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) 32958 (Completion Date 12/01/2023) and 28044 (Completion Date 08/14/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/01/2023 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-2160, WAC 388-78A-2600, WAC 388-78A-2600-2, WAC 388-78A-2600-2-a, WAC 388-78A-2600-2-f, WAC 388-78A-2600-2-g

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia West
Provider Type: Assisted Living Facility
License/Cert.#: 2497
Compliance Determination #: 28044
Intake ID: 90818
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/14/2023 through 08/14/2023
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a resident fall with injury in the community.

Investigation Methods:

Sample:
Total residents: 56
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Family members
Management

Record Reviews:
Hospital records
Incident investigation
Facility policies
Progress Notes
Care Plans

Investigation Summary:
Quality of Care/Treatment: Facility still investigating incident. Facility failed to follow the care plan as per the negotiated service agreement, and failed to notify the Complaint Resolution Unit timely, as per their policy. Failed practice identified.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia West
Provider Type: Assisted Living Facility
License/Cert.#: 2497
Compliance Determination #: 28044
Intake ID: 92694
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/14/2023 through 08/14/2023
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a resident fall with injury in the community.

Investigation Methods:

Sample:
Total residents: 56
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Family members
Management

Record Reviews:
Hospital records
Incident investigation
Facility policies
Progress Notes
Care Plans

Investigation Summary:
Quality of Care/Treatment: Facility failed to complete an incident report at the time of the incident as per policy. This resulted in family not being notified timely, and delay of resident care. Failed practice identified.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia West
Provider Type: Assisted Living Facility
License/Cert.#: 2497
Compliance Determination #: 28044
Intake ID: 92657
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/14/2023 through 08/14/2023
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: 56
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Family members
Management

Record Reviews:
Hospital records
Incident investigation
Facility policies
Progress Notes
Care Plans

Investigation Summary:
Quality of Care/Treatment: Facility failed to notify the Complaint Resolution Unit timely, after an incident occurred as per their policy. This issue was investigated. Please see Statement Of Deficiency dated 08/14/2023.

Conclusion / Action:

☐ Failed Provider Practice Identified / Citation(s) Written

☒ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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

Statement of Deficiencies	License #: 2497	Compliance Determination # 28044
Plan of Correction	Brookdale Olympia West	Completion Date
Page 1 of 7	Licensee: BKD Clare Bridge of Olympia LLC	08/14/2023

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 08/14/2023 and 08/14/2023 of:

Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following complaint number(s): 90818, 92694, 92657

The following sample was selected for review during the unannounced on-site visit: 4 of 56 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.

Cory Cisneros
Residential Care Services

08/28/2023
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) 9.7.23 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to follow and implement care as documented on the care plan for 1 of 4 residents, (Resident 2 [R2]) reviewed. This failure resulted in a resident fall with fracture.

Findings included...

Review of R2's face sheet showed that R2 was admitted to the facility on [redacted]/2023.

Review of Department Records showed that a report was made by the facility on 07/24/2023 at 10:41AM notifying the Department that R2 experienced a fall with injury on 07/22/2023 at 06:30AM. The report stated that the "Resident was taking a shower, turned around to rinse [their] hair and had slipped and fall landing on her hip. [R2] had complained of hip, lower back, and head pain. We had called EMT's they came out to assess and due to the pain they felt necessary for [R2] to be transferred. Resident had lots of discomfort and complaints of pain." R2 was transferred to the Emergency Room after evaluation by medics and was diagnosed with a "[redacted]." ([redacted]). Under the "Follow-Up Information" section of the report, it stated, "R2 was, up until this fall, on set-up assist and standby assist during showers, she was historically able to self-shower. Staff, who were outside the door of the bathroom, heard [R2] calling for help after this fall and responded."

