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) 35715 (Completion Date 01/24/2024) and 29837 (Completion Date 09/21/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/24/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2160

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia East
Provider Type: Assisted Living Facility
License/Cert.#: 2275
Compliance Determination #: 29837
Intake ID: 98953
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 09/20/2023 through 09/21/2023
Complainant Contact Date(s):

Allegation(s):

Resident/Patient/Client Neglect: Report of resident falling on the floor and not being checked on by staff throughout the night.

Investigation Methods:

Sample:
Total residents: 65
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Emergency Water Supply

Interviews:
Residents
Nursing staff
Management

Record Reviews:
Facility policies
Emergency Preparedness Manual
Letters/Notification to Residents
Incident Reports
Progress Notes and Alert Charting

Investigation Summary:

Resident/Patient/Client Neglect: Facility failed to provide resident their call-light pendant to summon staff help after they slid out of their chair and was unable to get up on their own. Facility did not follow care plan as written. Failed practice identified.

Conclusion / Action:

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

☐ N/A

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Statement of Deficiencies	License #: 2275	Compliance Determination # 29837
Plan of Correction	Brookdale Olympia East	Completion Date
Page 1 of 4	Licensee: EMERITUS CORPORATION	09/21/2023

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 09/20/2023 and 09/21/2023 of:

Brookdale Olympia East
616 ULLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 95324, 98953

The following sample was selected for review during the unannounced on-site visit: 4 of 85 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

10/04/2023
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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OLYMPIA, WA 98506

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Residential Care Services

Date

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

Administrator (or Representative) 10/04/2023 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to provide the care and services as agreed upon in the negotiated service agreement for 1 of 4 residents (Resident 1 [R1]), reviewed. This failure prevented the resident from summoning staff for assistance when they fell during the night and contributed to the resident being on the ground all night and having to sleep on the ground, and placed the resident at risk of unmet care needs.

Findings included...

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

Review of R1's Personal Service Plan (PSP), last reviewed on [redacted]2023, under the category titled, "Universal Fall Precautions for Brookdale Residents", stated, "Familiarize resident with call system and have him/her demonstrate use. Be Alert to placing resident's personal items within reach."

During an interview with Staff A, the Health and Wellness Director, on 09/21/2023 at 1:46PM, Staff A was asked what type of training was provided to staff regarding call lights. Staff A stated that staff were trained about call lights during on-boarding, and that staff were trained to not leave any residents without their call light pendant. Staff A stated staff were trained to ensure the call light pendant was either on the resident, or at the very least, within reach of the resident.

Review of R1's Incident Report, dated 09/15/2023, showed that R1 was found on the floor at approximately 10:30AM by facility staff. "Resident was found on living room floor by their Physical Therapist at about 10:30AM. Checked for injury found none." Under the "Follow Up Information" section of the Incident Report, it stated, "Spoke with [Staff B, a caregiver] who reported [they] put [R1] to bed that night. Explained that [R1] was found without [their] pendant by therapy. Education was verbally done with [Staff B] about making sure that [their] pendant and anyone else [residents] always has it on or within reach."

Administrator (or Representative) Date

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During an interview with Staff A, the Health and Wellness Director, on 09/21/2023 at 1:46PM, Staff A was asked what type of training was provided to staff regarding call lights. Staff A stated that staff were trained about call lights during on-boarding, and that staff were trained to not leave any residents without their call light pendant. Staff A stated staff were trained to ensure the call light pendant was either on the resident, or at the very least, within reach of the resident.

Review of R1's Incident Report, dated 09/15/2023, showed that R1 was found on the floor at approximately 10:30AM by facility staff. "Resident was found on living room floor by their Physical Therapist at about 10:30AM. Checked for Injury found none." Under the "Follow Up Information" section of the Incident Report, it stated, "Spoke with [Staff B, a caregiver] who reported [they] put [R1] to bed that night. Explained that [R1] was found without [their] pendant by therapy. Education was verbally done with [Staff B] about making sure that [their] pendant and anyone else [residents] always has it on or within reach."

During a phone interview with Staff B, on 09/21/2023 at 10:47AM, when asked if the resident was given a shower on the evening shift of 09/14/2023, they stated, "Yes, [R1] got a shower. After the shower I put [R1] in the chair. I put [R1] back in [their] seat because [they] wanted to sit in [their] seat." Staff D was asked if they remembered where they put the call light pendant. "I gave the call light back to [R1] and I put it around [their] neck."

Review of a facility provided written witness statement from Staff B, dated 09/21/2023, stated, "On September the 15th I showered [R1] and put [them] to bed. I forgot and put [R1] to bed. I forgot to put [R1's] pendant on and left it in the bathroom. [Staff A] spoke with me about leaving the pendant in the bathroom and that I should never leave a resident alone without a pendant."

During an interview with Confidential Collateral Contact 1 (CC1), on 09/21/2023 at 10:05AM, CC1 stated that upon entering R1's room to provide services on 09/15/2023 at approximately 9:30AM, they found the resident on the floor. CC1 stated, "The night before from what the patient told me is that [they] got a shower, and the staff member undressed [them], and took [their] call light pendant off and set it on a cabinet next to the shower. After the shower, [they] got [R1] ready and got [R1] up to the living room and put [R1] in the chair that [they] usually sit in and forgot to put the [call light] pendant back on [R1]. The resident stated that approximately 11pm [they] slid out of [their] chair, onto the floor and was not able to get any [staff's] attention until I arrived the following morning around 9:30am." CC1 stated that they looked for R1's call light pendant, and found it in the bathroom on the counter, right where R1 stated it would be.

During an interview with R1 on 09/21/2023 at 11:07AM, R1 was asked if they recalled falling recently. R1 stated, "I slid down the chair, and I could not get back up." R1 was not able to determine the time they fell but stated that they slid out of their chair sometime during the night. "The next morning, physical therapy found me. I did not have my pendant to call anyone." R1 stated that the call light pendant was left in the bathroom on the counter after they received their shower the previous night. "They brought me back to my chair, after my shower, but did not give me back my pendant. That was the problem. I was on the ground all night. I slept on the floor. There was nothing I could do, I just sat there and hoped somebody would come."

This was a previous consultation on 05/04/2022.

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) 11/10/2023

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

During a phone interview with Staff B, on 09/21/2023 at 10:47AM, when asked if the resident was given a shower on the evening shift of 09/14/2023, they stated, “Yes, [R1] got a shower. After the shower I put [R1] in the chair. I put [R1] back in [their] seat because [they] wanted to sit in [their] seat.” Staff D was asked if they remembered where they put the call light pendant. “I gave the call light back to [R1] and I put it around [their] neck.”

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Plan of Correction	Brookdale Olympia East	Completion Date
Page 4 of 4	Licensee: EMERITUS CORPORATION	09/21/2023

Administrator (or Representative) 11/10/2023 Date

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