



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

**AMENDED**

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) 39738 (Completion Date 04/15/2024) and 36948 (Completion Date 02/21/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/15/2024 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-2450, WAC 388-78A-2450-1, WAC 388-78A-2450-1-a, WAC 388-78A-2450-1-b, WAC 388-78A-2450-1-c, WAC 388-78A-2450-2, WAC 388-78A-2450-2-e, WAC 388-78A-2450-2-h, WAC 388-78A-2450-2-h-vi, WAC 388-78A-2450-2-h-vii

The Department staff who did the on-site verification:

Anissa Bearden, Licensors  
Cory Cisneros, Field Manager

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

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**Provider/Facility:** Brookdale Olympia West      **Provider Type:** Assisted Living Facility  
**License/Cert.#:** 2497  
**Compliance Determination #:** 36948      **Intake ID:** 117217  
**Investigator:** Anissa Bearden      **Region/Unit #:** RCS Region 3 / Unit E  
**Investigation Date(s):** 02/02/2024 through 02/21/2024  
**Complainant Contact Date(s):**

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### Allegation(s):

1) allegation that there are not enough staff that is placing the residents safety at risk.

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### Investigation Methods:

|                        |                                                                                                                            |
|------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 47<br>Resident sample size: 8<br>Closed records sample size: 0                                            |
| <b>Observations:</b>   | Residents<br>Activities<br>Dining<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| <b>Interviews:</b>     | Nursing staff<br>Residents<br>Family members<br>Housekeeping staff<br>Business office manager                              |
| <b>Record Reviews:</b> | Medical records<br>Grievance log<br>Facility policies<br>Personnel files<br>Staff training records<br>Staff patterns       |

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### Investigation Summary:

1) after observation, interview, and record review the facility did not have adequate staff to ensure the residents care and services were being provided that contributed to residents not getting showers that cause skin impairments, laundry services not being provided, rooms unkept, and residents that required nurse delegated task were administered by unqualified care staff. Failed Practice.

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### Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



## Residential Care Services Investigation Summary Report

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**Provider/Facility:** Brookdale Olympia West      **Provider Type:** Assisted Living Facility  
**License/Cert.#:** 2497  
**Compliance Determination #:** 36948      **Intake ID:** 118883  
**Investigator:** Anissa Bearden      **Region/Unit #:** RCS Region 3 / Unit E  
**Investigation Date(s):** 02/02/2024 through 02/21/2024  
**Complainant Contact Date(s):**

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### Allegation(s):

- 1) allegation that there are not enough staff working to meet the residents care needs
  - 2) facility continues to admit new residents with the staff challenges.
- 

### Investigation Methods:

|                        |                                                                                                                                                                       |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 47<br>Resident sample size: 8<br>Closed records sample size: 0                                                                                       |
| <b>Observations:</b>   | Residents<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions                                         |
| <b>Interviews:</b>     | Nursing staff<br>Residents<br>Family members<br>Housekeeping staff<br>Business office manager<br>Human resources<br>Laundry staff                                     |
| <b>Record Reviews:</b> | Medical records<br>Grievance log<br>State reporting log<br>Incident investigation<br>Facility policies<br>Personnel files<br>Staff training records<br>Staff patterns |

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### Investigation Summary:

- 1) after observation, interview, and record review the facility failed to have adequate staff to provide the care and services to the residents that resulted in laundry not being completed, showers not being done and contributed to residents to develop skin impairments, and unqualified staff passing nurse delegated tasks to the residents.



Failed practice identified

2) facility did admit one new resident to the facility despite the facility having staff challenges and meeting and full filling the current residents care and services. failed practice.

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**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 # 36948 |
| Plan of Correction        | Brookdale Olympia West                      | Completion Date                  |
| Page 1 of 18              | Licensee: BKD Clatsop Bridge of Olympia LLC | 02/21/2024                       |

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 02/02/2024 and 02/15/2024 of:

Brookdale Olympia West  
420 YAUGER WAY SW  
OLYMPIA, WA 985028660

This document references the following complaint number(s): 117217, 118863

The following sample was selected for review during the unannounced on-site visit: 8 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anissa Bearden, Licensor

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

03/04/2024  
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.



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| Statement of Deficiencies | License #: 2497                           | Compliance Determination #36948 |
| Plan of Correction        | Brookdale Olympia West                    | Completion Date                 |
| Page 1 of 18              | Licensee: BKD Clare Bridge of Olympia LLC | 02/21/2024                      |

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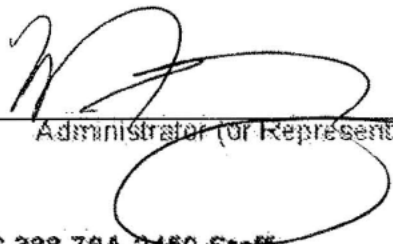
Residential Care Services

03/04/2024

Date

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| Plan of Correction        | Brookdale Olympia West                    | Completion Date                  |
| Page 2 of 18              | Licensee: BKD Clare Bridge of Olympia LLC | 02/21/2024                       |

  
\_\_\_\_\_  
Administrator (or Representative)

3/10/24  
\_\_\_\_\_  
Date

**WAC 388-78A-2450 Staff.**

- (1) Each assisted living facility must provide sufficient, trained staff persons to:
  - (a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;
  - (b) Maintain the assisted living facility free of safety hazards; and
  - (c) Implement fire and disaster plans.
- (2) The assisted living facility must:
  - (e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;
  - (h) Provide staff orientation and appropriate training for expected duties, including:
    - (vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and
    - (vii) Resident rights, including without limitation, those specified in chapter 70.128 RCW.

**This requirement was not met as evidenced by:**

Based on observations, interviews, and record reviews, the facility failed to ensure they had sufficient and qualified staff to meet resident needs for 2 of 2 memory care units (Clare and Bridge units) reviewed. This failure resulted in residents not receiving care and services per their Negotiated Service Agreements, and placed all 47 of 47 residents at risk for unmet care needs and decreased quality of life.

**Findings included...**

In an observation on 02/02/2024 at 8:40 AM, upon entering this secured memory care facility entrance, there was a large open area with multiple dining table and chairs and offices. The facility splits off to two separate hallways, one straight ahead to the left of the front door to the Clare side, and a hallway to the right that led to the Bridge side of the building. Each separated side of the building has a secured door for entry/exit requiring a code to unlock the doors to exit. Between the hallways there was shared office space for staff, and a town square used for activities. In order to access the Bridge side from the Clare side, one would exit the secured doors of Clare side in the front entryway, go down the hallway and enter through the secured doors of Bridge; and vice versa. Once inside either side of the building (Bridge or Clare), there was an alternative way to enter the other side through a locked door that entered the employee breakroom, down the hallway past

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\_\_\_\_\_  
Administrator (or Representative)

\_\_\_\_\_  
Date

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| Page 3 of 18              | Licensee: BKD Clara Bridge of Olympia LLC | 02/21/2024                       |

the kitchen's pantry then turned to go up another hallway that passed the other side of the kitchen to the door of the other side of the building, and vice versa.