According to the Medical Health Authority article titled, "Stand By Assist Meaning: Understanding the Benefits and Uses," last reviewed on 07/25/2023, stated, "Stand by assist refers to a type of assistance provided to individuals who require support with daily activities but can still perform them with minimal help. It involves having a caregiver or healthcare professional nearby to provide assistance if needed, without being directly involved in the activity."

Review of R2's Personal Service Plan (care plan), last reviewed on 06/20/2023, under the "Showering or Bathing" category stated, "Staff assist with set-up and stand-by assistance for safety."

During an interview with Staff A, the Executive Director on 08/14/2023 at 12:29PM, when asked to define what Stand-by Assist means, Staff A stated, "We standby and assist as needed for safety." Staff A was asked how close the proximity should be between the staff and the resident and Staff A stated that "they should be right near the resident. Within an arm's reach."

During an interview with Staff B, the Regional Nurse, on 08/14/2023 at 12:37PM, when asked to define what Stand-by Assist means, Staff B stated, "It depends on the resident. Some staff will brace the resident, and others just are nearby, and put their arms out just in case." Staff B was asked what proximity the staff should have to a resident who required Stand-By Assist, and Staff B stated that the staff should be close enough to touch the resident if needed. When asked why the staff member was outside of the bathroom and away from R2 while they were showering, Staff B stated that the staff member was not following the care plan.

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) October 16, 2023

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

Administrator (or Representative) 9.7.2023 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(f) In response to medical emergencies;

(g) When there are urgent situations in the assisted living facility requiring additional staff support;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to follow policies and procedures after incidents occurred requiring staff intervention for 4 of 4 residents, (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3] and Resident 4 [R4]) reviewed. This failure placed these

residents at increased risk for harm and delayed medical treatment.

Findings included...

Review of the facility policy, titled, "Abuse, Neglect & Exploitation Policy", last reviewed 05/2021, stated, "Any employee who witnesses, or 'has reasonable cause to believe' that a resident has been the subject of suspected or alleged abuse, neglect or exploitation, should immediately report such incident to the Executive Director or supervisor on duty and to the Washington State Department of Social and Health Services (Department) hotline at 1-800-562-6078 without retaliation from the licensee or administrator."

Review of the facility policy, titled, "BAIRS Incident Reporting Policy", last reviewed 04/2022, stated that in the event that a resident or visitor experiences an occurrence, the associate reporting the incident must "enter the incident into the Brookdale Automated Incident Reporting System (BAIRS) during the shift on the day of the incident in accordance with this policy." Occurrences were defined as, but not limited to: falls, vehicular transportation incident, resident unaccounted for; elopement, aggressive behavior, suicide, attempted suicide or suicide ideation, and/or injury of unknown origin.

Review of the facility policy, titled, "Alert Charting", last reviewed 12/2020, stated, "Associates should document in the resident record those events which include changes of condition that required nurse notification, additional monitoring, or specific intervention and documentation." Under the "Documentation of Alert Charting" section it stated, "Associates should notify the nurse of conditions or events as listed in Step 2 and enter appropriate information on the alert charting log." Step 2 lists a multitude of events which would require staff to place residents on Alert Charting. Some examples of the conditions or events include Falls (including any complaints of pain, bruising, scrapes, abrasions, skin tears, changes in ambulation [ability to walk]/mobility/movement or inability to complete activities of daily living), and behavioral changes.

During an interview with Staff E, a Caregiver, on 08/14/2023 at 10:37AM, when asked if residents were placed on alert after they experienced an incident/occurrence, Staff E confirmed that they were. When asked how they know which residents were on alert, Staff E stated, "On the Med Tech (Medication Technician) cart, we have a clip board that we check every time we come on shift. It says who is on alert, what happened etc. We follow what it says to look for on there. Every caregiver/med tech is supposed to check it right when we get on shift."

<R1>
Review of R1's face sheet showed that R1 was admitted to the facility on [redacted]/2023.

