



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

BKD Clare Bridge of Olympia LLC
Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

RE: Brookdale Olympia West License # 2497

Dear Administrator:

This letter addresses Compliance Determination(s) 32957 (Completion Date 11/30/2023) and 27019 (Completion Date 07/28/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/30/2023 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-2630, WAC 388-78A-2630-1, WAC 388-78A-2630-1-a, WAC 388-78A-2120, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4

The Department staff who did the on-site verification:

Paul Aube, ALF NCI

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

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



Residential Care Services Investigation Summary Report

Provider/Facility: Brookdale Olympia West **Provider Type:** Assisted Living Facility
License/Cert.#: 2497
Compliance Determination #: 27019 **Intake ID:** 89694
Investigator: Paul Aube **Region/Unit #:** RCS Region 3 / Unit E
Investigation Date(s): 07/21/2023 through 07/28/2023
Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility report of a resident-to-resident altercation in the community.

Investigation Methods:

Sample:	Total residents: 55 Resident sample size: 12 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Family members Management
Record Reviews:	Medical records Incident investigation Facility policies DOH Guidelines Progress Notes/Alert Charting Incident Reports/Investigations

Investigation Summary:

Quality of Care/Treatment: Facility investigated incident, implemented appropriate interventions to protect residents, and made notifications to appropriate parties. Facility failed to monitor the residents per facility policy after the incidents. Failed practice identified.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



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Statement of Deficiencies	License #: 2497	Compliance Determination # 27019
Plan of Correction	Brookdale Olympia West	Completion Date
Page 1 of 7	Licensee: BKD Clare Bridge of Olympia LLC	07/28/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 07/21/2023 and 07/21/2023 of:

Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following complaint number(s): 89680, 89971, 88121, 88513, 88560, 89694

The following sample was selected for review during the unannounced on-site visit: 12 of 55 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Staci Riley, IDR PM for Reg 3E
Residential Care Services

September 22, 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.

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



Administrator (or Representative)

9.28.23

Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to notify the department's Complaint Resolution Unit (CRU) hotline when they became aware of a resident-to-resident altercation that occurred in the facility, for 1 of 1 incident reviewed. This failure placed all residents who were involved in allegations or incidents of abuse at risk of unmet care and services due to the department inability to investigate the incident.

Findings included...

Review of the facility policy, titled, "Abuse, Neglect & Exploitation," last reviewed May 2021, stated, "Abuse" is defined in Washington as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a resident. In instances of abuse a resident who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a resident." Under the section titled, "External Reporting/Notification" it stated, "When there is reasonable cause to believe that abuse, neglect or exploitation has occurred, mandated reporters shall immediately report to the Washington State Department of Social and Health Services, using the hotline at 1-800-562-6078. Each report should contain as much as possible of the following information:

- 1)The name and address of the person making the report;
- 2)The name and address of the resident and the name of the facility providing care for the resident;
- 3)The name and address of the legal guardian or decision maker;
- 4)The nature and extent of the abandonment, abuse, financial exploitation, neglect, or self-neglect;
- 5)Any history of previous abandonment, abuse, financial exploitation, neglect, or self-neglect;
- 6)The identity of the alleged perpetrator, if known; and
- 7)Other information that may be helpful in establishing the extent of the abandonment, abuse, financial exploitation, neglect, or the cause of death of the deceased vulnerable

adult."

Review of department records on 07/05/2023 showed a report of a concern of a resident-to-resident altercation that occurred in the facility between Resident 11 (R11) and Resident 12 (R12) on 07/03/2023.

Review of the facility Incident Log from 06/21/2023 to 07/21/2023, showed no entry of a resident-to-resident altercation between R11 and R12.

During an interview with Staff A, the Executive Director, on 07/21/2023 at 12:37PM, when asked if they were aware of any altercations between R11 and R12 in the last 30 days, Staff A confirmed that there was an altercation.

Review of R11's face sheet showed that R11 was admitted to the facility on [REDACTED] 2021.

Review of R11's Incident Report, dated 07/03/2023, showed that an altercation occurred between R11, and R12. Under the section titled, "Notifications," there was no indication or documentation that the Department's CRU hotline was notified.

Review of R12's face sheet showed that R12 was admitted to the facility on [REDACTED] 2022.

Review of R12's Incident Report, dated 07/03/2023, showed that an altercation occurred between R12, and R11. Under the section titled, "Notifications," there was no indication or documentation that the Department's CRU hotline was notified.

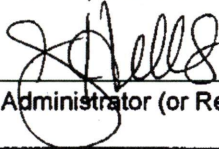
During an interview with Staff A on 07/21/2023 at 3:18PM, when asked if they could provide any documentation to show that the incident between R11 and R12 was reported, Staff A stated, "It probably wasn't [reported]." When asked why this was not reported, Staff A stated that another staff member was recently given the responsibility of making notifications to the Department's CRU hotline, and that they did not report this incident. Staff A stated that they would be taking that responsibility back.

Review of department record on 07/21/2023 showed no facility report for the resident-to-resident altercation between R11 and R12 on 07/03/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia West is or will be in compliance with this law and / or regulation on (Date) 9.11.23.

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



Administrator (or Representative)

9.28.23

Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.
- (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to monitor and evaluate changes in resident's physical, emotional, and mental functioning after incidents of injuries of unknown origin, resident-to-resident altercations, and resident elopements took place in the facility for 6 of 12 residents (Resident 4 [R4], Resident 5 [R5], Resident 6 [R6], Resident [R7], Resident 8 [R8], and Resident 9 [R9]) reviewed. This failure placed residents at risk of unmet care needs and lack of response to address changes in resident conditions.

