



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) 41778 (Completion Date 05/24/2024) and 39055 (Completion Date 04/04/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/24/2024 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-2660, WAC 388-78A-2660-1

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,

PP 

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 #: 39055 **Intake ID:** 125211
Investigator: Paul Aube **Region/Unit #:** RCS Region 3 / Unit E
Investigation Date(s): 03/29/2024 through 04/04/2024
Complainant Contact Date(s):

Allegation(s):

1. Admission, Transfer & Discharge Rights: Public report of facility failing to provide a 30-day written discharge notice when they became aware a resident exceeded level of care.
 2. Misappropriation of Property: Public report of facility moving resident's belongings out of the room without notice.
-

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 2 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Management Resident Representatives
Record Reviews:	Facility policies Admission Agreements Service Plans/Agreements Billing Statements

Investigation Summary:

1. Admission, Transfer & Discharge Rights: Facility failed to provide a 30-day written discharge notice, as per Residency Agreement, when they became aware a resident exceeded level of care. Failed practice identified.
 2. Misappropriation of Property: Resident out of facility for over 60 days. Facility is not charging resident for storage of property as stated per Residency Agreement. Facility paid for resident's belongings to be packed professionally, and will store on-site until family makes arrangements to pick up. No failed practice.
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Conclusion / Action:

- ☒ 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 # 39055
Plan of Correction	Brookdale Olympia East	Completion Date
Page 1 of 4	Licensee: EMERITUS CORPORATION	04/04/2024

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

The department completed data collection for an unannounced on-site complaint investigation on 03/29/2024 and 04/04/2024 of:

Brookdale Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 121644, 125211, 125668

The following sample was selected for review during the unannounced on-site visit: 2 of 67 current residents and 1 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.

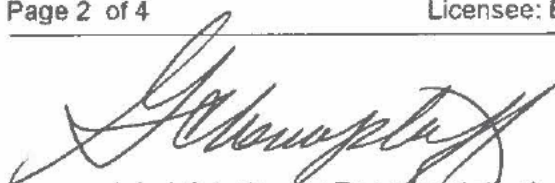
Cory Cisneros
Residential Care Services

04/09/2024
Date

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

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

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Administrator (or Representative)


Date

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 Assisted Living Facility (ALF) failed to provide residents or their representatives a thirty-day written notice to notify them of the reason for discharge from the facility when they determined the resident exceeded the facility's level of care for 1 of 1 resident reviewed (Resident 1 [R1]). This failure resulted in R1 being discharged from the facility and belongings moved out of room without required notice.

Findings included...

"RCW 70.129.110 Disclosure, transfer, and discharge requirements... (4)(a) Except when specified in this subsection, the notice of transfer or discharge required under subsection (3) of this section must be made by the facility at least thirty days before the resident is transferred or discharged. (b) Notice may be made as soon as practicable before transfer or discharge when: (iii) An immediate transfer or discharge is required by the resident's urgent medical needs; (5) The written notice specified in subsection (3) of this section must include the following: (a) The reason for transfer or discharge; (b) The effective date of transfer or discharge; (c) The location to which the resident is transferred or discharged; (d) The name, address, and telephone number of the state long-term care ombuds."

During an interview with Collateral Contact 1 (CC1), R1's Financial Guardian, on 04/03/2024 at 12:30PM, CC1 stated R1 was sent out of the facility to the hospital and treated for an infection in late 2024. CC1 stated that when R1 was cleared to discharge from the hospital, R1 was discharged to a Skilled Nursing Facility (SNF) for rehabilitation. CC1 stated that on 02/25/2024, they received a phone call from Staff A, the Executive Director, who notified them that R1 exceeded the facility's level of care, and that they were no longer able to safely meet R1's needs, and that they would be discharging R1. CC1 notified Staff A that they were never notified of R1's condition from the SNF. CC1 asked Staff A if arranging a Bed-Hold agreement would be option. CC1 stated Staff A told them that they would reach back out to them with a decision on the Bed Hold after speaking with their Corporate Office. CC1 stated that they never received a follow up call from Staff A. CC1 stated that on 03/18/2024, they received a phone call from Staff B, the Business Office Manager, who stated that the family needed to come to the facility to pick up the R1's belongings. CC1 notified Staff B that they were waiting for a call from Staff A to determine whether or not they could set up a Bed-Hold agreement for R1. CC1 stated that Staff B told them that they would speak to Staff A about this. CC1 stated that they never received a follow up call from the ALF. On 03/29/2024, CC1 stated that they received notification that the ALF was moving R1's belongings out of his room and placing them

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into another vacant empty room for storage. CC1 stated that R1's family went to the facility and was not able to stop or reverse the discharge. CC1 was asked if the facility ever provided a written notice of discharge, or a letter to them, or R1's family, and CC1 stated they never received any written notice.

