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

10/16/2025

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

RE: Brookdale Meadow Springs # 2311

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 67223 (Completion Date 10/16/2025) and 62886 (Completion Date 08/20/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/16/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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;

The Department staff who did the On Site verification:
Krista Connelly, Community Nurse Consultant

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

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF 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: 184586
Compliance Determination #: 62886
Region/Unit #: RCS Region 1 / Unit G
Investigator: Krista Connelly
Investigation Date(s): 07/22/2025 through 08/20/2025
Complainant Contact Date(s): 07/22/2025, 08/22/2025

Allegation(s):

1. The Identified Resident is not getting weekly housekeeping services.
2. The facility will not allow visitors to clean the Identified Resident's apartment.
3. The Identified Resident's laundry and bedding are not getting washed weekly.

Investigation Methods:

Sample:	Total residents: 73 Resident sample size: 2 Closed records sample size: 1
Observations:	Identified resident Residents Dining Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Housekeeping staff Executive Director
Record Reviews:	Medical records

Investigation Summary:

1. Observation of the sampled resident rooms and common areas used by residents showed the facility did not maintain these areas in a safe, sanitary condition. Interviews with the the Identified Resident, other sampled residents showed housekeeping concerns had been an ongoing problem for several months. Failed practice identified, see Statement of Deficiencies dated 08/20/2025. 2. Interviews with the Identified Resident and visitors showed the facility allowed the visitor to clean their apartment using personal or facility cleaning solution in the past. Staff reported the facility hired an additional housekeeper that was in the orientation period and they were no longer able to allow outside visitors clean using facility

products. No failed practice identified. 3. Observation of all sampled residents' rooms, interviews with all sampled residents and family showed the facility had not washed personal clothing and bedding weekly as care planned for all sampled residents. Failed practice identified. See Statement of Deficiency dated 08/20/2025.

Conclusion / Action:

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

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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 an unannounced on-site complaint investigation on 07/22/2025 of:

Brookdale Meadow Springs
770 Gage Blvd
Richland, WA 99352

This document references the following complaint number(s): 184586, 186240

The following sample was selected for review during the unannounced on-site visit: 2 of 73 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Krista Connelly, Community Nurse Consultant

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.

Laura Williams-Davis
Residential Care Services

09/02/2025
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)

9/12/2025
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;

This requirement was not met as evidenced by:

Based on observation, interview and record review showed the assisted living facility failed to maintain a safe, sanitary and well-maintained environment in facility common areas and in two of two resident (Resident 1 & 2) rooms. This failure had the potential risk of exposure to disease producing bacteria and a decreased quality of life.

Findings included...

Record review of policies provided by the facility showed they did not have a facility policy on housekeeping and environmental services.

Record review of the facility's Disclosure of Service, dated 01/2023, showed that the facility maintained all residents' living quarters and any other areas used by the residents in a safe, clean and comfortable condition.

Record review of the facility's Resident Characteristic Roster, dated 07/22/2025, showed there were 84 residents living on two levels in the assisted living facility.

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.

Residential Care Services | Date

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

Administrator (or Representative) | 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;

This requirement was not met as evidenced by:

Based on observation, interview and record review showed the assisted living facility failed to maintain a safe, sanitary and well-maintained environment in facility common areas and in two of two resident (Resident 1 & 2) rooms. This failure had the potential risk of exposure to disease producing bacteria and a decreased quality of life.

Findings included…

Record review of policies provided by the facility showed they did not have a facility policy on housekeeping and environmental services.

Record review of the facility's Disclosure of Service, dated 01/2023, showed that the facility maintained all residents' living quarters and any other areas used by the residents in a safe, clean and comfortable condition.

Record review of the facility's Resident Characteristic Roster, dated 07/22/2025, showed there were 84 residents living on two levels in the assisted living facility.

Facility common areas:

Observation on 07/22/2025 at 12:41 PM showed a hall with resident rooms numbered 117-129. The carpeting throughout the length of the hall had spots of black, brown stains with a large orange stain outside an electric room door. At the end of the hall was a bench with two red/brown colored stains.

Observation on 07/22/2025 at 12:49 PM showed a laundry room on the first floor of the facility that was used by both residents and staff. The laundry room had an odor of urine and there were seven hampers of soiled resident laundry hampers and a pile of wet bedding on the floor. There were cabinets under a countertop, both cabinets had black colored stains and were cracked. One of the cabinets had tape keeping it attached to the frame and the tape was coming off. There were two washing machines, and one had resident laundry in it. The other washing machine did not have a lid and was labeled out of order. Both machines had fluffy clumps of dust, hair and lint behind the machines and on the floor between them. Both washing machines had red rust build-up stains inside the lids with yellow and black colored marks inside and outside of the machines. The laundry room had a sink for handwashing; the soap and paper towel dispensers were both empty.

Interview on 07/22/2025 at 12:49 PM, Staff A, Executive Director, stated the facility had run out of the soap used in the dispenser and paper towels. Staff A reported that the housekeeper was responsible for filling the soap and paper towel dispensers.