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed there were 24 memory care residents that resided on Clare side of the facility. Out of the 24 memory care residents on Clare, there were 5 residents that were identified to exit seek (attempts to find a way out of the building) or wander, 9 residents that experienced behaviors, 13 residents that required moderate (resident assessed needs that may require assistance with such as guiding, standby assistance for transfers, or ambulation, bathing and toileting) to maximum (resident assessed needs that may require assistance with ADL'S (Activities of Daily Living) such as needing a one person or two person transfer, required staff to assist with care, resident needed assistance with turning, sitting up or laying down, staff must physically turn the resident while in bed) assistance with activities of daily living (ADL), 18 residents that were incontinent (inability to control loss of urine or bowel resulting in accidents) of bowel and urine, and 17 residents that were identified as a fall risk and used an assistive device. Review of the Bridge side of the building showed there were 23 residents that resided on that side of the facility. There were 7 residents that were identified to exit seek or wander, 8 residents that experienced behaviors, 7 residents that required moderate to maximum assistance with their ADL's, 13 residents that were incontinence of bowel and urine, and 12 residents that used an assistive device or was at risk for falls.

Record review of the facility's document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, that was provided to the Department on 02/15/2024, showed the facility had a new resident admit to the facility on [REDACTED] 2024.

Record review of the facility's disclosure of services, undated, showed the facility must provide laundry services to keep the residents clothes clean and in good repair, and provide them with clean towels, wash cloths, and bed linens at least once per week. The weekly linen service was included in the monthly fees. The facility must maintain the resident's living quarters and other areas the residents may use in a safe, clean, and comfortable condition. The monthly fee included light housekeeping services once per week.

Record review of the facility's document titled, "Fresh Impressions: Regional, District & Community commitment to Operational Excellence", dated 12/2023, under the section titled, Resident Experience, showed the residents apartments and common areas were to give a fresh impression that appeared clean, odor-free, and comfortable. Residents personal items were laundered separately from other residents laundry, soiled incontinence or contaminated items were washed immediately.

Record review of the facility's document titled, "Fresh Impressions- Resident and Contaminated Laundry", dated 06/2023, showed the laundry workloads were to be balanced across seven days. The first shift were to collect the dirty laundry, the cart was to be used to collect and return laundry, and remove the clothes from the dryer promptly to avoid wrinkles. The second shift was to put the laundry away, and the third shift was to wash, dry, and fold the laundry.



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|                           |                                           |                                  |
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Record review of the facility's policy titled, Service Plan Process, dated 03/2020, showed individual resident service plans were developed through the evaluation process or other identified systems and provide information about resident needs to the care associates (care staff). Service plans were implemented and maintained for each resident to address these needs.

Record review of the facility's document titled, "Morning Shift 6-2", undated showed it was a timeline of what the day shift care staff were expected to do. The expectations included routine rounds of the residents to ensure residents were toileted and clean, set up the dining room for breakfast and lunch, assist the residents with getting up for the day that included brushing their teeth, washing their face, combing hair, and putting on clean clothes. The care staff were to remove the trash, dirty laundry, and make the residents bed before they left the room. Care staff were to assist the residents to the dining room for breakfast and lunch. Care staff were to help serve residents their food plates and drinks. Care staff were to assist with cleaning up the dining room with cleaning all the dishes and the dirty linens. The kitchen linens were to be washed and dishes returned to the kitchen. Assist resident with showers, escorts to town square for activities, ensure resident rooms are tidied, and residents were toileted multiple times throughout the shift. Residents were to be provided snacks to both sides of the facility in between breakfast and lunch. Care staff were to double check all the resident's rooms, showers rooms and take out the kitchenette's trash before they ended their shift.

Record review of the facility's document titled, "Evenings 2-10", undated, showed it was a timeline of what the evening shift care staff were expected to do. The expectations included making routine rounds that ensured residents beds were made, rooms had the required supplies, and residents had night clothes set out. Snacks were to be passed out and showers started for the residents. Laundry was to be checked and switched over, put away, and fold the residents laundry. Care staff were to ensure the dining room was set up for dinner and residents were toileted. Care staff to assist the residents from town square activities and into the dining room for dinner. Care staff were to help pass out dinner plates, assist any resident that required assistance for eating, and then helped clean up after the meal. Care staff were to assist lying down the residents for bed that included checking for their room to be clean, laundry was put away, and window blinds were closed. Care staff were to ensure the kitchenettes refrigerator was stocked with resident snacks and they were to complete a final round check on the residents to ensure all trash was out of the resident's rooms and laundry rooms. Care staff were to switch over any laundry that needed to be and then report off and complete walking rounds with the night care staff at the end of the shift. There was no night shift (10 PM-6 AM) care staff expectations task list for review.

Record review of the facility's document titled, "what does the float do?", undated, showed the float was an aid to the associates (care staff) on the floor and they do "what is needed" in the moment. The float should complete without request to be first responder to all door alarms, answer call lights, set up dining room for each meal, pour drinks, engage the residents in the dining room, run meals for both sides of the facility, assist with feeding and balance the dining room. No dining room should have only one aide present, the medication technician should always be opposite the float and the nurse. Assist the



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| Page 5 of 18              | Licensee: BKD Clare Bridge of Olympia LLC | 02/21/2024                       |

residents with getting up and moving after meals and into town square for activities. They were to sweep the dining rooms and wipe the tables after each meal, clear the kitchenette(s) of dishes, drinks, and garbage. They were to wash, fold, dry, and return table linens and resident laundry. The laundry belonged to all shifts to complete. The float was to assist with two-person transfers and cares. All surfaces of the table tops, coffee tables, handrails, desks, window sills, baby dolls, and small television room tables were to be wiped down and all common spaces were to be vacuumed and trash picked up. The float was also to help relieve the other care staff for lunches and breaks.

Record review of the facility's document titled, "Clare Side Showers", undated, showed on day shift there were four resident showers and laundry services scheduled every Sunday through Thursday and on Friday and Saturday there was three residents that were scheduled for showers and laundry services. The Evening shift was scheduled to complete three resident showers and laundry services every Sunday through Wednesday and two resident showers and laundry services daily on Thursday through Saturday. The form showed "beds must be changed and laundry pulled by the RA [resident assistant/care staff] assigned to that resident every shower day!! No bed baths unless directed by Health and Wellness Director".

Record review of the facility's document titled, "Bridge Side Showers", undated, showed for day shift there were four residents scheduled for showers and laundry services on Sunday through Tuesday, Thursday, and Saturday. There were three resident showers and laundry services scheduled every Wednesday and Friday. For evening shift there were three residents scheduled for showers and laundry services every Friday through Tuesday and on Wednesday and Thursday there were two resident showers and laundry services scheduled.

Record review of the facility's document titled, "Clinical Schedule", dated 02/06/2024 through 02/13/2024, showed for day shift 6 AM until 2 PM, the facility was to have one medication technician scheduled for each side of Clare and Bridge. There was to be two care staff for each Clare and Bridge side of the facility. For the evening shift 2 PM until 10 PM, showed there would be one medication technician for each side of the building, one caregiver for each side of the building, and a caregiver that floated/trained. Review of night shift, 10 PM, until 6 AM, showed there would be one medication technician to cover both sides of the facility and one caregiver for each side of the building on shift. The scheduled showed that on 02/11/2024 on day shift there were two medication technicians and four care staff that were scheduled to work for the entire shift and for evening shift there were two medication technicians and two caregivers scheduled to work.

