 388-78A-2371, WAC 388-78A-2371-2, WAC 388-78A-2371-3

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

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



Residential Care Services Investigation Summary Report

Provider/Facility: Brookdale Olympia East **Provider Type:** Assisted Living Facility
License/Cert.#: 2275
Compliance Determination #: 23894 **Intake ID:** 81572
Investigator: Paul Aube **Region/Unit #:** RCS Region 3 / Unit E
Investigation Date(s): 06/16/2023 through 07/25/2023
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Neglect: Public report of injury to resident during transferring, which resulted in resident hospitalization.
 2. Quality of Care/Treatment: Public report of injury to resident during transferring, which resulted in resident hospitalization.
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Investigation Methods:

Sample:	Total residents: 62 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Activities Dining
Interviews:	Nursing staff Residents Family members Management Identified resident
Record Reviews:	Medical records Incident investigation Facility policies Billing Statements Negotiated Service Agreements Incident Reports/Investigations

Investigation Summary:

1. Resident/Patient/Client Neglect: Facility failed to conduct a thorough investigation after allegations were made, and failed to determine the circumstances of the event. In doing so, the facility was placing residents at further risk for injury. Failed Practice Identified.
2. Quality of Care/Treatment: Facility failed to conduct a thorough investigation after

allegations were made, and failed to determine the circumstances of the event. In doing so, the facility was placing residents at further risk for injury. Failed Practice Identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: Brookdale Olympia East **Provider Type:** Assisted Living Facility
License/Cert.#: 2275
Compliance Determination #: 23894 **Intake ID:** 83215
Investigator: Paul Aube **Region/Unit #:** RCS Region 3 / Unit E
Investigation Date(s): 06/16/2023 through 07/25/2023
Complainant Contact Date(s):

Allegation(s):

1. Fraud/False Billing: Public report of facility charging for services not agreed upon.
 2. Resident/Patient/Client Rights: Public report of facility charging for services not agreed upon.
-

Investigation Methods:

Sample:	Total residents: 62 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Activities Dining
Interviews:	Nursing staff Residents Family members Management Identified resident
Record Reviews:	Medical records Incident investigation Facility policies Billing Statements Negotiated Service Agreements Incident Reports/Investigations Personnel files Staff training records

Investigation Summary:

1. Fraud/False Billing: Facility failed to provide 30-day written notice during for changes in care and services, and failed to have the agreements signed/agreed upon as per Admission Agreement. Failed Practice Identified.
2. Resident/Patient/Client Rights: Facility failed to provide 30-day written notice

during for changes in care and services, and failed to have the agreements signed/agreed upon as per Admission Agreement. Failed Practice Identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2275	Compliance Determination # 23894
Plan of Correction	Brookdale Olympia East	Completion Date
Page 1 of 7	Licensee: EMERITUS CORPORATION	07/25/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 06/16/2023 and 07/25/2023 of:

Brookdale Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 80798, 81572, 83215

The following sample was selected for review during the unannounced on-site visit: 3 of 62 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

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

08/03/2023
Date

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

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


Administrator (or Representative)08/15/2023
Date**RCW 70.129.030 Notice of rights and services – Admission of individuals.**

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide residents or their representatives a thirty-day written notice prior to making changes to charges for services after updating the Negotiated Service Agreement for 2 of 4 residents, (Resident 2 [R2], and Resident 3 [R3]). This failure resulted in the residents and their representatives receiving an increase in charges and services without notice due to being retroactively charged for the provision of new services by the facility.

Findings included...

Review of a State of Washington Department of Social and Health Services, Aging and Long-Term Support Administration, Dear Provider Letter, dated 09/15/2017, titled, "ALF #2017-012 NOTICE REQUIREMENTS FOR NEW CHARGES", regarding the facility's responsibility, showed, "Resident charges may not be increased until the revised negotiated service agreement has been completed or updated in accordance with Chapter 388-78A... If the resident's admission agreement allows the facility to do so, and if an amended or updated negotiated service agreement is in place, the facility may retroactively charge for the provision of the new services in accordance with the terms of the admission agreement."

R2

Review of a R2's face sheet showed R2 was admitted to the facility on [REDACTED]/2021.

Review of the R2's "Residency Agreement", dated 08/17/2021, under "Section III: Rates, 'Rate Changes'", stated "We will provide thirty (30) days written notice of any change in the rates or pricing method for Basic Services, Personal Services, Select Services and Therapeutic Services. We may offer or require a change in the Personal Service Plan when we determine additional services are requested or required. The new Personal Service Rate resulting from a change in your personal Service Plan [Negotiated Service Agreement] is effective immediately after written notice is given."