Findings included...

Review of the facility policy, titled, "Alert Charting," last reviewed December 2020, stated, "Associates should document in the resident record those events which include changes of condition that require nurse notification, additional monitoring, or specific intervention and documentation. "Associates should observe and document the resident's response/condition for 72-hours in the resident record." "Examples of events or conditions that would prompt Alert Charting include, but are not limited to: Falls, any complaints of pain, bruising, scrapes, abrasions, skin tears, changes in ambulation/mobility/movement

or inability to complete Activities of Daily Living (ADL), new medications, abnormal test results, infections or illnesses, changes in level of consciousness, behavioral changes, changes in appetite/fluid intake, and COVID-19 Positive or presumed positive residents." "The nurse will determine the frequency of documentation within the 72-hour period or until resolution of the issue which may include ranges from each shift, up to daily." "The nurse or designee on the last shift of the 72-hour period is responsible for documenting that the condition is resolved or that the documentation needs to be continued."

During an interview with Staff A, the Executive Director (ED) on 07/21/2023 at 9:50AM, when asked what the expectation of staff was when a resident experienced an incident, Staff A stated, "Staff are to put residents on alert charting for minimum 72 hours. Management is notified, and staff are to monitor them [accordingly]."

During an interview with Staff C, a Medication Technician, on 07/21/2023 at 2:40PM, when asked what they were required to do when a resident had an incident, they stated, "I would evaluate the resident. Fax their doctor, notify POA, and notify [the Health and Wellness Director] and [the Executive Director]. I would put them on alert and do alert charting for them for 72 hours."

Review of R4's face sheet showed that R4 was admitted to the facility on [REDACTED] 2022.

Review of the facility Incident Log from 06/21/2023 to 07/21/2023 showed R4 was involved in a Resident-to-Resident Altercation dated 07/15/2023 at 12:00PM.

Review of R4's progress notes showed the R4 was placed on alert monitoring on 07/15/2023 for the Resident-to-Resident Altercation. Further review of the progress notes showed there was no monitoring or alert charting documentation in the resident record for 07/16/2022.

Review of R5's face sheet showed that R5 was admitted to the facility on [REDACTED] 2022.

Review of the facility Incident Log from 06/21/2023 to 07/21/2023 showed R5 eloped from the facility on 07/14/2023 at 6:30PM.

Review of R5's progress notes showed that R5 was placed on alert monitoring on 07/14/2023 for the resident eloping from the facility. Further review of R5's progress notes showed that there was no monitoring or alert charting documentation in the resident record for 07/15/2023, and 07/16/2023.

Review of R6's face sheet showed that R6 was admitted to the facility on [REDACTED] 2022.

Review of the facility Incident Log from 06/21/2023 to 07/21/2023 showed R6 eloped

from the facility on 07/14/2023 at 6:30PM.

Review of R6's progress notes showed that R6 was placed on alert monitoring on 07/14/2023 for the resident eloping from the facility. Further review of R6's progress notes showed that there was no monitoring or alert charting documentation in the resident record for 07/15/2023, and 07/16/2023.

Review of R7's face sheet showed that R7 was admitted to the facility on [REDACTED] 2023.

Review of the facility Incident Log from 06/21/2023 to 07/21/2023 showed R7 was involved in a Resident-to-Resident Altercation dated 07/15/2023 at 12:00PM.

Review of R7's progress notes showed that R7 was placed on alert monitoring on 07/15/2023 for the Resident-to-Resident Altercation. Further review of the progress notes showed there was no monitoring or alert charting documentation in the resident record for 07/16/2022.

Review of R8's face sheet showed that R8 was admitted to the facility on [REDACTED] 2020.

Review of the facility Incident Log from 06/21/2023 to 07/21/2023 showed R8 eloped the facility on 07/14/2023 at 6:30PM.

Review of R8's progress notes showed that R8 was placed on alert monitoring on 07/14/2023 for the resident eloping from the facility. Further review of R6's progress notes showed that there was no monitoring or alert charting documentation in the resident record for 07/15/2023, and 07/16/2023.

Review of R9's face sheet showed that R9 was admitted to the facility on [REDACTED] 2022.

Review of the facility Incident Log from 06/21/2023 to 07/21/2023 showed R9 was discovered to have an injury of unknown origin on 07/03/2023 at 5:15PM.

Review of R9's progress notes showed there was no entry placing the resident on alert monitoring on 07/03/2023, and 07/04/2023. The resident's injury was first monitored and documented in the resident record on 07/05/2023. On 07/06/2023, the progress notes showed there was an alert charting entry regarding R9 starting new antibiotics, but no monitoring or alert charting documentation on monitoring of R9's injury. There was no monitoring or alert charting documentation in the resident record on 07/07/2023, and 07/08/2023.

During an interview with Staff A on 07/21/2023 at 3:18PM, when asked why there was no

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charting for all of these resident incidents, Staff A stated that there should have been, and that staff should know to place these residents on alert and monitor them.

This is a recurring deficiency previously cited on 05/07/2021.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia West is or will be in compliance with this law and / or regulation on (Date) 9.28.23.

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



Administrator (or Representative)

9.28.23

Date

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