Review of the R1's Face sheet showed that the R1 was admitted to the facility on [REDACTED]/2021. Review of Facility Move-Out List, from 01/09/2024-03/27/2024 showed that R1 was financially discharged from the facility on [REDACTED]/2024.

Review of R1's Admission Agreement, signed by both CC1 on 07/09/2021 and a facility representative on 07/13/2021, under section IV titled, "TERM AND TERMINATION", it stated, "We may terminate this Agreement, upon providing you thirty (30) days written notice, for any of the following events, as determined by us... The transfer or discharge is necessary for your welfare, and your needs cannot be met in the Community... We may, upon written notice to you, terminate this Agreement, and transfer or discharge you with less than thirty (30) days' notice for urgent medical reasons or when the health or safety of individuals in the Community would be endangered. In these instances, we will notify you and your legal representative as soon as practicable before transfer or discharge. We will provide a written explanation for termination with less than thirty (30) days' notice."

Review of R1's progress note, dated [REDACTED]/2024 at 2:52PM, stated "Resident was sent out to the ER [Emergency Room] for check-up due to injury fall this morning." In another R1 Progress Note, dated 02/19/2024 at 3:06PM, stated that a hospital representative called the ALF to ask about R1's baseline health and behavior. The hospital representative notified the ALF that R1 was combative with staff at the hospital, aggressive, spitting out their medications, and that they required 2-3 persons for transfer in a mechanical lift. The hospital representative stated that Physical Therapy was recommending SNF (skilled nursing facility) for placement after discharge from the hospital. In another R1 Progress Note, dated 03/28/2024 at 9:16AM, a Move-Out/Discharge Note was written in R1's record which stated, "Prog[ress] Notes from SNF also report [R1] refuses medications and displays impulsive and physical behaviors re: throwing medications, non-compliance. [Staff A] instructed [Staff B] to contact family re: emptying apartment on 3/22/2024. [Staff B] was instructed by [CC1] to have [Staff A] report [with] bed hold information. [R1's] personal items remaining in # [REDACTED] were temporarily placed in #230 in locked vacant apartment. There has been discussion with [family and CC1] regarding potential Bed Hold payment on 02/02/2023 prior to information regarding medical determination. [R1] was unable to return to facility on 03/01/2024." In another R1 Progress Note, dated 03/28/2024 at 1:05PM, stated "It is documented that [R1] becomes upset, yells and is easily agitated. [R1] is not appropriate for this setting. ED notified of this note and decision."

During an interview with Staff B, the Business Office Manager, on 04/03/2024 at 2:39PM, Staff B was asked to explain the process on what the facility would do when they felt a resident had exceeded the level of care and initiated a discharge of that resident. Staff B stated, "I think that depends on the situation. I do not do the communication to the family. Most of that would be done by the Nurse or the Executive Director." Staff B was asked if a letter was sent to the resident or representative of the notice of discharge, or if the notification was done by phone, or in person meeting. Staff B stated, "I do not know the process, but I feel those all would be appropriate." Staff B was asked if they were aware

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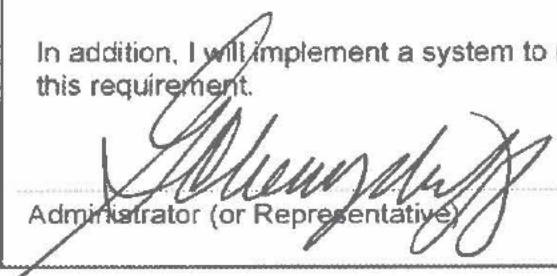
that per the Admission Agreement, it stated that the facility would provide a written discharge notice. Staff B stated that they were not aware that there needed to be a written notice to the resident's family when the facility deemed the resident to have exceeded their level of care.

During an interview on 04/04/2024 at 12:48PM, Staff A was asked the circumstances behind the facility discharging R1. Staff A stated that after communicating with the SNF, they learned that R1 was still experiencing problems with mobility, and other behavioral problems. Staff A stated that at that time, they deemed R1 inappropriate to return to their facility safely. Staff A was asked if at any time, a written discharge notice/letter was provided to the R1, or their representative. Staff A stated, "No."

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) 04/15/2024.

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


Administrator (or Representative)

04/15/2024
Date