Review of the Incident Log from 07/14/2023 to 08/14/2023 showed that R1 experienced a fall with fracture to the left hip on 08/06/2023 at 2:30AM. The notes stated, "At

approximately 1:30PM, staff attempted to get [R1] up and out of bed. While attempting to get [R1] up, [R1] started yelling stating [their] hip hurt...Staff reported at that time, [R1] had a fall at approximately 2:30AM and reported that [R1] was standing behind the staff lounge door when a staff member came through, door hitting [them] causing [them] to fall on to [their] bottom. Staff got the resident up and escorted [them] into [their] room and assisted [them] to bed."

Review of BAIRS Incident Report for R1's fall on 08/06/2023 showed statements made by the staff persons involved. Review of Staff C's statement, a Medication Technician (Med Tech), showed that at approximately 2:30AM, they opened the door to the staff lounge, and R1 was standing behind the door when it hit them. Staff C reported that R1 fell, but they did not see the fall or how hard R1 hit the ground. Staff C stated that R1 was screaming and making complaints of leg pain. Staff C stated that they instructed Staff D, a Med Tech/Caregiver, and another caregiver to assist R1 off of the floor, into their wheelchair, escort them back to their room and help them back into bed. Review of Staff D's statement showed that Staff D was working as a caregiver at the time of the injury to the R1. Staff D stated that after running over to assist R1 after the fall, they asked Staff C if R1 fell, to which Staff C responded, "I don't know, I might have hit [them] with the door." Staff D stated that after checking the resident's skin for redness or skin tears, that Staff C stated to assist R1 up and into their wheelchair. Staff D reported that while lifting the resident, R1 said, "Ow, Ow!" Staff D stated that R1 was taken to their room and assisted into bed. At 6:00AM, Staff D took over as the Med Tech on duty. At 1:30PM, Staff D entered the room and noticed R1's left knee was swollen. Staff D gently touched R1's knee to which R1 shouted, "Ow!" Staff D then touched R1's left hip to which R1 screamed out in discomfort. Staff D called 911 for medical evaluation at that time. After evaluation from Emergency Personnel, R1 was subsequently sent to the Emergency Room and was diagnosed with [redacted] which required surgical correction the following day. Review of the incident report also showed under the "Notification" section for "State Agency" the department was notified of the incident on 08/07/2023 at 9:00AM. This incident was not reported to the State Agency within 24 hours.

Review of R1's resident record showed that despite R1's claims of pain, there was no notification to 911 Emergency Personnel after the initial injury on 08/06/23 at 2:30AM to have the resident evaluated

Review of the Alert Charting Log, which included monitoring dates from 08/06/2023 to 08/13/2023, showed that R1's incident was not listed.

<R2>
Review of R2's face sheet showed that R2 was admitted to the facility on [redacted]/2023.

Review of Department Records showed that a report was made by the facility on 07/24/2023 at 10:41AM notifying the Department that R2 experienced a fall with injury on 07/22/2023 at 06:30AM. The report stated that the "Resident was taking a shower, turned around to rinse [their] hair and had slipped and fall landing on her hip. [R2] had complained of hip, lower back, and head pain. We had called EMT's they came out to assess and due to the pain, they felt necessary for [R2] to be transferred. Resident had lots

of discomfort and complaints of pain." R2 was transferred to the Emergency Room after evaluation by medics and was diagnosed with a "[redacted]," ([redacted]).

Review of the Incident Log from 07/14/2023 to 08/14/2023 showed no falls for R2.

Review of a Preliminary (In-Progress) Incident Report/Investigation for R2 on 07/22/2023 confirmed that the fall with injury of R2 occurred on 07/22/2023 at approximately 6:30AM. Under the "Notification" section for "State Agency" there was no notification listed and was left blank. This incident was not reported to the State Agency within 24 hours.

<R3>
Review of R3's face sheet showed that R3 was admitted to the facility on [redacted]/2022.

