STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

EMERITUS CORPORATION
Brookdale Meadow Springs
770 Gage Blvd
Richland, WA 99352

RE: Brookdale Meadow Springs License # 2311

Dear Administrator:

This letter addresses Compliance Determination(s) 34366 (Completion Date 12/26/2023) and 31440 (Completion Date 11/02/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/26/2023 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:
WAC 388-78A-2320-2-c, WAC 388-78A-2320-2-b, WAC 388-78A-2320-2-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1, WAC 388-78A-2466-1-a, WAC 388-78A-2468-1, WAC 388-78A-2468-3, WAC 388-78A-2468-4, WAC 388-78A-24681-1, WAC 388-78A-24681-2, WAC 388-78A-24681, WAC 388-78A-2480-1, WAC 388-78A-2620-2-a, RCW 70.129.030.4, WAC 388-78A-3000-3, WAC 388-78A-3040-7-a-i, WAC 388-78A-3040-7-a-ii, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-d, WAC 388-78A-3090-1, WAC 388-112A-0200-1, WAC 388-112A-0200-2-a, WAC 388-112A-0720-2-a, WAC 388-112A-0720-2-b, WAC 388-112A-0220-1, WAC 388-112A-0220-2, WAC 388-112A-0220-2-a

The Department staff who did the on-site verification:
Elaine Lopez, Licensor
Tracy Ramirez, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher
Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

EMERITUS CORPORATION
Brookdale Meadow Springs
770 Gage Blvd
Richland, WA 99352

RE: Brookdale Meadow Springs # 2311

Dear Administrator:

This document references the following complaint numbers 101673, 102290, 102510.

The Department completed a full inspection of your Assisted Living Facility on 11/02/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Gwin Kaercher, Field Manager
Residential Care Services

Region 1, Unit G
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 246-980-030 Can a nonexempt long-term care worker work before obtaining certification as a home care aide?

(1) A nonexempt 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.

The Assisted Living Facility failed to submit the home care aid application to the department within 14 days of hire.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

The Assisted Living Facility failed to ensure staff obtained food worker cards according to the regulations.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.

o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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 and complaint investigation on 10/23/2023, 10/24/2023, 10/25/2023 and 10/26/2023 of:

Brookdale Meadow Springs
770 Gage Blvd
Richland, WA 99352

This document references the following complaint numbers: 101673, 102290, 102510.

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:

Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor
Tracy Ramirez, Assisted Living Facility Licensor
Robin Rainville, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher
Residential Care Services

11/14/2023
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.

Administrator (or Representative) — 11/21/2023 Date

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.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a safe system was implemented for nurse delegation as required for 4 of 4 residents (Resident 2, 5, 6, 7) who received delegated task assistance from staff. These failures placed residents at risk of their needs not being met and delegated tasks performed incorrectly.

Findings included...

Review of Washington Administrative Code (WAC) 246-840-0010 showed that delegation meant that a Registered Nurse could assign specific nursing tasks to competent staff by following the nurse delegation process.

Review of WAC 246-840-930 showed that the Registered Nurse Delegator (RND) was to assess the resident, identify specific tasks to be delegated, and provide direction to staff for each task for individual residents. Additionally, the RND is responsible to review and reassess the appropriateness for delegation every 90 days.

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

Administrator (or Representative) Date

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.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a safe system was implemented for nurse delegation as required for 4 of 4 residents (Resident 2, 5, 6, 7) who received delegated task assistance from staff. These failures placed residents at risk of their needs not being met and delegated tasks performed incorrectly.

Findings included…

Review of Washington Administrative Code (WAC) 246-840-0010 showed that delegation meant that a Registered Nurse could assign specific nursing tasks to competent staff by following the nurse delegation process.

Review of WAC 246-840-930 showed that the Registered Nurse Delegator (RND) was to assess the resident, identify specific tasks to be delegated, and provide direction to staff for each task for individual residents. Additionally, the RND is responsible to review and reassess the appropriateness for delegation every 90 days.

Resident 2

Review of Resident 2's October 2023 Medication Administration Record (MAR), showed that they had diagnoses that included [redacted] The MAR showed that Resident 2 required routine insulin (an injected medication to regulate blood sugar levels) three times a day. Additionally, the resident received sliding scale insulin (amount given to resident depended on their blood sugar test result) before meals. The MAR showed that Resident 2's blood sugar was to be checked three times a day.

Review of Resident 2's Negotiated Service Agreement, dated 10/10/2023, showed that the resident required staff to administer their insulin and perform their Capillary Blood Glucose (CBG) testing (a finger prick test to monitor blood sugar levels).

Record review of a delegation form in Resident 2's record titled, "Nurse Delegation: Consent for Delegation," dated 12/29/2022, showed that the resident agreed to have delegated tasks completed by staff. The form included the diagnosis of [redacted]

Record review of a delegation form in Resident 2's record titled, "Nurse Delegation: Nursing Visit," dated 01/05/2023 showed that the box provided to identify which tasks to be delegated was blank. The record did not show the specific delegated tasks for monitoring blood sugars and administering insulin. Additionally, the form did not show the necessary instructions required to perform delegated tasks.

Record review of a delegation form in Resident 2's record titled, "90 – Day Assessment," dated 12/29/2022, showed that it was completed by Staff H, RND. The record showed that the resident had not been assessed or evaluated for nurse delegation for 301 days as of 10/26/2023, when the licensors exited the facility.

Resident 5

Review of Resident 5's October 2023 MAR, showed that they had diagnoses that included [redacted] The MAR showed that Resident 5 required routine insulin daily. Additionally, the resident received sliding scale insulin before meals and their blood sugar was to be checked three times a day.

Review of Resident 5's NSA, dated 10/11/2023, showed that the resident required staff to administer their insulin and perform their CBG testing.

Record review of a delegation form in Resident 5's record titled, "Nurse Delegation: Consent for Delegation," dated 05/12/2023, showed that the resident agreed to have delegated tasks completed by staff. The form included the diagnosis of [redacted]

Review of a delegation form in Resident 5's record titled, "Nurse Delegation: Nursing Visit," dated 05/12/2023, showed nurse delegation was provided for "blood sugar checks and insulin admin [administration]." The record did not show the specific tasks for monitoring blood sugars and administering insulin for Resident 5. Additionally, the form did not show the necessary instructions required to perform delegated tasks.

Review of a delegation form in Resident 5's record titled, "90 – Day Assessment," undated, showed that it was completed by Staff H, RND. The resident had not had an assessment completed in the past 90 days. The record did not show an assessment completed in the last 90 days as required.

Resident 6

Review of Resident 6's October 2023 MAR, showed that they had diagnoses that included [redacted] The MAR showed that Resident 6 required routine insulin two times a day. Additionally, the resident required CBG testing and received sliding scale insulin before meals.

Review of Resident 6's NSA, dated 10/20/2023, showed that the resident required staff to administer their insulin and perform their CBG testing.

Review of a delegation form in Resident 6's record titled, "Nurse Delegation: Consent for Delegation," dated 12/27/2022, showed that the resident agreed to have delegated tasks completed by staff. The form included the diagnosis of [redacted]

Review of a delegation form in Resident 6's record titled, "Nurse Delegation: Nursing Visit," dated 01/05/2023, showed nurse delegation was provided for "blood sugar checks and insulin administration." The record did not show the specific tasks for monitoring blood sugars and administering insulin for Resident 6. Additionally, the form did not show the necessary instructions required to perform delegated tasks.

Review of a delegation form in Resident 6's record titled, "90 – Day Assessment," dated 12/27/2022, showed that it was completed by Staff H, RND. Resident 6's record did not show that they were assessed or evaluated for nurse delegation services for 308 days as of 10/26/2023, when the licensors exited the facility.

Resident 7

Review of Resident 7's October 2023 MAR, showed that they had diagnoses that included [redacted] The MAR showed that Resident 7 required routine insulin once daily. Additionally, the resident required CBG testing twice daily.

Review of Resident 7's NSA, dated 10/11/2023, showed that the resident required staff to administer their insulin and perform their CBG testing.

Record review of a delegation form in Resident 7's record titled, "Nurse Delegation: Consent for Delegation," dated 12/27/2022, showed that the resident agreed to have delegated tasks completed by staff. The form included the diagnosis of [redacted]

Review of a delegation form in Resident 7's record titled, "Nurse Delegation: Nursing Visit," dated 01/05/2023, showed nurse delegation was provided for "blood sugar checks and insulin administration." The record did not show the specific tasks for monitoring blood sugars and administering insulin for Resident 7. Additionally, the form did not show the necessary instructions required to perform delegated tasks.

Review of a delegation form in Resident 7's record titled, "90 – Day Assessment," dated 12/27/2022, showed that it was completed by Staff H, RND. Resident 7's record did not show that they were assessed or evaluated for nurse delegation services for 302 days as of 10/26/2023, when the licensors exited the facility.

On 10/25/2023 at 2:50 PM, Staff E, Medication Technician (MT) and Staff I (MT) stated that they were initially trained on delegated tasks by Staff H, RND, over six months ago. They had not been trained on delegated tasks since.

In an interview on 10/25/2023 at 3:01 PM, Staff H, RND, acknowledged nurse delegation was required to be reviewed every ninety days. Staff H, RND, stated that they had not done any nurse delegation updates since their initial assumption of delegation for the facility.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/31/2023 17th.

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

Administrator (or Representative) — 11/21/2023 Date

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.

Review of Resident 7's NSA, dated 10/11/2023, showed that the resident required staff to administer their insulin and perform their CBG testing.

Record review of a delegation form in Resident 7's record titled, "Nurse Delegation: Consent for Delegation," dated 12/27/2022, showed that the resident agreed to have delegated tasks completed by staff. The form included the diagnosis of [redacted]

Review of a delegation form in Resident 7's record titled, "Nurse Delegation: Nursing Visit," dated 01/05/2023, showed nurse delegation was provided for "blood sugar checks and insulin administration." The record did not show the specific tasks for monitoring blood sugars and administering insulin for Resident 7. Additionally, the form did not show the necessary instructions required to perform delegated tasks.

Review of a delegation form in Resident 7's record titled, "90 – Day Assessment," dated 12/27/2022, showed that it was completed by Staff H, RND. Resident 7's record did not show that they were assessed or evaluated for nurse delegation services for 302 days as of 10/26/2023, when the licensors exited the facility.

On 10/25/2023 at 2:50 PM, Staff E, Medication Technician (MT) and Staff I (MT) stated that they were initially trained on delegated tasks by Staff H, RND, over six months ago. They had not been trained on delegated tasks since.

In an interview on 10/25/2023 at 3:01 PM, Staff H, RND, acknowledged nurse delegation was required to be reviewed every ninety days. Staff H, RND, stated that they had not done any nurse delegation updates since their initial assumption of delegation for the facility.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a Washington State name and date of birth background check was submitted to the department every two years for 2 of 2 staff (Staff E, F) who worked in the ALF for more than two years. This failure placed residents at risk of being cared for by disqualified staff.

Findings included...

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1:00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff E, Medication Technician, showed that they were hired on 11/16/2020. Staff E's file showed a Washington state name and date of birth background check result, dated 06/08/2021. Staff E's file showed a subsequent background check result dated 06/22/2023, which was 14 days late.
- The file for Staff F, Resident Care Coordinator, showed that they were hired on 06/28/2018. Staff F's file showed a Washington state name and date of birth background check result dated 03/25/2021. Staff F's file showed a subsequent background check result dated 06/15/2023, which was 82 days late.

On 10/25/2023 at 1:21 PM Staff G stated that they were off on personal leave in June 2023 so that might be why Staff E and F's two-year background checks were done late.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/4/2023 17th.

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

Administrator (or Representative) — 11/21/2023 — Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may

(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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a Washington State name and date of birth background check was submitted to the department every two years for 2 of 2 staff (Staff E, F) who worked in the ALF for more than two years. This failure placed residents at risk of being cared for by disqualified staff.

Findings included…

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1: 00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff E, Medication Technician, showed that they were hired on 11/16/2020. Staff E's file showed a Washington state name and date of birth background check result, dated 06/08/2021. Staff E's file showed a subsequent background check result dated 06/22/2023, which was 14 days late.
- The file for Staff F, Resident Care Coordinator, showed that they were hired on 06/28/2018. Staff F's file showed a Washington state name and date of birth background check result dated 03/25/2021. Staff F's file showed a subsequent background check result dated 06/15/2023, which was 82 days late.

On 10/25/2023 at 1:21 PM Staff G stated that they were off on personal leave in June 2023 so that might be why Staff E and F's two-year background checks were done late.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of

birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

(3) Has received three positive references for the person;

(4) Does not allow the person to have unsupervised access to any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to submit a background check to the department within one business day after hire for 1 of 4 staff (Staff B). Additionally, the ALF failed to ensure three positive references were obtained for 2 of 4 staff (Staff A, B). These failures placed the residents at risk of being care for by disqualified and potentially unfit staff.

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1:00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

Staff A:

The file for Staff A, Administrator, showed that they were hired on 08/07/2023. Their file did not show that three positive references had been verified.

Staff B:

The file for Staff B, Licensed Practical Nurse (LPN)/Health and Wellness Director, showed that they were hired on 07/30/2023. Staff B, LPN's file did not show a Washington state name and date of birth background form had been submitted for Staff B, LPN, for 82 days since they were hired. Additionally, Staff B, LPN's file did not show that three positive references had been verified.

On 10/23/2023 at 10:00 AM, Staff A stated that Staff B, LPN, was responsible for doing all full and ongoing nursing assessments for the residents.

On 10/26/2023 at 10:30 AM, Staff G stated that the facility's corporate recruiters had managed the hiring of Staff A and Staff B, LPN, and had not sent the ALF their new hire paperwork.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/29/2023 17th

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

Administrator (or Representative) — Date: 11/21/2023

WAC 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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a fingerprint background result was pending for 1 of 1 provisionally hired staff (Staff B) who had unsupervised access to the residents in the home. This failure placed residents at risk of being cared for by disqualified staff members.

Findings included...

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1:00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff D, Caregiver, showed they were hired on 06/13/2023. Their file showed a Washington state name and date of birth background check result dated 06/08/2023. Staff D's file did not show that a national fingerprint background request had been submitted and was pending, for 134 days after they were hired.

Review of the ALF's October 2023 staff schedules showed that Staff D typically worked unsupervised as the 2:00 PM – 10:00 PM caregiver assigned to the 1st floor of the facility.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a fingerprint background result was pending for 1 of 1 provisionally hired staff (Staff B) who had unsupervised access to the residents in the home. This failure placed residents at risk of being cared for by disqualified staff members.

Findings included…

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1: 00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff D, Caregiver, showed they were hired on 06/13/2023. Their file showed a Washington state name and date of birth background check result dated 06/08/2023. Staff D's file did not show that a national fingerprint background request had been submitted and was pending, for 134 days after they were hired.

Review of the ALF's October 2023 staff schedules showed that Staff D typically worked unsupervised as the 2:00 PM – 10:00 PM caregiver assigned to the 1st floor of the facility.

On 10/25/2023 at 1:19 PM, Staff G stated that they thought a fingerprint appointment had been scheduled for Staff D and that they did not go to the appointment.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/4/2023 17H.

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

Administrator (or Representative) — Date: 11/21/2023

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure screening for tuberculosis (TB) was completed within three days of hire for 4 of 4 staff (Staff A, B, C, D), who were hired since the last full inspection. This failure placed residents at risk of potential exposure to a communicable disease.

Findings included...

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1:00 PM. Staff G stated that they were responsible for maintaining and tracking staff records. Staff G also stated that they were out of the ALF on personal leave from June to October 2023, and the ALF had part time interim help from a sister facility to manage staff records during that time.

On 10/25/2023 at 1:18 PM, Staff G stated that upon hire, they would give a new staff member's TB testing paperwork to the facility nurse, so that TB screening could be done.

- The file for Staff A, Administrator, showed that they were hired on 08/07/2023. Staff A's file did not include documentation that they had been screened or tested for TB since they were hired.
- The file for Staff B, Licensed Practical Nurse (LPN)/Health and Wellness Director, showed that they were hired on 07/30/2023. Staff B, LPN's file did not include documentation that they had been screened or tested for TB since they were hired.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure screening for tuberculosis (TB) was completed within three days of hire for 4 of 4 staff (Staff A, B, C, D), who were hired since the last full inspection. This failure placed residents at risk of potential exposure to a communicable disease.

Findings included…

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1: 00 PM. Staff G stated that they were responsible for maintaining and tracking staff records. Staff G also stated that they were out of the ALF on personal leave from June to October 2023, and the ALF had part time interim help from a sister facility to manage staff records during that time.

On 10/25/2023 at 1:18 PM, Staff G stated that upon hire, they would give a new staff member's TB testing paperwork to the facility nurse, so that TB screening could be done.

- The file for Staff A, Administrator, showed that they were hired on 08/07/2023. Staff A's file did not include documentation that they had been screened or tested for TB since they were hired.
- The file for Staff B, Licensed Practical Nurse (LPN)/Health and Wellness Director, showed that they were hired on 07/30/2023. Staff B, LPN's file did not include documentation that they had been screened or tested for TB since they were hired.

On 10/26/2023 at 10:30 AM, Staff G stated that the facility's corporate recruiters had managed the hiring of Staff A and Staff B, LPN, and had not sent the ALF their new hire

paperwork.

- The file for Staff C, Maintenance Director, showed that Staff C was hired on 07/14/2023. Staff C's file did not include documentation that they had been screened or tested for TB since they were hired.
- The file for Staff D, Caregiver, showed that they were hired on 06/13/2023. Staff D' s file did not include documentation that they had been screened or tested for TB since they were hired.

On 10/25/2023 at 1:32 PM, Staff G stated that they did not know why Staff C and D had not been screened for TB upon hire.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/27/2023 1748

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

Administrator (or Representative) — Date: 11/21/2023

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;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to maintain pet records for 2 pets for 1 of 9 residents (Resident 1) and 2 pets for 2 of 2 supplemental residents (Resident 10, 11) who had pets residing at the facility. This failure placed residents and staff at risk for exposure to transmittable diseases.

Findings included...

paperwork.

- The file for Staff C, Maintenance Director, showed that Staff C was hired on 07/14/2023. Staff C's file did not include documentation that they had been screened or tested for TB since they were hired.
- The file for Staff D, Caregiver, showed that they were hired on 06/13/2023. Staff D' s file did not include documentation that they had been screened or tested for TB since they were hired.

On 10/25/2023 at 1:32 PM, Staff G stated that they did not know why Staff C and D had not been screened for TB upon hire.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) 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;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to maintain pet records for 2 pets for 1 of 9 residents (Resident 1) and 2 pets for 2 of 2 supplemental residents (Resident 10, 11) who had pets residing at the facility. This failure placed residents and staff at risk for exposure to transmittable diseases.

Findings included…

Record review of Resident 1's vaccination file showed there were no examination or

vaccination records for Resident 1's two pets that resided at the facility.

Record review of Resident 10's vaccination file showed there were no examination or vaccination records for Resident 10's pet that resided at the facility.

Record review of Resident 11's vaccination file showed there were no examination or vaccination records for Resident 10's pet that resided at the facility.

On 10/25/2023 at 2:00 PM in an interview with Staff A, Executive Director, they stated that there were no vaccination records for Resident 1, 10, and 11's pets. They acknowledged that four of nine pets did not have up to date examinations or vaccinations.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/29/2023 17th.

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

Administrator (or Representative) — Date: 11/21/23

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:

vaccination records for Resident 1's two pets that resided at the facility.

Record review of Resident 10's vaccination file showed there were no examination or vaccination records for Resident 10's pet that resided at the facility.

Record review of Resident 11's vaccination file showed there were no examination or vaccination records for Resident 10's pet that resided at the facility.

On 10/25/2023 at 2:00 PM in an interview with Staff A, Executive Director, they stated that there were no vaccination records for Resident 1, 10, and 11's pets. They acknowledged that four of nine pets did not have up to date examinations or vaccinations.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) 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 Assisted Living Facility (ALF) failed to inform each resident at least every 24 months in writing of the service items, activities available in the facility, and the rules of the facility's operation for 2 of 2 residents (Resident 3, 7), who

lived in the facility for more than 24 months. This failed practice did not allow residents to make informed decisions regarding living choices.

Findings included..

Twenty-four month notification record review occurred on 10/25/2023 at 2:35 PM with Staff G, Business Office Coordinator.

- The facility's resident characteristic roster showed that Resident 3 was admitted on [redacted]/2016. Resident 3's rental agreement was signed and dated on 05/17/2016. There were no additional agreements in Resident 3's record.
- The facility's resident characteristic roster showed that Resident 7 was admitted on [redacted]/2014. Resident 7's rental agreement was signed and dated on [redacted]/2014. There were no additional agreements in Resident 7's record.

On 10/25/2023 at 2:35 PM, Staff G stated that there were no current rental agreements for Resident 3 and 7, the ALF was not aware the facility needed to.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/27/23 12/14

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

Administrator (or Representative) — 11/21/2023 Date

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation, and

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide and maintain intact sixteen mesh screens in 4 of 4 areas (east, north, west, south). This failed practice placed residents at risk of having pests and bugs enter their apartments.

lived in the facility for more than 24 months. This failed practice did not allow residents to make informed decisions regarding living choices.

Findings included…

Twenty-four month notification record review occurred on 10/25/2023 at 2:35 PM with Staff G, Business Office Coordinator.

- The facility's resident characteristic roster showed that Resident 3 was admitted on [redacted]/2016. Resident 3's rental agreement was signed and dated on 05/17/2016. There were no additional agreements in Resident 3's record.
- The facility's resident characteristic roster showed that Resident 7 was admitted on [redacted]/2014. Resident 7's rental agreement was signed and dated on [redacted]/2014. There were no additional agreements in Resident 7's record.

On 10/25/2023 at 2:35 PM, Staff G stated that there were no current rental agreements for Resident 3 and 7, the ALF was not aware the facility needed to.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3000 Ventilation. The assisted living facility must meet the ventilation requirements of the mechanical code as adopted and amended by the Washington state building council; and

(3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide and maintain intact sixteen mesh screens in 4 of 4 areas (east, north, west, south). This failed practice placed residents at risk of having pests and bugs enter their apartments.

Findings included…

The ALF's exterior environmental tour occurred on 10/23/2023 at 11:00 AM with Staff A, Administrator, and Staff C, Maintenance Director. Observations during the tour showed 38 damaged screens and missing screens from the 123 total screens as follows:

- North side: 4 missing and damaged screens
- East side: 14 missing and damaged screens
- South side: 12 missing and damaged screens
- West side: 8 missing and damaged screens

On 10/23/2023 at 12:20 PM Staff A, Executive Director, and Staff C, Maintenance Director, acknowledged that there were screens missing and or damaged in several areas of the building.

- North side: 4 missing and damaged screens
- East side: 14 missing and damaged screens
- South side: 12 missing and damaged screens
- West side: 8 missing and damaged screens

On 10/23/2023 at 12:20 PM Staff A and Staff C acknowledged that there were screens missing and or damaged on the windows in several areas of the building.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/2/2023 12/1/2023.

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

Administrator (or Representative) — 11/21/2023 Date

WAC 388-78A-3040 Laundry.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(i) A utility sink;

The ALF's exterior environmental tour occurred on 10/23/2023 at 11:00 AM with Staff A, Administrator, and Staff C, Maintenance Director. Observations during the tour showed 38 damaged screens and missing screens from the 123 total screens as follows:

- North side: 4 missing and damaged screens
- East side: 14 missing and damaged screens
- South side: 12 missing and damaged screens
- West side: 8 missing and damaged screens

On 10/23/2023 at 12:20 PM Staff A, Executive Director, and Staff C, Maintenance Director, acknowledged that there were screens missing and or damaged in several areas of the building.

- North side: 4 missing and damaged screens
- East side: 14 missing and damaged screens
- South side: 12 missing and damaged screens
- West side: 8 missing and damaged screens

On 10/23/2023 at 12:20 PM Staff A and Staff C acknowledged that there were screens missing and or damaged on the windows in several areas of the building.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3040 Laundry.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(i) A utility sink;

(ii) A table or counter for folding clean laundry;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide a safe and sanitary environment for all residents for 1 of 2 laundry rooms. This failure placed residents at risk for exposure to non-sanitary areas for handwashing and for their clean clothing.

Findings included…

On 10/23/2023 at 11:40 AM in an environmental tour with Staff A, Administrator, and Staff C, Maintenance Director, observation showed that in the first-floor laundry room, there were wet towels and a sock in the utility sink, soiled clothing on the counter in the soiled laundry room, and unlabeled clean laundry on the counter in the clean laundry room. There was not space on either counter for residents to place their soiled or clean laundry.

On 10/23/2023 at 11:50 AM, observation showed that the second-floor laundry room could not be accessed by residents.

On 10/23/2023 at 11:52 AM Staff A stated that there had been a flood in the second-floor laundry room and they were down to one laundry room for the facility.

On 10/23/2023 at 2:41 PM in an interview with Resident 1, they stated that they did their own laundry in the facility laundry room.

On 10/25/2023 at 9:45 AM, observation showed the wet towels and a sock that were in the utility sink on 10/23/2023, had not been moved. The soap had two ounces in the container and the paper towel dispenser was empty. The counter in the clean laundry room had blankets, sheets, a bed pad, bathmat, electrical cord, a book, a plastic garbage can, and a washcloth on it.

On 10/26/2023 at 10:42 AM, observation showed the same wet towels from 10/23/2023 and 10/25/2023 in the utility sink and the counter in the soiled laundry room had soiled laundry on it in two large piles. Additionally, the counter in the clean laundry room had items from the previous days on it, with three feet of available space for residents to fold their clean laundry.

On 10/26/2023 at 1:15 PM in an interview with Staff A, they stated that the laundry room is used by residents at the facility for their personal laundry.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/26/2023 17th

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

Administrator (or Representative) — Date: 11/21/2023

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

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 areas of the facility (hallways, common areas, and west exterior). This failure placed residents at risk for a decreased quality of life from poorly maintained interior and exterior environments, potential exposure to serious health concerns from pests, and unclean conditions.

Findings included...

On 10/23/2023 at 11:00 AM, observation showed that 5 common areas (first and second floor living rooms, activity room, dining room, and resident restroom) had furniture and carpets that were stained throughout all common areas. There were hard water marks on the picture windows, the window blinds had missing sections, there was a hole in the ceiling drywall in the center in the dining room. 1 of 2 main resident restrooms had a non-cleanable floor due to the flooring peeling upwards, a non-secured toilet paper holder, and an odor that was present.

On 10/23/2023 at 11:20 AM, observation showed 6 of 6 hallways on the first floor and second floor that were heavily stained throughout the entirety of the hallways, with frayed edges near the drain covers, and an odor of urine present. Black streaks showed on the handrails, brown liquid was dried

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 areas of the facility (hallways, common areas, and west exterior). This failure placed residents at risk for a decreased quality of life from poorly maintained interior and exterior environments, potential exposure to serious health concerns from pests, and unclean conditions.

Findings included…

On 10/23/2023 at 11:00 AM, observation showed that 5 common areas (first and second floor living rooms, activity room, dining room, and resident restroom) had furniture and carpets that were stained throughout all common areas. There were hard water marks on the picture windows, the window blinds had missing sections, there was a hole in the ceiling drywall in the center in the dining room. 1 of 2 main resident restrooms had a non-cleanable floor due to the flooring peeling upwards, a non-secured toilet paper holder, and an odor that was present.

On 10/23/2023 at 11:20 AM, observation showed 6 of 6 hallways on the first floor and second floor that were heavily stained throughout the entirety of the hallways, with frayed edges near the drain covers, and an odor of urine present. Black streaks showed on the handrails, brown liquid was dried on the baseboards and walls, dust and debris were

behind the fire doors and on the molding in the middle of the wall. The resident doors had scratches, chipped paint, and dark streaks that went across the door and kick boards of the doors. Additionally, the ceiling tiles had torn out pieces and there and the walls throughout the hallways had been damaged.

On 10/23/2023 at 12:20 PM, observation showed that on the west side of the facility, the gutters drooped and were filled with weeds. One of the downspouts was missing and there was a damaged soffit (protective covering that protects the rafters from the outside elements) in the lower corner of the roof. Additionally, wasp nests were noted in the gaps of the gutters along the roofline.

On 10/23/2023 at 3:28 PM, Resident 1 stated that housekeeping had not come to clean their apartment for two weeks.

On 10/25/2023 at 10:38 AM, Resident 4 stated that they had been at the facility since [redacted] and housekeeping was to come two times a week. They stated that since they had moved in, housekeeping had come two times total. Resident 4 stated they have been moping their apartment floor and their spouse had been cleaning the bathroom.

On 10/24/2023 at 10:00 AM during the Resident group meeting, 3 of the 8 residents who attended the meeting stated that the facility was dirty, that the facility was short staffed and there has not been housekeeping staff on the second floor, and the weekly cleaning has not been happening.

On 10/23/2023 at 3:43 PM, Staff A, Administrator, acknowledged the maintenance and cleaning that had not been done. Additionally, they stated that they had a housekeeper who was assigned to the second floor, that had not been able to work.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/11/2023

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

Administrator (or Representative) — Date: 11/21/2023

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

behind the fire doors and on the molding in the middle of the wall. The resident doors had scratches, chipped paint, and dark streaks that went across the door and kick boards of the doors. Additionally, the ceiling tiles had torn out pieces and there and the walls throughout the hallways had been damaged.

On 10/23/2023 at 12:20 PM, observation showed that on the west side of the facility, the gutters drooped and were filled with weeds. One of the downspouts was missing and there was a damaged soffit (protective covering that protects the rafters from the outside elements) in the lower corner of the roof. Additionally, wasp nests were noted in the gaps of the gutters along the roofline.

On 10/23/2023 at 3:28 PM, Resident 1 stated that housekeeping had not come to clean their apartment for two weeks.

On 10/25/2023 at 10:38 AM, Resident 4 stated that they had been at the facility since [redacted] and housekeeping was to come two times a week. They stated that since they had moved in, housekeeping had come two times total. Resident 4 stated they have been moping their apartment floor and their spouse had been cleaning the bathroom.

On 10/24/2023 at 10: 00 AM during the Resident group meeting, 3 of the 8 residents who attended the meeting stated that the facility was dirty, that the facility was short staffed and there has not been housekeeping staff on the second floor, and the weekly cleaning has not been happening.

On 10/23/2023 at 3:43 PM, Staff A, Administrator, acknowledged the maintenance and cleaning that had not been done. Additionally, they stated that they had a housekeeper who was assigned to the second floor, that had not been able to work.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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 seventy-hour long-term care worker 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 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.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete the facility orientation before staff had regular interactions with residents for 3 of 3 staff (Staff B, C, D). Additionally, the ALF failed to complete the two-hour orientation training before staff hired as long-term care workers provided care to residents as required, for 2 of 3 staff (Staff D, E). This failure placed residents at risk of being cared for by untrained staff.

Findings included…

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1: 00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

Facility orientation:

- The file for Staff B, Licensed Practical Nurse (LPN)/Health Services Director, showed that they were hired on 07/30/2023. Staff B, LPN’s file included a facility orientation certificate dated 08/24/2023, 25 days after they were hired.
- The file for Staff C, Maintenance Director, showed that they were hired on 07/14/2023. Staff C’s file included a facility orientation certificate dated 08/24/2023, 41 days after they were hired.

On 10/25/2023 at 1:14 PM, Staff G stated that the dates on the certificates for Staff B, LPN, and Staff C probably had not been changed to reflect the date they were trained.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/29/2023 1741

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

Administrator (or Representative) — Date: 11/21/2023

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

(b) Licensed nurses working in assisted living facility must have and maintain a valid CPR card or certificate within thirty days of their date of hire.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that Cardio-Pulmonary Resuscitation (CPR) certificates were obtained and maintained for 2 of 4 staff (Staff B, E) who were required to have the certification. This failure placed residents at risk of not receiving emergency treatment by qualified staff.

Findings included...

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1:00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff B, Licensed Practical Nurse (LPN)/Health and Wellness Director, showed that they were hired on 07/30/2023. Their file did not include a CPR certificate.

On 10/26/2023 at 10:30 AM, Staff G stated that the facility's corporate recruiters had managed the hiring of Staff B, LPN, and had not sent the ALF their new hire paperwork which would include a CPR certificate.

- The file for Staff D, Medication Technician, showed that they were hired on

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

(b) Licensed nurses working in assisted living facility must have and maintain a valid CPR card or certificate within thirty days of their date of hire.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that Cardio-Pulmonary Resuscitation (CPR) certificates were obtained and maintained for 2 of 4 staff (Staff B, E) who were required to have the certification. This failure placed residents at risk of not receiving emergency treatment by qualified staff.

Findings included…

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1: 00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff B, Licensed Practical Nurse (LPN)/Health and Wellness Director, showed that they were hired on 07/30/2023. Their file did not include a CPR certificate.

On 10/26/2023 at 10:30 AM, Staff G stated that the facility's corporate recruiters had managed the hiring of Staff B, LPN, and had not sent the ALF their new hire paperwork which would include a CPR certificate.

- The file for Staff D, Medication Technician, showed that they were hired on 11/16/2020. The file included a CPR certificate that expired on 04/30/2023.

On 10/25/2023 at 1:48 PM, Staff G stated that they did not know if Staff D had renewed their CPR certificate.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/29/2023 1/24

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

Administrator (or Representative) — Date: 11/21/2023

WAC 388-112A-0220 What is safety training, who must complete it, and when should it be completed?

(1) Safety training is part of the long-term care worker requirements. It is a three hour training that must meet the requirements of WAC 388-112A-0230 and include basic safety precautions, emergency procedures, and infection control.

(2) The following individuals must complete safety training:

(a) All long-term care workers who are not exempt from certification as described in RCW 18.88B.041 hired after January 7, 2012, must complete three hours of safety training. This safety training must be provided by qualified instructors that meet the requirements in WAC 388-112A-1260

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete the three hour safety training before staff provided care to residents as required, for 2 of 3 staff (Staff D, E) who were hired as long term care workers. This failure placed residents at risk of being cared for by untrained staff.

Findings included:

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1:00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff D, Caregiver, showed they were hired on 06/13/2023. Staff D's file did not show that they had received long term care worker safety training.

On 10/25/2023 at 1:48 PM, Staff G stated that they did not know if Staff D had renewed their CPR certificate.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-112A-0220 What is safety training, who must complete it, and when should it be completed?

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This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete the three hour safety training before staff provided care to residents as required, for 2 of 3 staff (Staff D, E) who were hired as long term care workers. This failure placed residents at risk of being cared for by untrained staff.

Findings included…

Staff records were reviewed with Staff G, Business Office Coordinator, on 10/25/2023 at 1:00 PM. Staff G stated that they were responsible for maintaining and tracking staff records.

- The file for Staff D, Caregiver, showed they were hired on 06/13/2023. Staff D's file did not show that they had received long term care worker safety training.

On 10/25/2023 at 1:21 PM Staff G stated that they were off on personal leave in June 2023 so that might be why Staff D did not get the safety training.

- The file for Staff E, Medication Technician, showed that they were hired on 11/16/2020. Staff E's file did not show that they had received long term care worker safety training.

On 10/25/2023 at 1:43 PM, Staff G stated that they did not know why Staff E's file did not show documentation of their safety training.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date) 12/29/2023 17AD.

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

Administrator (or Representative) — Date: 11/21/2023

• The file for Staff E, Medication Technician, showed that they were hired on 11/16/2020. Staff E's file did not show that they had received long term care worker safety training.

On 10/25/2023 at 1:43 PM, Staff G stated that they did not know why Staff E's file did not show documentation of their safety training.

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 Meadow Springs is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

1200 Alder St

Union Gap, WA 98903

The following is the Plan of Correction for Brookdale Meadow Springs regarding the Statement of Deficiencies dated 11/14/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Deficiency #1: WAC 388-7A-2320 intermittent nursing services systems

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; Quarterly assessments to be completed by 12-~~29~~-2023. 1778

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken; Audit of all resident assessments to determine residents to be re-assessed by 12-~~29~~-2023. 1778

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); Discussion of all delegation and/or delegated residents during collaborative care review monthly

Element 5. Date by which the correction will be made 12-~~29~~-2023 1778

Deficiency #2: WAC 388-7A-2466 Background checks (Valid for two years)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice; Staff E and F background has been completed.

Element 2. How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken; community will audit all employee files by 12-~~29~~-2023. 1778

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); audit tool will be reviewed weekly for accuracy.

Deficiency #3 WAC 388-7A-2468 Background checks (Conditional hire)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice; Staff A and B background has been completed.

Element 2. How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken; community will audit all employee files by 12-~~29~~-2023.
17th

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); audit tool will be reviewed weekly for accuracy

Element 5. Date by which the correction will be made. 12-~~29~~-2023
17th

Deficiency #4 WAC 388-78A-2480 Tuberculosis Testing (required)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice; Staff A, B, C, and D TB have been completed.

Element 2. How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken; community will audit all employee files by 12-~~29~~-2023.
17th

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); audit tool will be reviewed weekly for accuracy

Element 5. Date by which the correction will be made. 12-~~29~~-2023
17th

Deficiency #5 WAC 388-7A-2620 Pets (Immunizations, Examinations)

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; Pet records for Residents 1, 10, 11 have been completed.

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken; Audit of all resident pet records has been completed 11-17-2023.

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); resident pet records will be reviewed at monthly collaborative care

Deficiency # 6 : RCW 70.129.030 Notice of rights and servicesElement 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; 24 month notification review will be completed for the named residents by 12-~~29~~-2023. 17H

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken; Audit of all resident agreements will be completed by 12-~~29~~-2023 to ensure 24 month notifications are completed 17H

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); after move in, community will inform each resident at least every 24 months in writing of the service items, activities available in the community and the rules of the facilities operations.

Element 5. Date by which the correction will be made. 12-~~29~~-2023 17H

Deficiency #7 WAC 388-7A-3000 Ventilation

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; Screens have been ordered and will be installed by vendor by 12-~~29~~-2023. 17H

Deficiency #8 WAC 388-7A—3040 Laundry

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; Laundry room will be cleaned and sanitized for resident use by 12-~~29~~-2023. 17H Second floor laundry room repairs will be completed by 12-~~29~~-2023 pending construction review. Staff will be in-serviced on cleaning and sanitation of laundry room facilities by 12-~~29~~-2023. 17H

Deficiency #9 WAC 388-7A-3090 Maintenance & Housekeeping

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; housekeeping has been completed for resident 1 and 4 on 11-02-2023.

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken; all maintenance and housekeeping concerns will be completed by 12-~~29~~-2023. 17H

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

appearance.

Element 5. Date by which the correction will be made. 12-29-2023
17H

Deficiency #10 WAC 388-112A-0200 Facility Orientation training

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice; Staff B, C, and D have completed facility orientation. Staff D and E have completed the two-hour orientation training.

Element 2. How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken; community will audit all employee files by 12-29-2023 for completed facility orientation and two-hour orientation as appropriate.
17H

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); audit tool will be reviewed weekly.

Element 5. Date by which the correction will be made. 12-29-2023
17H

Deficiency #11 WAC-388-112A=0720 (CPR & First Aid Requirements)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice; Staff B and D have active CPR certifications.

Element 2. How the Community will identify other staff with the potential of being affected by the alleged deficient practice and what corrective action will be taken; community will audit all employee files by 12-29-2023 for completed CPR certifications as appropriate.
17H

Element 3. Who is responsible for the corrective action; Bo Phillipy, Executive Director, or designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); audit tool will be reviewed weekly.

Element 5. Date by which the correction will be made. 12-29-2023
17H

Deficiency #12 WAC-388-112A-0220 Safety Training (3 hrs)

Element 1. What corrective actions will be taken for those staff found to have been affected by the alleged deficient practice; Staff D and E have received safety training.

Element 2. How the Community will identify other staff with the potential of being affected by the

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance); audit tool will be reviewed weekly.

Element 5. Date by which the correction will be made. 12-~~28~~-2023.
1744