Observation on 07/22/2025 at 1:05 PM, showed the resident hall that had rooms 101-116 had two fire extinguisher cabinets. One of the extinguishers was missing the pane of glass on the locking door. The other extinguisher had an unlocked door and a broken piece of metal on the top of the cabinet.

Interview on 07/22/2025 at 4:18 PM, Staff A stated they were not aware of any of the fire extinguishers missing the pane of glass or broken parts.

Observation on 07/22/2025 at 1:15 PM, showed two plastic rolling carts with wheels next to the kitchen door. The rolling carts were used by the staff to deliver dishes and food to the residents during meal services. The handles used to push the rolling carts had built up black particles of grease and food debris as well as around the bases where the wheels were. The carts had plastic racks used to hold clean or dirty dishes. The plastic racks were scratched and had areas with built up black particles of grease and food debris.

Observation on 07/22/2025 at 1:17 PM showed the dining room had a handwashing sink near a garbage can on the east side of it. The sink had brown colored particles around the faucet handles and in the bottom of the sink. The garbage can had brown and yellow food spills on the lid, down the sides and on the wall behind it. Outside the dining

room there was a hand sanitizer that was empty.

In an interview on 07/22/2025 at 4:18 PM, Staff A stated the night shift care staff were supposed to do a full sweep and mop of the dining room floors, wipe down counters, tables and any food stains on the equipment. When asked how many care staff worked at night, they reported at least 2 staff members.

Observation on 07/22/2025 at 1:21 PM, showed several residents using the facility elevator located in the middle of the front lobby to go up and down between the first and second floors. Inside the elevator there was peeling paint on the wall with the control panel and areas where the paint had worn away from the wall. The control panel had buttons with spill stains that were yellow and brown colored.

Observation on 07/22/2025 at 1:23 PM, showed the resident hall that had rooms 201-216. The hall had a hand sanitizer dispenser that was empty and a pull cord panel that residents could use to call for help. The pull cord panel was missing the pull cord.

Observation on 07/22/2025 at 1:53 PM, showed the resident hall that had rooms 221-234. There were black carpet stains throughout the hall and outside room 224.

Observation on 07/22/2025 at 1:55 PM, showed a laundry room used by residents and staff on the second floor. The laundry room had a handwashing sink that was also an eyewash station (a unit for washing off chemicals or substances that may have splashed into an individual eyes.) The sink had three cupboards below it; one was missing a door. The bottom of the sink was covered in layer of brown particles with items of debris (popcorn, strawberry, wrappers.) The faucet of the sink was noted to have brown colored particles surrounding the spigot and around the hot and cold knobs. The soap dispenser and the paper towel dispenser were both empty.

In an interview on 07/22/2025 at 4:18 PM, Staff A stated the facility used a telecommunication system that allowed text-based messages to be sent and received by a teleprinter over their telephone lines. Staff A stated these messages were then put on a list for the maintenance man to follow up with. Staff A stated the facility did not have an environmental policy that they followed to track repairs and/or the maintenance of equipment.

Resident 1

Review of Resident 1’s care plan, dated 07/23/2025, that showed the resident had diabetes, (a disease that affects how the body uses sugar, a source of energy needed by the body) and asthma, (a disease that makes it difficult to breathe and get enough oxygen to survive.) The care plan showed Resident 1 had weakness, fatigue, nerve pain and difficulty breathing that interfered with their activities of daily living. The care plan

also showed Resident 1 had a dog that lived in the apartment with her. The care plan further showed Resident 1 required assistance with housekeeping and laundry.

Observation on 07/22/2025 at 2:17 PM, showed Resident 1 sitting in a wheelchair in their apartment. The apartment had a living/sleeping area, a small kitchenette area and a bathroom. Inside the apartment, there was an unpleasant earthy and musky smell. When asked about the source of the smell, Resident 1 reported they believed the smell was because the apartment had not been getting cleaned on a regular basis. They stated they had gotten used to the smell but visitors to the apartment always commented on it. On the inside of the apartment door were signs posted that their housekeeping days were Fridays and laundry days were Saturdays.

Observation on 07/22/2025 at 2:19 PM, showed Resident 1's bed was not made and the bottom fitted sheet had three stains that were yellow in the center with brown stains surrounding the yellowed stains.

In an interview on 07/22/2025 at 2:19 PM, Resident 1 stated the bedding had last been washed two or three weeks ago.

Observation on 07/22/2025 at 2:22 PM, showed the carpet in Resident 1's room had several black and brown stains throughout the apartment.

Observation on 07/22/2025 at 2:24 PM, showed Resident 1's sink in the kitchenette area was stacked full of dirty dishes and the sink had brown colored food or fluid spills down the inside and bottom of the sink.

Observation on 07/22/2025 at 2:26 PM showed a soiled incontinent brief (an undergarment used to prevent urine from leaking out onto clothing) in the bathroom garbage. The bathroom smelled of urine and the toilet had brown colored splattered stains on the seat and lid. The inside of the toilet bowl had a brown and black colored ring around it.