Review of Department Records showed that a report was made by the facility on 08/07/2023 at 8:27AM notifying the Department that R3 was involved in a Resident-to-Resident altercation in the community on 08/06/2023 at 3:30AM. The report stated that "Safely You" (the facility video surveillance system) observed R3 to enter R4's room at approximately 3:30AM and sat down in [their] recliner. R4 woke up, got out of bed, and attempted to pull R3 out of their recliner, while pulling R3's hair, hitting, smacking, and jabbing the upper parts of their body.

Review of the Incident Log from 07/14/2023 to 08/14/2023 showed no entries regarding R3 for 08/06/2023.

Review of BAIRS Incident Report for R3's Resident-to-Resident altercation on 08/06/2023 confirmed that the altercation occurred on 08/06/2023 at approximately 3:30AM. Under the "Notification Information" section for "State Agency," it showed that the Department was notified on 08/07/2023 at 8:30AM. This incident was not reported to the State Agency for greater than 48 hours.

<R4>
Review of R4's face sheet showed that R4 was admitted to the facility on [redacted]/2023.

Review of the Incident Log from 07/14/2023 to 08/14/2023 showed that R4 was involved in a Resident-to-Resident altercation in the community on 08/06/2023 at 3:30AM. The notes stated, "At approximately 3:30AM Safely You captured R3 entering R4's room at approximately 3:30AM and sat down in [their] recliner. R4 woke up, got out of bed, and attempted to pull R3 out of their recliner, while pulling R3's hair, hitting, smacking, and jabbing the upper parts of their body."

Review of BAIRS Incident Report for R4's Resident-to-Resident altercation on 08/06/2023 confirmed that the altercation occurred on 08/06/2023 at approximately 3:30AM. Under the "Notification Information" section for "State Agency," it showed that the Department was notified on 08/07/2023 at 8:30AM. This incident was not reported to the State Agency within 24 hours.

During an interview with Staff A, the Executive Director, on 08/14/2023 at 12:29PM, when asked what staff were expected to do when a resident experienced an incident/occurrence, Staff A stated, [staff are required to] "Do an assessment, [check the resident's] range of motion, make sure nothing is injured. If any grimacing, complaints of pain, or anything outside of what we know of that resident, they need to call 911 and have medics to come assess the resident. They are to notify me, notify the family and the [resident's] doctor. If the resident gets sent out [to the hospital], they would notify me." When asked if staff were required to complete an incident report, Staff A confirmed that staff would be required to complete one. Staff A was asked when that report should be completed, and Staff A stated, "They are supposed to do incident reports on shift...If [the resident] [is] cleared to stay [in the facility after being evaluated by the medics], [staff] would put [the resident] on alert." Staff A was asked why the Incident Report for R1 was not completed on shift of the injury, and why the resident was not placed on alert, Staff A stated, "I did not know any of that until I came in. No one called me about the incident. It was not reported to me." Staff A stated that during [their] investigation, Staff C informed Staff A that they thought R1 was at their baseline behaviors, and that R1 did not make any complaints of pain. However, during their investigation, Staff A was able to confirm with three other staff witnesses that R1 was showing signs of pain at the time of their injury. Staff A was asked when the Department (State) would be notified of resident incidents/occurrences, Staff A stated, "State would be notified within 24-hours of me discovering the incident." When asked if the notification to State should be 24-hours from their notification, or 24-hours from the incident, Staff A stated, "Within 24 hours of the incident, but some have been once I found out what happened." Staff A was asked why the incident involving R1 was not reported to state for greater than 24-hours, the incident involving R2 was not reported to state for greater than 48 hours, and the incident involving R3 and R4's resident altercation was not reported to the state immediately, Staff A stated, "No one was here to do it." Staff A stated that they understand that every staff person is cable of making the state report and could report it but stated that generally Staff A makes reports to the State Department.

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) October 6, 2023

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

Administrator (or Representative) 9.7.2023 Date