Review of R2's Negotiated Service Agreements, dated:

- [REDACTED]/2021: showed no signatures from the resident, their representative, or facility representative.
- 09/15/2021: showed no signatures from the resident, their representative, or facility representative.
- 03/24/2022: showed no signatures from the resident, their representative, or facility representative.
- 04/13/2022: showed no signatures from the resident, their representative, or facility representative.
- 05/11/2023: showed no signatures from the resident, their representative, or facility representative.

The Negotiated Service Agreements for R2 were not agreed to, due to lack of signatures from the resident, their representative, or the facility representative.

On 06/16/2023, copies of R2's signed Negotiated Service Agreement, and written communication that the facility was communicating to the resident/resident representative to notify them of any changes to R2's care and services were requested from Staff A, the Executive Director. As of 07/06/2023, no documentation was received from the facility. A second request was made on 07/06/2023. The facility was unable to provide any written documentation sent to the resident, or their representative, of any notice of changes to care costs, and services. The facility was also unable to provide a signed resident service plan record to show that R2's resident service plan was signed and agreed upon.

R3

Review of a R3's face sheet showed R3 was admitted to the facility on [REDACTED]/2021.

Review of the R3's "Residency Agreement", dated 07/09/2021, under "Section III: Rates, 'Rate Changes'", stated "We will provide thirty (30) days written notice of any change in the rates or pricing method for Basic Services, Personal Services, Select Services and Therapeutic Services. We may offer or require a change in the Personal Service Plan when we determine additional services are requested or required. The new Personal Service Rate resulting from a change in your personal Service Plan [Negotiated Service Agreement] is effective immediately after written notice is given."

Review of R3's Negotiated Service Agreements, dated:

- [REDACTED]/2021: showed no signatures from the resident, their representative, or facility representative.
- 07/30/2021: showed no signatures from the resident, their representative, or facility representative.
- 03/24/2022: showed no signatures from the resident, their representative, or facility representative.
- 04/13/2022: showed no signatures from the resident, their representative, or facility representative.
- 05/11/2023: showed no signatures from the resident, their representative, or facility representative.

The Negotiated Service Agreements for R3 were not agreed to, due to lack of signatures from the resident, their representative, or the facility representative.

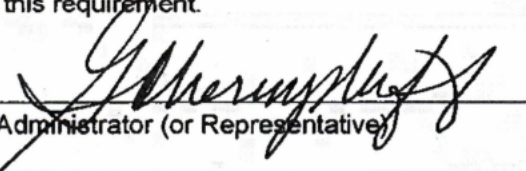
On 06/16/2023, copies of R3's signed Negotiated Service Agreement, and written communication that the facility was communicating to the resident/resident representative to notify them of any changes to R3's care and services were requested from Staff A. As of 07/06/2023, no documentation was received from the facility. A second request was made on 07/06/2023. The facility was unable provide any written documentation sent to the resident, or their representative, of any notice of changes to care costs, and services. The facility was also unable to provide a signed resident service plan record to show that R3's resident service plan was signed and agreed upon.

In an interview with Collateral Contact 1 (CC1), representative of R2 and R3, on 06/15/2023 at 12:22PM, CC1 stated that the facility was charging for services that were not agreed upon. CC1 stated that they attended a care conference along with R2, R3, their family, and with facility representatives to discuss what kinds of services the facility felt needed to be provided to R2 and R3 and have the opportunity to negotiate some of those items. CC1 stated that after that care conference, they asked multiple facility representatives, including Staff A, to provide to them the updated Negotiated Service Agreements, and Nursing Assessments of R2 and R3 for review, but the facility never provided them. CC1 stated that the facility continued to bill them despite this and was increasing the costs. CC1 stated, "[The] bills kept coming and growing larger. They were telling us that [R2] required more personal services but didn't explain what those were." "I can't pay these bills if we don't know what they are, and we have not agreed to anything."

During an interview on 06/16/2023 at 10:36AM, Staff A was asked to explain the process when there was a change in a resident's care, and how that was communicated to the resident's representatives. Staff A stated that when there was a change in care, the facility scheduled a care conference with the resident's and family, and the care was reviewed during that time. Staff A was asked if the communication to the families was ever sent in writing, and Staff A stated that changes in the plan of care, and care costs were discussed via a phone call, or an in-person conversation. Staff A stated, "75% of the time this is done during the care conference." RCW 70.129.030 was provided to Staff A for review. Staff A reported that they had a different understanding of the law and was not aware that they had to send notices in writing.