Record review of the facility's document, titled, "Condensed Employee Time Detail [time card punches]", dated 01/19/2024 through 02/05/2024, showed on 02/11/2024 for day shift showed there was two medication technicians and three caregivers that worked. On 02/11/2024 for evening shift showed there were two medications technicians and one care staff from 2 PM until 3:15 PM when another care staff clocked on shift. At 4:30 PM one care staff ended their shift leaving two medication technicians and one care staff for 47 residents across the two separate units until 6 PM. The time details showed from 6 PM until 9 PM there was only one unqualified medication technician (Staff C) that worked and covered both sides of the facility. On 02/01/2024, 10 PM- 6 AM showed there were only

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Record review of the facility's document titled, "Clare Side Showers", undated, showed on day shift there were four resident showers and laundry services scheduled every Sunday through Thursday and on Friday and Saturday there was three residents that were scheduled for showers and laundry services. The Evening shift was scheduled to complete three resident showers and laundry services every Sunday through Wednesday and two resident showers and laundry services daily on Thursday through Saturday. The form showed "beds must be changed and laundry pulled by the RA [resident assistant/care staff] assigned to that resident every shower day!! No bed baths unless directed by Health and Wellness Director".

Record review of the facility's document titled, "Bridge Side Showers", undated, showed for day shift there were four residents scheduled for showers and laundry services on Sunday through Tuesday, Thursday, and Saturday. There were three resident showers and laundry services scheduled every Wednesday and Friday. For evening shift there were three residents scheduled for showers and laundry services every Friday through Tuesday and on Wednesday and Thursday there were two resident showers and laundry services scheduled.

Record review of the facility's document titled, "Clinical Schedule", dated 02/06/2024 through 02/13/2024, showed for day shift 6 AM until 2 PM, the facility was to have one medication technician scheduled for each side of Clare and Bridge. There was to be two care staff for each Clare and Bridge side of the facility. For the evening shift 2 PM until 10 PM, showed there would be one medication technician for each side of the building, one caregiver for each side of the building, and a caregiver that floated/trained. Review of night shift, 10 PM, until 6 AM, showed there would be one medication technician to cover both sides of the facility and one caregiver for each side of the building on shift. The scheduled showed that on 02/11/2024 on day shift there were two medication technicians and four care staff that were scheduled to work for the entire shift and for evening shift there were two medication technicians and two caregivers scheduled to work.

Record review of the facility's document, titled, "Condensed Employee Time Detail [time card punches]", dated 01/19/2024 through 02/05/2024, showed on 02/11/2024 for day shift showed there was two medication technicians and three caregivers that worked. On 02/11/2024 for evening shift showed there were two medications technicians and one care staff from 2 PM until 3:15 PM when another care staff clocked on shift. At 4:30 PM one care staff ended their shift leaving two medication technicians and one care staff for 47 residents across the two separate units until 6 PM. The time details showed from 6 PM until 9 PM there was only one unqualified medication technician (Staff C) that worked and covered both sides of the facility. On 02/01/2024, 10 PM- 6 AM showed there were only

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two care staff that worked and no medication technicians. Comparison of the time card punches to the clinical schedule, showed the facility did not staff to the levels they indicated were necessary and documented.

In an interview on 02/02/2024 at 3:47 PM, Staff A, Executive Director, and Staff H, District Director of Operations, Staff A stated they worked night shift from 10 PM until 6 AM on 02/01/2024. Staff A stated they held the two medication carts keys. Staff A stated they completed the narcotic count for the medication carts with the off going medication technician. Staff A stated there was not a delegated medication technician or a licensed nurse that worked 02/01/2024 from 10 PM until 6 AM. Staff A stated they staff the facility based on the resident's acuity of care that was generated from all the residents service plans. Staff A was unaware how many residents that resided at the facility required two person staff assistance. Staff H stated the resident's assessments were broken up into time. Staff H stated the time then equates to the number of staff that were required to work for each shift. Staff H stated they would staff the facility to meet the residents care and service's needs.

Record review of the facility's safety plan sent to the department on 02/02/2024 at 5:50 PM, titled, "Safety Plan - Brookdale Olympia West 02/02/2024 RE: Safety plan re: med tech coverage," dated 02/02/2024, showed "The community execs to maintain safe and appropriate medication distribution by using Med Tech's and Licensed Nurse."

Record review of the facility's safety plan sent to the Department 02/16/2024 at 5:23 PM, titled, "Clinical Schedule", dated 02/16/2024 through 02/23/2024, showed the facility was coordinating with staffing agency to have caregivers and licensed nurses (in lieu of medication technicians) staff to fill the shifts they did not have staff to work. There were 38 shifts that were either filled by agency staff and were needing to be filled by agency staff on the schedule for day, evening, and night shift.

Record review of the Washington State (WA) Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2024", showed it was mandatory for delegation to a long term care worker that the Registered Nurse (RN) must ensure the long term care worker was currently a registered or certified as a nursing assistant or home care aide in WA state without restrictions, they completed the nurse delegation for caregiver's core training, and if they were to administer insulin, the special focus on diabetes training was completed.

Record review of the facility policy, titled, "Nurse Delegation Policy", dated 01/2023, showed "Before performing any delegated task, the RN must: a. Verify that the nursing assistant or home care aid is currently registered in Washington state without restriction; b. Verify that the nursing assistant or home care aide has completed both basic caregiver training and core delegation training before performing any delegated task; c. Verify that the nursing assistant or home care aid has evidence as required by the department of social and health services of successful completion of nurse delegation core training; and nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client... Delegation may only be done through written instructions to the nursing assistant or home care aide with a copy maintained in the resident record. Nursing



two care staff that worked and no medication technicians. Comparison of the time card punches to the clinical schedule, showed the facility did not staff to the levels they indicated were necessary and documented.

In an interview on 02/02/2024 at 3:47 PM, Staff A, Executive Director, and Staff H, District Director of Operations, Staff A stated they worked night shift from 10 PM until 6 AM on 02/01/2024. Staff A stated they held the two medication carts keys. Staff A stated they completed the narcotic count for the medication carts with the off going medication technician. Staff A stated there was not a delegated medication technician or a licensed nurse that worked 02/01/2024 from 10 PM until 6 AM. Staff A stated they staff the facility based on the resident's acuity of care that was generated from all the residents service plans. Staff A was unaware how many residents that resided at the facility required two person staff assistance. Staff H stated the resident's assessments were broken up into time. Staff H stated the time then equates to the number of staff that were required to work for each shift. Staff H stated they would staff the facility to meet the residents care and service's needs.

Record review of the facility's safety plan sent to the department on 02/02/2024 at 5:50 PM, titled, "Safety Plan – Brookdale Olympia West 02/02/2024 RE: Safety plan re: med tech coverage," dated 02/02/2024, showed "The community execs to maintain safe and appropriate medication distribution by using Med Tech's and Licensed Nurse."

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Record review of the Washington State (WA) Department of Social and Health Services document titled, "Community Nurse Delegation Orientation 2024", showed it was mandatory for delegation to a long term care worker that the Registered Nurse (RN) must ensure the long term care worker was currently a registered or certified as a nursing assistant or home care aide in WA state without restrictions, they completed the nurse delegation for caregiver's core training, and if they were to administer insulin, the special focus on diabetes training was completed.

Record review of the facility policy, titled, "Nurse Delegation Policy", dated 01/2023, showed "Before performing any delegated task, the RN must: a. Verify that the nursing assistant or home care aid is currently registered in Washington state without restriction; b. Verify that the nursing assistant or home care aide has completed both basic caregiver training and core delegation training before performing any delegated task; c. Verify that the nursing assistant or home care aid has evidence as required by the department of social and health services of successful completion of nurse delegation core training; and nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client... Delegation may only be done through written instructions to the nursing assistant or home care aide with a copy maintained in the resident record... Nursing



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assistants or home care aids: a. must show the certificate of completion of both the basic caregiver training and core delegation training (this can be obtained from any approved trainer) to the registered nurse delegator. b. Who may be completing insulin injections, must give a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator."

Record review on 02/02/2024 of the RN Delegation binder showed there were no credential and training verification, Washington state Department of Health (DOH) credentials, nurse delegation certificate, or diabetes specialty delegation certificate for Staff A, Executive Director; Staff F, Medication Technician; Staff O, Medication Technician; and Staff P, Medication Technician for review. In the binder for Staff E, Medication Technician, there was a credential and training verification form that had only Staff E's name and no other information documented for review. Staff E's WA DOH credential verification, dated 12/04/2023, showed Staff E had a Nursing Assistant Registration credential that expired on 03/26/2019. 4 of 5 (Staff E, Staff F, Staff O and Staff P) listed medication technicians on the facility provided employee list were not qualified and did not have the required documentation to provide nurse delegated tasks, and did not have all the required credentials, verifications and training, and required certifications.

Record review of facility provided documents on 02/05/2024 at 1:00 PM, showed Staff C's credentials and training verification was completed on 02/03/2024. Staff C did not have a certification for their WA home care aide core basic training for review. Review of Staff F's credentials and training verification form showed it was completed on 02/02/2024. Staff F's WA DOH credential verification and certificates for nurse delegation core and diabetes were not provided for review.

In an interview on 02/05/2024 at 1:45 PM, Staff E, Medication Technician, stated they were waiting to be delegated by the nurse so they could provide nurse delegated task to the residents.

In an interview on 02/15/2024 at 11:44 AM, Staff J stated on 02/11/2024 Staff C was the only medication technician on shift from 6 PM until 9 PM to pass medications for all the residents in the facility.

In an interview on 02/15/2024 at 1:03 PM, Staff C stated on 02/11/2024 they did not have a lot of staff that day for evening shift 2 PM until 10 PM. Staff C stated it was just Staff I and themselves on shift for to cover both separated units. Staff C stated they called staff to help with staffing and earliest they could come in was at 6 PM. Staff C stated Staff I was training a new employee when they got overwhelmed and quit after being on shift for an hour. Staff C stated the new employee told them that they could not handle it. Staff C stated they were the medication technician for Clare side and Staff D was the medication technician for Bridge side only until 6 PM and then Staff C was the only medication technician for both sides of the building until the night shift medication technician came on due to Staff D's shift ending at 6 PM. Staff C stated Staff D was the medication technician and the care staff for Bridge side on 02/11/2024. Staff C stated they have been working as a medication technician and passing medications to residents. Staff C stated they were to be delegated by the RN today (02/15/2024) for all the residents nurse.

assistants or home care aids: a. must show the certificate of completion of both the basic caregiver training and core delegation training (this can be obtained from any approved trainer) to the registered nurse delegator. b. Who may be completing insulin injections, must give a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator."

Record review on 02/02/2024 of the RN Delegation binder showed there were no credential and training verification, Washington state Department of Health (DOH) credentials, nurse delegation certificate, or diabetes specialty delegation certificate for Staff A, Executive Director; Staff F, Medication Technician; Staff O, Medication Technician; and Staff P, Medication Technician for review. In the binder for Staff E, Medication Technician, there was a credential and training verification form that had only Staff E's name and no other information documented for review. Staff E's WA DOH credential verification, dated 12/04/2023, showed Staff E had a Nursing Assistant Registration credential that expired on 03/26/2019. 4 of 5 (Staff E, Staff F, Staff O and Staff P) listed medication technicians on the facility provided employee list were not qualified and did not have the required documentation to provide nurse delegated tasks, and did not have all the required credentials, verifications and training, and required certifications.

Record review of facility provided documents on 02/05/2024 at 1:00 PM, showed Staff C's credentials and training verification was completed on 02/03/2024. Staff C did not have a certification for their WA home care aide core basic training for review. Review of Staff F's credentials and training verification form showed it was completed on 02/02/2024. Staff F's WA DOH credential verification and certificates for nurse delegation core and diabetes were not provided for review.

In an interview on 02/05/2024 at 1:45 PM, Staff E, Medication Technician, stated they were waiting to be delegated by the nurse so they could provide nurse delegated task to the residents.

In an interview on 02/15/2024 at 11:44 AM, Staff J stated on 02/11/2024 Staff C was the only medication technician on shift from 6 PM until 9 PM to pass medications for all the residents in the facility.

In an interview on 02/15/2024 at 1:03 PM, Staff C stated on 02/11/2024 they did not have a lot of staff that day for evening shift 2 PM until 10 PM. Staff C stated it was just Staff I and themselves on shift for to cover both separated units. Staff C stated they called staff to help with staffing and earliest they could come in was at 6 PM. Staff C stated Staff I was training a new employee when they got overwhelmed and quit after being on shift for an hour. Staff C stated the new employee told them that they could not handle it. Staff C stated they were the medication technician for Clare side and Staff D was the medication technician for Bridge side only until 6 PM and then Staff C was the only medication technician for both sides of the building until the night shift medication technician came on due to Staff D's shift ending at 6 PM. Staff C stated Staff D was the medication technician and the care staff for Bridge side on 02/11/2024. Staff C stated they have been working as a medication technician and passing medications to residents. Staff C stated they were to be delegated by the RN today (02/15/2024) for all the residents nurse



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delegated tasks. Staff C stated if Staff D was not working then they worked alone as the only medication technician for both sides of the buildings.

In an interview on 02/02/2024 at 3:47 PM, Staff A stated they were unsure if Staff C and Staff F had completed the delegation trainings and received their delegation certificates.

Resident 1 (R1)

Record review of R1's Admission Record, dated 02/18/2024, showed R1 moved into the facility on 09/27/2013 with multiple medical diagnoses that included [REDACTED], [REDACTED], [REDACTED], and [REDACTED].

Record review of R1's Personal Service Plan (facility version of the Negotiated Service Agreement and nurses assessment), dated 10/18/2023, showed R1 had Alzheimer's (a progressive brain disorder that slowly destroys ones memory, thinking skills, and eventually ones ability to carry out simple daily living tasks). R1 was not oriented to place or time. R1 was unable to verbalize their needs and preferences. R1 would talk in word salad (speech that consist of a mix of unintelligible, random words together that often do not correlate with each other). R1 required assistance from staff with eating, hands on assistance with dressing, grooming, and two showers per week. R1 required two staff members to assist R1 to stand but had a history of getting tired and frequently required R1 to be transferred with two staff members and a Hoyer lift (a device that cradles the resident's entire body and lifts them up in a secured sling to move them from one area to another). R1 was confined to a wheelchair that they were not able to self-propel or move. R1 was incontinent of urine and bowel and required R1 to wear disposable protective underwear. Staff were to assist R1 four times a shift to check and change R1's disposable underwear. R1 required the staff to escort R1 to and from the dining room and activities in their wheelchair.

Record review of R1's Nurse Delegation: Nursing Visit form, dated 10/30/2023, showed R1 was delegated for medication administration. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff C, Staff E, Staff F, Staff O, and Staff P were not listed to have been reviewed, trained, and observed and approved to administer R1's RN delegated tasks.

Record review of R1's Medication Administration Record (MAR), dated 01/01/2024 through 01/31/2024, showed Staff F administered R1's medications 1 of 31 days, Staff P administered R1's medications 3 of 31 days, and Staff E administered R1's medications 7 of 31 days.

Record review of R1's MAR, dated 02/01/2024 through 02/18/2024, showed Staff C administered R1's medications 2 of 18 days and Staff E administered R1's medications

delegated tasks. Staff C stated if Staff D was not working then they worked alone as the only medication technician for both sides of the buildings.

In an interview on 02/02/2024 at 3:47 PM, Staff A stated they were unsure if Staff C and Staff F had completed the delegation trainings and received their delegation certificates.

#### Resident 1 (R1)

Record review of R1's Admission Record, dated 02/18/2024, showed R1 moved into the facility on [REDACTED] /2013 with multiple medical diagnoses that included [REDACTED] ([REDACTED]), [REDACTED] ([REDACTED]), and [REDACTED] ([REDACTED]).

Record review of R1's Personal Service Plan (facility version of the Negotiated Service Agreement and nurses assessment), dated 10/18/2023, showed R1 had Alzheimer's (a progressive brain disorder that slowly destroys ones memory, thinking skills, and eventually ones ability to carry out simple daily living tasks). R1 was not oriented to place or time. R1 was unable to verbalize their needs and preferences. R1 would talk in word salad (speech that consist of a mix of unintelligible, random words together that often do not correlate with each other). R1 required assistance from staff with eating, hands on assistance with dressing, grooming, and two showers per week. R1 required two staff members to assist R1 to stand but had a history of getting tired and frequently required R1 to be transferred with two staff members and a Hoyer lift (a device that cradles the resident's entire body and lifts them up in a secured sling to move them from one area to another). R1 was confined to a wheelchair that they were not able to self-propel or move. R1 was incontinent of urine and bowel and required R1 to wear disposable protective underwear. Staff were to assist R1 four times a shift to check and change R1's disposable underwear. R1 required the staff to escort R1 to and from the dining room and activities in their wheelchair.

Record review of R1's Nurse Delegation: Nursing Visit form, dated 10/30/2023, showed R1 was delegated for medication administration. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff C, Staff E, Staff F, Staff O, and Staff P were not listed to have been reviewed, trained, and observed and approved to administer R1's RN delegated tasks.

Record review of R1's Medication Administration Record (MAR), dated 01/01/2024 through 01/31/2024, showed Staff F administered R1's medications 1 of 31 days, Staff P administered R1's medications 3 of 31 days, and Staff E administered R1's medications 7 of 31 days.

Record review of R1's MAR, dated 02/01/2024 through 02/18/2024, showed Staff C administered R1's medications 2 of 18 days and Staff E administered R1's medications



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once with their WA DOH credentials expired.

Resident 6 (R6)

Record review of R6's Admission Record, dated 12/27/2024, showed R6 moved into the facility on [REDACTED] /2018, with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R6's Personal Service Plan, dated 11/29/2023, showed R6 was oriented to self only. R6 was unable to use the call system appropriately and required frequent checks for safety. R6 required at times, full assistance from staff with eating, as R6 had a history of unable to feed self. R6 required two staff persons assistance with transferring in and out of the shower and one person physical assist from one staff member for showering needs two times a week. Two staff members were required to physically assist R6 to the toilet for safety. R6 was incontinent of bowel and urine that required R6 to use disposable underwear. Staff were to toilet the resident upon rising and frequently during the day and evening also a couple times during the night. R6 has a history of attempting to toilet self that had resulted in falls. Two staff members were to use a Hoyer lift on R6 for all transfers.

In an interview on 02/15/2024 at 2:47 PM, Staff Q stated R6 required staff to provide total care. Staff Q stated R6 required a hooyer lift and two staff members to transfer R6.

Resident 4 (R4)

Record review of R4's Admission Record, dated 10/30/2023, showed R4 moved into the facility on [REDACTED] 2023 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R4's Personal Service Plan, dated [REDACTED] 2023, showed R4 required one person staff assist with transfers. R4 required stand by assistance for all showers two times a week. R4 had a diagnosis of [REDACTED] and [REDACTED]. Staff were to monitor R4's skin with each shower and as needed with care. The staff were to review the Medication Administration Record for specific instructions.

Record review of R4's Nurse Delegation Nursing Visit, dated 10/30/2023, showed R4 required nurse delegation for tasks that included medication administration, insulin administration, and blood sugar checks. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff C, Staff E, Staff F, Staff O, and Staff P were not listed to have been reviewed, trained, and observed and approved to administer R4's RN delegated tasks.

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

once with their WA DOH credentials expired.

#### Resident 6 (R6)

Record review of R6's Admission Record, dated 12/27/2024, showed R6 moved into the facility on [REDACTED]/2018, with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R6's Personal Service Plan, dated 11/29/2023, showed R6 was oriented to self only. R6 was unable to use the call system appropriately and required frequent checks for safety. R6 required at times, full assistance from staff with eating, as R6 had a history of unable to feed self. R6 required two staff persons assistance with transferring in and out of the shower and one person physical assist from one staff member for showering needs two times a week. Two staff members were required to physically assist R6 to the toilet for safety. R6 was incontinent of bowel and urine that required R6 to use disposable underwear. Staff were to toilet the resident upon rising and frequently during the day and evening also a couple times during the night. R6 has a history of attempting to toilet self that had resulted in falls. Two staff members were to use a Hoyer lift on R6 for all transfers.

In an interview on 02/15/2024 at 2:47 PM, Staff Q stated R6 required staff to provide total care. Staff Q stated R6 required a hoyer lift and two staff members to transfer R6.

#### Resident 4 (R4)

Record review of R4's Admission Record, dated 10/30/2023, showed R4 moved into the facility on [REDACTED]/2023 with multiple medical diagnoses that included [REDACTED], [REDACTED], and [REDACTED].

Record review of R4's Personal Service Plan, dated [REDACTED]/2023, showed R4 required one person staff assist with transfers. R4 required stand by assistance for all showers two times a week. R4 had a diagnosis of [REDACTED] ([REDACTED]) and [REDACTED]. Staff were to monitor R4's skin with each shower and as needed with care. The staff were to review the Medication Administration Record for specific instructions.

Record review of R4's Nurse Delegation Nursing Visit, dated 10/30/2023, showed R4 required nurse delegation for tasks that included medication administration, insulin administration, and blood sugar checks. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff C, Staff E, Staff F, Staff O, and Staff P were not listed to have been reviewed, trained, and observed and approved to administer R4's RN delegated tasks.



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Record review of R4's MAR, dated 01/01/2024 through 01/31/2024, showed R4 had an order for nystatin powder (medicated powder to help dry up and resolve a yeast rash on the skin) to apply to affected areas two times daily. The MAR showed the powder was applied under R4's breasts and groin area. The MAR showed Staff F administered R4's medications 8 of 31 days, Staff C administered R4's medications 1 of 31 days, Staff E administered R4's medications 3 of 31 days, and Staff O administered R4's medications 5 of 31 days.

Record review of R4's MAR, dated 02/01/2024 through 02/18/2024, showed R4 had an order for doxycycline monohydrate (prescribed antibiotic medications to help treat infection) take one tablet two times daily for inflamed redness and rash on skin for 10 days, mupirocin ointment (prescribed medicated ointment that treats skin infections) to apply to affected skin three times daily for skin irritation, and triamcinolone acetonide ointment (prescribed medicated steroid ointment that helps reduce swelling, discomfort, redness cause by skin conditions) to apply to affected skin areas two times daily for skin irritation, and nystatin powder as needed for yeast/redness that was administered on 02/05/2024 at 10:32 AM. The MAR showed Staff C administered R4's medications 8 of 18 days and Staff E administered R4's medication once with their WA DOH credential expired.

In an observation and interview on 02/05/2024 at 10:25 AM, Staff D went to R4's room to apply R4's medicated powder to their skin. When Staff D opened R4's door to their apartment there was a strong odor that was present in the room. When Staff D was asked what the smell was, Staff D stated it was from R4's yeast rash. Staff D stated R4's room smelled like that every day. R4 was compliant with allowing Staff D to look at their skin and apply the powder. R4 was noted their disposable underwear was soiled with feces and urine. Staff D had lifted up both of R4's breast and the skin was shiny, red, and had white matter. Staff D cleansed the area with a wet rag and dried it off. Staff D then applied the medicated powder. All over R4's stomach and middle body area, where there were multiple tiny red pinpoint areas. Some of the areas were scabbed over and others just red. Staff D stated those areas were a new rash that had developed in the last few weeks and recently saw their doctor. Staff D then assisted R4 to remove their pants. Under R4's stomach fold, the skin was bright red with white matter. The redness continued into R4's groin area between their thigh and lower stomach area. When Staff D was cleansing the areas in the groin and the lower stomach area, a strong foul odor was present. The smell was the same odor that was noted when Staff D entered R4's room.

Resident 8 (R8)

Record review of R8's Admission Record, dated 09/13/2023, showed R8 moved into the facility on [REDACTED] 2021 with multiple medical diagnoses that included [REDACTED]

Record review of R8's Personal Service Plan, dated 11/21/2023, showed a delegated medication technician or licensed nurse was to check R8's blood sugar check and administer R8's insulin two times daily. R8 was not always oriented to time.

Record review of R4's MAR, dated 01/01/2024 through 01/31/2024, showed R4 had an order for nystatin powder (medicated powder to help dry up and resolve a yeast rash on the skin) to apply to affected areas two times daily. The MAR showed the powder was applied under R4's breasts and groin area. The MAR showed Staff F administered R4's medications 8 of 31 days, Staff C administered R4's medications 1 of 31 days, Staff E administered R4's medications 3 of 31 days, and Staff O administered R4's medications 5 of 31 days.

Record review of R4's MAR, dated 02/01/2024 through 02/18/2024, showed R4 had an order for doxycycline monohydrate (prescribed antibiotic medications to help treat infection) take one tablet two times daily for inflamed redness and rash on skin for 10 days, mupirocin ointment (prescribed medicated ointment that treats skin infections) to apply to affected skin three times daily for skin irritation, and triamcinolone acetonide ointment (prescribed medicated steroid ointment that helps reduce swelling, discomfort, redness cause by skin conditions) to apply to affected skin areas two times daily for skin irritation, and nystatin powder as needed for yeast/redness that was administered on 02/05/2024 at 10:32 AM. The MAR showed Staff C administered R4's medications 8 of 18 days and Staff E administered R4's medication once with their WA DOH credential expired.

In an observation and interview on 02/05/2024 at 10:25 AM, Staff D went to R4's room to apply R4's medicated powder to their skin. When Staff D opened R4's door to their apartment there was a strong odor that was present in the room. When Staff D was asked what the smell was, Staff D stated it was from R4's yeast rash. Staff D stated R4's room smelled like that every day. R4 was compliant with allowing Staff D to look at their skin and apply the powder. R4 was noted their disposable underwear was soiled with feces and urine. Staff D had lifted up both of R4's breast and the skin was shinny, red, and had white matter. Staff D cleansed the area with a wet rag and dried it off. Staff D then applied the medicated powder. All over R4's stomach and middle body area, where there were multiple tiny red pinpoint areas. Some of the areas were scabbed over and others just red. Staff D stated those areas were a new rash that had developed in the last few weeks and recently saw their doctor. Staff D then assisted R4 to remove their pants. Under R4's stomach fold, the skin was bright red with white matter. The redness continued into R4's groin area between their thigh and lower stomach area. When Staff D was cleansing the areas in the groin and the lower stomach area, a strong foul odor was present. The smell was the same odor that was noted when Staff D entered R4's room.

#### Resident 8 (R8)

Record review of R8's Admission Record, dated 09/13/2023, showed R8 moved into the facility on [REDACTED]/2021 with multiple medical diagnoses that included [REDACTED].

Record review of R8's Personal Service Plan, dated 11/21/2023, showed a delegated medication technician or licensed nurse was to check R8's blood sugar check and administer R8's insulin two times daily. R8 was not always oriented to time.



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Record review of R8's Nurse Delegation: Nursing Visit form, dated 10/30/2024, showed R8 required nurse delegation for medication administration, insulin administration and blood sugar checks. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff C, Staff E, Staff F, Staff O, and Staff P were not listed to have been reviewed, trained, and observed and approved to administer R8's RN delegated tasks.

Review of R8's Nurse Delegation: Instructions for Nursing Task form, dated 10/30/2023, showed R8 was delegated for all oral (in the mouth) medication administrations.

Record review of R8's MAR, dated 01/01/2024 through 01/31/2024, showed Staff F had administered R8's medications 12 of 31 days. Staff F had checked R8's blood sugar and administered insulin to R8 3 of 31 days. Staff O had administered R8's medications 4 of 31 days. Staff O checked R8's blood sugar 4 of 31 days and administered R8's insulin 3 of 31 days. Staff F had administered R8 their medications 3 of 31 days, checked R8's blood sugar 4 times in 31 days, and administered R8's insulin 4 times in 31 days. Staff C administered R8's medications 2 of 31 days and administered R8's insulin 1 time in 31 days.

Record review of R8's MAR, dated 02/01/2024 through 02/18/2024, showed Staff C administered R8's insulin and checked R8's blood sugar 8 of 18 days.

Resident 5 (R5)

Record review of R5's Admission Record, dated 02/18/2024, showed R5 moved into the facility on [REDACTED] 2022 with multiple medical diagnoses that included [REDACTED]

Record review of R5's Person Service Plan, dated 07/05/2023, showed R5 required one-person physical assist with dressing and grooming needs. R5 had a history of refusing to get dressed and required the staff to make multiple attempts to change R5's clothes and provide care. R5 required physical staff assistance with two times a week showers with a history of requiring two to three staff members related to R5's aggressive behaviors. R5 was incontinent of bowel and bladder and was required to use disposable underwear. Staff were to physically assist R5 with changing disposable underwear and proper cleaning. R5 used a wheelchair and required staff to escort to and from the dining room and activities. R5 had a history of falling and remained at risk to have further falls so staff were to keep a close visual eye on R5. R5 had a history of refusing care and medications, exhibited behaviors of kicking, hitting, and scratching, experienced anxiousness, hallucinations, and obsessive behaviors towards evening time. R5 required multiple staff and caregivers to assist R5 with redirection. The service plan did not indicate how many staff were required to assist R5 with transfers.

Record review of R5's alert charting note, dated 01/12/2024 at 5:05 AM, showed R5 was on alert for an injury fall and a non-injury fall. R5 had presented tired and drained during the shift and was not put to bed until night shift started even though the medication technician (Staff R) instructed care staff to lay R5 down because R5 was sleeping in their

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Record review of R8's Nurse Delegation: Nursing Visit form, dated 10/30/2024, showed R8 required nurse delegation for medication administration, insulin administration and blood sugar checks. Review of the section titled, "long-term care worker (LTCW) Training/Competency", showed Staff A, Staff C, Staff E, Staff F, Staff O, and Staff P were not listed to have been reviewed, trained, and observed and approved to administer R8's RN delegated tasks.

Review of R8's Nurse Delegation: Instructions for Nursing Task form, dated 10/30/2023, showed R8 was delegated for all oral (in the mouth) medication administrations.

Record review of R8's MAR, dated 01/01/2024 through 01/31/2024, showed Staff F had administered R8's medications 12 of 31 days. Staff F had checked R8's blood sugar and administered insulin to R8 3 of 31 days. Staff O had administered R8's medications 4 of 31 days. Staff O checked R8's blood sugar 4 of 31 days and administered R8's insulin 3 of 31 days. Staff F had administered R8 their medications 3 of 31 days, checked R8's blood sugar 4 times in 31 days, and administered R8's insulin 4 times in 31 days. Staff C administered R8's medications 2 of 31 days and administered R8's insulin 1 time in 31 days.

Record review of R8's MAR, dated 02/01/2024 through 02/18/2024, showed Staff C administered R8's insulin and checked R8's blood sugar 8 of 18 days.

#### Resident 5 (R5)

Record review of R5's Admission Record, dated 02/18/2024, showed R5 moved into the facility on [REDACTED]/2022 with multiple medical diagnoses that included [REDACTED].

Record review of R5's Person Service Plan, dated 07/05/2023, showed R5 required one-person physical assist with dressing and grooming needs. R5 had a history of refusing to get dressed and required the staff to make multiple attempts to change R5's clothes and provide care. R5 required physical staff assistance with two times a week showers with a history of requiring two to three staff members related to R5's aggressive behaviors. R5 was incontinent of bowel and bladder and was required to use disposable underwear. Staff were to physically assist R5 with changing disposable underwear and proper cleaning. R5 used a wheelchair and required staff to escort to and from the dining room and activities. R5 had a history of falling and remained at risk to have further falls so staff were to keep a close visual eye on R5. R5 had a history of refusing care and medications, exhibited behaviors of kicking, hitting, and scratching, experienced anxiousness, hallucinations, and obsessive behaviors towards evening time. R5 required multiple staff and caregivers to assist R5 with redirection. The service plan did not indicate how many staff were required to assist R5 with transfers.

Record review of R5's alert charting note, dated 01/12/2024 at 5:05 AM, showed R5 was on alert for an injury fall and a non-injury fall. R5 had presented tired and drained during the shift and was not put to bed until night shift started even though the medication technician (Staff N) instructed care staff to lay R5 down because R5 was sleeping in their



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wheelchair. R5 had not been changed either causing a complete change and cleanup of R5 who was combative and drowsy from not being put to bed earlier in the day.

In an interview on 02/15/2024 at 2:44 PM, Staff Q stated R5 required total care with toileting, dressing, and showers. Staff Q stated R5 required to be transferred with two staff members. Staff Q stated they were provided the information about R5's transfer status from their supervisor. Staff Q had a paper that showed R5 was written as "2 person assist".

### Resident 3 (R3)

Record review of R3's Admission Record, dated 09/13/2024, showed R3 moved into the facility on [REDACTED] 2023, with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of R3's Person Service Plan, dated 10/13/2023, showed R3 had a cat. R3 required assistance with managing the cat's litter box. Staff were to ensure the litter box was cleaned daily and that excess litter was regularly swept off of the floor. Staff were to assist and ensure the cat had food and water during all interactions in R3's room.

In an observation and interview on 02/05/2024 at 7:35 AM, upon opening Resident 3's (R3) room door on the ground was multiple white particles that resembled cat litter, that covered the entire floor. There was a strong smell that resembled ammonia (a colorless gas that releases a strong foul odor). Staff E, Medication Technician, walked towards R3 that was lying in bed to check on them. Staff E's shoes made a crunch noise when they walked on the white particles on the floor. The floor in front of the cat box had large amounts of the white particles and an area of brown substance that resembled cat feces on the ground. Under R3's window was a black miniature refrigerator. On top of the black miniature refrigerator was an empty plastic container of wet cat food. There was a second empty plastic container of wet cat food that was on the ground. There were two bowls on the ground to the right of the black miniature refrigerator that were empty. Staff E was observed to open a plastic container of wet cat food and poured it into one of the bowls and filled the other bowl with water. Staff E stated care staff were responsible for feeding and cleaning after R3's cat.

The Department requested on 02/05/2024 at 3:58 PM, on 02/14/2024 at 5:31 AM, and on 02/29/2024 at 6:09 AM, for the facility to send the algorithm that was generated by the residents assessments and service plans to show how many staffing hours the residents were required for care and services. This algorithm was explained by Staff H, District Director of Operations, was how they knew how many staff were needed to work on each shift to ensure the residents care and services needs were being met. As of 02/21/2024 at 5 PM, the Department did not receive any algorithm or documentation that showed how many hours all the residents assessments and service plans showed the facility were to staff for review.

### Resident 2 (R2)

wheelchair. R5 had not been changed either causing a complete change and cleanup of R5 who was combative and drowsy from not being put to bed earlier in the day.

In an interview on 02/15/2024 at 2:44 PM, Staff Q stated R5 required total care with toileting, dressing, and showers. Staff Q stated R5 required to be transferred with two staff members. Staff Q stated they were provided the information about R5's transfer status from their supervisor. Staff Q had a paper that showed R5 was written as "2 person assist".

### Resident 3 (R3)

Record review of R3's Admission Record, dated 09/13/2024, showed R3 moved into the facility on [REDACTED] 2023, with multiple medical diagnoses that included [REDACTED] and [REDACTED] ([REDACTED]).

Record review of R3's Person Service Plan, dated 10/13/2023, showed R3 had a cat. R3 required assistance with managing the cat's litter box. Staff were to ensure the litter box was cleaned daily and that excess litter was regularly swept off of the floor. Staff were to assist and ensure the cat had food and water during all interactions in R3's room.

In an observation and interview on 02/05/2024 at 7:35 AM, upon opening Resident 3's (R3) room door on the ground was multiple white particles that resembled cat litter, that covered the entire floor. There was a strong smell that resembled ammonia (a colorless gas that releases a strong foul odor). Staff E, Medication Technician, walked towards R3 that was lying in bed to check on them. Staff E's shoes made a crunch noise when they walked on the white particles on the floor. The floor in front of the cat box had large amounts of the white particles and an area of brown substance that resembled cat feces on the ground. Under R3's window was a black miniature refrigerator. On top of the black miniature refrigerator was an empty plastic container of wet cat food. There was a second empty plastic container of wet cat food that was on the ground. There were two bowls on the ground to the right of the black miniature refrigerator that were empty. Staff E was observed to open a plastic container of wet cat food and poured it into one of the bowls and filled the other bowl with water. Staff E stated care staff were responsible for feeding and cleaning after R3's cat.

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### Resident 2 (R2)



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In an interview on 01/24/2024 at 5:31 PM, Collateral Contact 1 (CC1), Daughter of R2, stated they had to hire an additional personal caregiver to ensure that R2's room was getting cleaned and R2 received showers and shaved as they had come to visit R2 on multiple occasions and found feces in R2's bathroom, bed was unmade, and laundry was soiled. CC1 stated they had to hire the personal caregiver because the facility staff were not shaving or showering R2 per their negotiated service agreement. CC1 stated they had to go to the facility's laundry room and observed multiple large plastic bags of soiled laundry. CC1 stated during their visit it was rare to see a care staff in the building and would wait a long time to talk with them.

In an observation on 02/02/2024 at 2:45 PM, walking through the town square area there were multiple residents engaged in an ice cream social. R2 was observed to be enjoying their ice cream. R2 was noted to have an excessive amount of facial hair and was unshaved.

In an observation and interview on 02/05/2024 at 7:21 AM, R2 was observed to be unshaved with facial hair. R2 stated they were not impressed with the facility and that their toilet needed to be cleaned. Observation of the toilet showed there was brown matter that resembled feces on the inside lip of the toilet bowl. Inside on the bottom of the toilet bowl had a film of brown substance. On the grab bar on the wall to the right of the call light system's pull cord was a large brown smudged area that resembled feces. R2 stated they did not always get their clothes back from the laundry. R2 stated the staff just leave these bags in their room and pointed to a big clear bag that sat on the ground just inside their room. The large clear bag had R2's name written in black marker on the bag. The bag had folded linens and clothes inside. R2 stated they were unsure if the clothes were clean or dirty.

The Department requested on 02/05/2024 at 3:58 PM, on 02/16/2024 at 6:01 AM, and on 02/20/2024 at 10 AM, for the facility to send all the residents skin check shower sheets for review of the residents showers had been completed. As of 02/21/2024 at 5 PM, the Department did not receive any resident skin check shower sheets for review.

In an interview on 02/01/2024 at 10:09 AM, the Department received a public call from an Anonymous Collateral Contact 1 (ACC1) that stated they had concerns for the facility. ACC1 stated not all medication technicians were nurse delegated but were administering nurse delegated tasks to residents, multiple residents developed skin rashes from not receiving their showers as scheduled, residents family members had expressed concerns that resident's laundry was not getting completed, and multiple employees that included the head nurse (Health and Wellness Director), business office manager, and care staff had quit working there, making unsafe staffing levels for the residents.

In an interview on 02/02/2024 at 8:45 AM, Staff A, Executive Director, stated that their Health and Wellness Director Registered Nurse (Staff G) and their business office manager had quit the day before on 02/01/2024.

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In an interview on 01/24/2024 at 5:31 PM, Collateral Contact 1 (CC1), Daughter of R2, stated they had to hire an additional personal caregiver to ensure that R2's room was getting cleaned and R2 received showers and shaved as they had come to visit R2 on multiple occasions and found feces in R2's bathroom, bed was unmade, and laundry was soiled. CC1 stated they had to hire the personal caregiver because the facility staff were not shaving or showering R2 per their negotiated service agreement. CC1 stated they had to go to the facility's laundry room and observed multiple large plastic bags of soiled laundry. CC1 stated during their visit it was rare to see a care staff in the building and would wait a long time to talk with them.

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In an interview on 02/01/2024 at 10:09 AM, the Department received a public call from an Anonymous Collateral Contact 1 (ACC1) that stated they had concerns for the facility. ACC1 stated not all medication technicians were nurse delegated but were administering nurse delegated tasks to residents, multiple residents developed skin rashes from not receiving their showers as scheduled, residents family members had expressed concerns that resident's laundry was not getting completed, and multiple employees that included the head nurse (Health and Wellness Director), business office manager, and care staff had quit working there, making unsafe staffing levels for the residents.

In an interview on 02/02/2024 at 8:45 AM, Staff A, Executive Director, stated that their Health and Wellness Director Registered Nurse (Staff G) and their business office manager had quit the day before on 02/01/2024.



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In an interview on 02/02/2024 at 3:47 PM, Staff A stated Staff G, Former Health and Wellness Director/Registered Nurse, had expressed concerns prior to quitting about staffing and residents care and services needs were not being provided. Staff A was unaware how many residents that resided at the facility required two person staff assistance.

In an observation on 02/02/2024 from 9:50 AM until 10:04 AM, the door alarm to the emergency exit door leading to the exterior of the building was ringing to alert staff the door had been opened. At 10:00 am an unidentified staff member was observed to walk down the opposite hall and ignore the door alarming. The main locked door to the town square area at the front of the building was propped open. Staff A and an unidentified sales and marketing coordinator were both sitting in their offices while the alarm was ringing without responding. Residents were observed to be walking the hallways near the hall with the door alarming and residents began coming out of their rooms and inquiring about the alarm noise. At 10:03 AM Staff F, Medication Technician, was walking through the town square area into the Clare side of the building. At 10:04 AM, Staff F was observed to come check the alarming door and look to see if any residents had eloped. No staff came and checked the door for elopement of residents from 9:50 AM-10:04 AM. Further observation showed that at no time during or after the incident that staff did a head count to ensure no memory care resident had eloped.

In an observation on 02/15/2024 at 2:35 PM, the door alarm was triggered and alarmed near the "F court refreshment station". There was an un-named resident coming out of the F court refreshment station that was near the call system pull cord with the light illuminated red and alarm ringing. Staff Q, Care Staff, was observed to look at the wall of alarm lights and location and then walked away. Staff Q stated they were not sure where the alarm was triggered from. Staff Q was observed to walked to the end of a hallway and look around. Staff Q stated they thought the alarm was triggered at the end of the hallway. Staff Q was shown by the licensior where the alarm was triggered. Staff Q silenced the alarm at 2:41 PM.

In interview on 02/02/2024 at 2:17 PM, Staff C, Medication Technician, stated she worked the 2 PM-10 PM shift. Staff C stated there were not enough staff scheduled to meet all of the residents needs, especially those requiring two-person assistance. Staff C stated they had approximately four residents requiring two-person assistance in the building. Staff C stated in the case of a fire or emergency, they would not be able to safely evacuate or assist residents as there was not enough staff to stay with residents for supervision, assist two-person assistance residents, and also assist all other residents.

In interview on 02/02/2024 at 3:33 PM, when asked where the facility evacuation meeting place was, Staff A stated, she "did not know and would get it from the fire department."

In an interview on 02/02/2024 at 2:32 PM, Anonymous Staff 1 (AS1), care staff, stated that they were not able to meet all the residents needs due to not enough staff. AS1 stated that the staff were responsible for providing residents with ADL (Activities of Daily Living) care, showers, laundry, and all other care needs. AS1 stated it was impossible to meet all the residents needs with their current staffing. AS1 stated they were unable to provide showers.

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In an interview on 02/02/2024 at 3:47 PM, Staff A stated Staff G, Former Health and Wellness Director/Registered Nurse, had expressed concerns prior to quitting about staffing and residents care and services needs were not being provided. Staff A was unaware how many residents that resided at the facility required two person staff assistance.

In an observation on 02/02/2024 from 9:50 AM until 10:04 AM, the door alarm to the emergency exit door leading to the exterior of the building was ringing to alert staff the door had been opened. At 10:00 am an unidentified staff member was observed to walk down the opposite hall and ignore the door alarming. The main locked door to the town square area at the front of the building was propped open. Staff A and an unidentified sales and marketing coordinator were both sitting in their offices while the alarm was ringing without responding. