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) 26504 (Completion Date 07/13/2023) and 23878 (Completion Date 05/17/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/13/2023 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-2660-4, WAC 388-78A-2660-2

The Department staff who did the on-site verification:
Laurel Knight, Community Complaint Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Meadow Springs **Provider Type:** Assisted Living Facility

License/Cert.#: 2311
Intake ID: 81646
Compliance Determination #: 23878
Region/Unit #: RCS Region 1 / Unit G
Investigator: Laurel Knight
Investigation Date(s): 05/12/2023 through 05/17/2023
Complainant Contact Date(s): 05/12/2023, 05/17/2023, 05/24/2023

Allegation(s):

1. Identified resident was told by identified staff that they could not have their briefs changed because it had not been long enough.
2. Identified resident was not receiving care and services in a timely manner.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Corporate staff Residents Family members
Record Reviews:	Medical records Negotiated service agreement notes Incident investigation Call light logs

Investigation Summary:

1. Interview with the identified resident and their representative confirmed the resident was told they could not be changed because it had not been enough time in between despite the negotiated service agreements direction to change on request. The identified resident was left with a wet brief and were uncomfortable sitting in the brief. Facility investigation record review showed the resident was told they could not be changed because it had not been two hours and more than two hours had passed between care being provided. Deficient practice was identified, please see the

Statement of Deficiency dated 05/17/2023 for failing to ensure resident care and services were provided per resident choice WAC 388-78a-2660.
2. Interview with the identified resident confirmed the resident did not have their call light answered in under 30 minutes and that sometimes despite putting the light on they had to make a telephone call to the front desk to actually receive help. Facility staff interview confirmed there were multiple times the resident had to wait for more than 30 minutes for help. Facility call light log review showed wait times greater than 30 minutes. Deficient practice was identified, please see the Statement of Deficiency dated 05/17/2023 for failing to ensure resident care and services were provided per resident choice WAC 388-78a-2660.

Conclusion / Action:

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

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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 05/12/2023 and 05/17/2023 of:

Brookdale Meadow Springs
770 Gage Blvd
Richland, WA 99352

This document references the following complaint number(s): 81646

The following sample was selected for review during the unannounced on-site visit: 3 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator

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

05/26/2023
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) 6/8/23 Date

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

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record reviews, the Assisted Living, (ALF,) failed to ensure resident preferences for care and services including timely response for staff assistance for 1 of 1 (Resident 1). These failures resulted in this resident changing their hygiene habits, developing skin breakdown and placed the resident at risk for a decreased quality of life.

Findings included...

Resident 1

Resident 1 was admitted to the ALF on [redacted]2022. The Negotiated Service Agreement (NSA) dated 04/14/2023 showed the resident needed assistance with medications, dressing and incontinence care. The resident would use their light to notify staff of the need for assistance and the staff are to use two people to provide personal care and cleaning. The resident required the use of an EWC lift (specialized lift system permanently installed in the room to transfer the resident via sling) for safe transfers.

Resident 1 was observed at the facility on 05/12/2023 at 1:08 PM. Facility Staff D, Medication Technician and E, Caregiver were providing personal care and when completed, transferred the resident back to their recliner with the EWC lift. The facility staff placed the sling so that it was positioned just barely below the resident's briefs and caused an excess amount of the sling to be above the resident's head when seated.

On 05/12/2023 at 1:15 PM Staff D stated they were to provide brief changes and provide personal care for Resident 1 every two hours and more often if the resident called for assistance, which happened occasionally. They stated they had heard staff say that Resident 1 was to be changed only every two hours but had not been personally directed not to do more frequently. Staff E stated they were to assist the resident with brief changes every two hours.

On 05/12/2023 at 1:20 PM Resident 1 stated that they had last had their briefs changed about 9:00 AM. They stated they sometimes had to wait more than 30 minutes for someone to answer their requests but if staff didn't come, they knew that they could try to call the front desk to ask for help. Resident 1 stated the facility staff mostly treated them with dignity and respect.

On 05/12/2023 at 12:07 PM, Collateral Contact (CC1) Resident's Representative stated they had seen staff change Resident 1's briefs at 9:03 AM in the camera they installed for communication in Resident 1's apartment. They stated Resident 1 had their call light on at that time. The CC 1 stated Staff C Medication Technician had told Resident 1 on 05/08/2023 they could not be changed because it had not been two hours. Later that day they directed other staff to not change the resident yet because it had not been two hours in between. Resident 1's collateral contact stated that they had noticed the resident having their light on and asking to be changed and being told they would not after that.

On 05/12/2023 at 3:15 PM Staff B, Licensed Nurse stated that Resident 1 had a urine infection and needed to be changed more frequently one day but was no longer having the sensation of needing to urinate that often. They stated the briefs are made to absorb and wick urine away from the resident's skin so they would not need to be changed as often if they were not soaked. Staff B stated they had not asked for a repeat urine test to ensure the resident no longer had a urine infection.

On 05/12/2023 at 3:15 PM Staff A stated that if they heard staff directing other staff to only change a resident every two hours. Changes, other than every two hours would have to be a case-by-case evaluation, but that staff should change the resident if they insisted.

On 05/12/2023 at 3:58 PM Staff C, Medication Technician stated that Resident 1 was to have brief changes and personal care every two hours. Staff C stated they may have told staff in hearing range of the resident that they would have to wait to be assisted. Staff C stated they usually knew how many times Resident 1 had been changed except for that day because they didn't have a walkie talkie to communicate with other staff that day.

On 05/17/2023 at 3:40 PM Staff F stated they had reviewed the video supplied by CC1 and confirmed on 05/08/2023 that Staff C told Resident 1 they could not be changed because it had not been two hours and directed staff not to change them until later. Staff F stated that the resident looked uncomfortable and was shifting in their chair after that. They stated their investigation confirmed the resident had not been changed every two hours on 05/12/2023. Staff F stated that Staff G, Regional Nurse completed a resident assessment on 05/16/2023 it showed incontinence dermatitis (skin inflammation), skin breakdown from being in contact with urine.

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) 7/1/23 .

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

Administrator (or Representative) — Date: 6/8/23