In an interview on 07/22/2025 at 2:27 PM, Resident 1 reported that neither the bathroom or the toilet had been cleaned for a couple weeks. Resident 1 further explained that one of their visitors tried to clean it for them. Resident 1 stated they could not recall when the facility staff had cleaned the bathroom last.

Observation on 07/22/2025 at 3:00 PM, showed the apartment's heating and air conditioning unit on the wall had gray colored dust (a mixture of particulate matters like pet dander, soil, dead skin cells that can be blown throughout the air of the room and be inhaled) on the vents of the unit. The unit's air filter was removed and showed it was covered in the same gray colored dust.

In an interview on 07/22/2025 at 3:01 PM, Resident 1 stated they could not recall anyone dusting the vents or cleaning the filter. Resident 1 stated they often felt like they could not catch their breath which limited their activity.

Resident 2

Review of Resident 2's care plan, dated 04/15/2025, showed the resident had myasthenia gravis (a disease that results in muscle weakness, fatigue, using your arms, legs and difficulty breathing) and urinary retention (difficulty releasing urine from the body.) The care plan showed Resident 2 used a foley catheter (a flexible tube inserted into the bladder to drain urine into a collection bag) and required staff assistance to empty and manage the collection bags. The care plan showed Resident 2 required assistance with housekeeping and laundry.

Observation on 07/22/2025 at 3:53 PM, showed Resident 2 sitting inside their apartment. The apartment had a living/sleeping area, a small kitchenette area and a bathroom. Inside the apartment, there was stale (a lack of freshness) damp, musky smell that was unpleasant and inside the bathroom was a strong odor of urine. Inside Resident 2's closest was a laundry hamper full of soiled clothing. There were two small rugs, one near the bed and one near a recliner. Both rugs were matted with brown and black colored stains and had pieces of garbage that included paper, partial wrappers and lint.

Observation on 07/22/2025 at 3:54 PM showed the apartment's heating and air conditioning unit on the wall had gray colored dust (a mixture of particulate matters like soil particles, textiles fibers and dead skin cells that can be blown throughout the air of the room and be inhaled) on the vents of the unit. The unit's air filter was removed and showed it was covered in the same gray colored dust.

Observation on 07/22/2025 at 3:54 PM, showed Resident 2's bed was not made; the sheets and pillowcases were a faded brown color that was a residue buildup where they were slept on the bottom sheet and pillowcase.

In an interview on 07/22/2025 at 3:56 PM, Resident 2 stated their room was cleaned every two to three weeks. When asked how often their bedding was cleaned, Resident 2 stated every so often and could not recall the last time it was washed. When asked how often their personal clothing got washed Resident 2 stated they were doing their own laundry because it was quicker, and the staff didn't always do it. Resident 2 stated they sometimes spilled urine when emptying their catheter bag which made the room smell like urine.

In an interview on 07/22/2025 at 3:23 PM, Staff B, Housekeeper, stated they worked full time. Staff B stated they were the only housekeeper the facility had and there wasn't

anyone to cover their days off. Staff B explained that without another full-time housekeeper, they were only able to clean resident rooms and common areas every two or three weeks. Staff B further stated each resident room was supposed to be cleaned every week and included vacuuming, dusting, cleaning the bathroom, changing the bedding and using carpet cleaner to remove any spot stains on the carpets inside the resident apartments. They stated the common areas used by the residents (including front lobby and hallways) were supposed to be cleaned weekly as well.

In an interview on 07/22/2025 at 4:18 PM, Staff A stated each resident room was cleaned weekly and included vacuuming, dusting and bathrooms. Staff A reported all the common areas were cleaned by Staff B when they arrived at work and the laundry rooms located on each floor. Staff A stated care staff were supposed to change each residents' bedding, do personal laundry every week, tidy up the apartments, take the trash out and do any dishes that may need to be washed.

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) ~~10-17-2025~~ 10-04-2025 B

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

Administrator (or ~~Representative~~)

9/12/2025
Date
09-17-2025 B

anyone to cover their days off. Staff B explained that without another full-time housekeeper, they were only able to clean resident rooms and common areas every two or three weeks. Staff B further stated each resident room was supposed to be cleaned every week and included vacuuming, dusting, cleaning the bathroom, changing the bedding and using carpet cleaner to remove any spot stains on the carpets inside the resident apartments. They stated the common areas used by the residents (including front lobby and hallways) were supposed to be cleaned weekly as well.

In an interview on 07/22/2025 at 4:18 PM, Staff A stated each resident room was cleaned weekly and included vacuuming, dusting and bathrooms. Staff A reported all the common areas were cleaned by Staff B when they arrived at work and the laundry rooms located on each floor. Staff A stated care staff were supposed to change each residents' bedding, do personal laundry every week, tidy up the apartments, take the trash out and do any dishes that may need to be washed.

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