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) 08-15-2023

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


Administrator (or Representative)

09-17-2023
Date

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

- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to determine the circumstances of an incident and take appropriate measures to prevent reoccurrence for 1 of 1 resident reviewed, (Resident 1 [R1]). This failure placed the residents at risk for sustaining similar injuries due to the facility failing to identify the cause of the incident and implement measures to prevent similar future situations from recurring.

Findings included...

Review of R1's face sheet showed that the resident was admitted to the facility on [REDACTED]/2023.

During an interview with R1 on 05/12/2023 at 10:32AM, R1 stated that towards the end of shift, between 7:30PM and 8:30PM on 05/07/2023, caregivers entered their room to help readjust, and boost them up in their bed. R1 stated that normally there were two people that boost them up in the bed, using a draw sheet which was underneath of them. R1 stated that one person goes on each side of the bed, and they boost them up using the draw sheet. R1 stated that on this particular occasion, a single staff person placed their arms under R1's armpits and attempted to boost them up into bed. "One person grabbed a hold of me, and [their] thumb went into my chest. I felt a "pop" and I screamed; the pain was incredible. The next day, my breast was 3 times the normal size, hard as a rock, and as purple as an eggplant."

Review of R1's progress notes, dated 05/07/2023 at 11:36AM, stated, "Resident stated that [R1] was pulled up in bed she got hurt. There is a bruise on [R1's] inner right breast that is large covering approximately 80% of [R1's] right breast on the inside. [R1] stated

that when [they] [were] being pulled up during the night is when [R1] got the hurt and that [R1] screamed out."

During an interview with Staff D, a Medication Technician/Caregiver, on 05/12/2023 at 12:22PM, when asked if they ever received training on how to properly boost residents up into bed, they stated that they had. When asked to explain that process, Staff D stated, "When boosting people up in bed, we try and make sure there is a drawsheet underneath them. We have one person on each side of the bed, and we would use the drawsheet to lift them up. It is not comfortable when we lift the resident under the arms."

During an interview with Staff B, The Regional Nurse, on 05/12/2023 at 12:22PM, when asked if they completed their investigation regarding the injury to R1, they stated that the injury may have been due to staff being non-compliant with their education, but stated they needed to investigate further to be sure. When asked what staff were trained to do regarding re-adjusting residents in bed, Staff B stated that staff were trained to use a drawsheet to boost the residents up in bed, and that staff were trained to not lift residents using their bodies.

During an interview with Staff C, the Health and Wellness Director, on 06/16/2023 at 9:44AM, they stated that they had completed the investigation into R1's injury and stated, "there was nothing significantly found." Staff C stated that they were unable to substantiate that the injury that R1 sustained was related to improper technique used from staff, as Staff C stated all staff that were interviewed reported to have adjusted the resident correctly, using two persons with a draw sheet.

Review of the completed Incident Report for R1, dated 05/13/2023 stated, "Interviewed the staff and they report that they use the draw sheet with two people when [R1] needs the assistances [R1] uses [their] legs, and the side transfer canes to reposition in the bed. The staff reported that they don't go under the arms to pull [them] up." The Incident Report showed two witness statements for the staff who were directly involved with R1's injury. Review of Staff E's, a Caregiver, witness statement, which was undated, stated, "[R1] needed assistance being pulled up in bed. [Their] yellow-pull was not enough to pull [them] up in bed, so [Staff F] went under [R1's] arms and lifted [them] up." Review of Staff F's, a Medication Technician/Caregiver, witness statement, undated, stated, "Was helping resident adjust in bed. Resident requested to be pulled up in bed, which was attempted with yellow strap. Resident wasn't moving up much. I attempted to pull resident up from under arms and [R1] push with [their] legs."

In an interview on 06/16/2023 at 2:25PM, staff C was shown the two witness statements from Staff E, and Staff F. Staff C immediately recognized that the allegation made by R1 of staff boosting them up in bed incorrectly to be founded and determined that this was related to the sustained injury of R1. After recognizing the missed witness statements, Staff C stated, "I just missed those." Staff C stated that they would contact Staff E, and Staff F to discuss the situation further.

This is a recurring deficiency previously cited on 08/23/2022, and 11/02/2022.

Statement of Deficiencies

License #: 2275

Compliance Determination # 23894

Plan of Correction

Brookdale Olympia East

Completion Date

Page 7 of 7

Licensee: EMERITUS CORPORATION

07/25/2023

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia East is or will be in compliance with this law and / or regulation on (Date) 08/15/2023.

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


Administrator (or Representative)

08-18-2023
Date

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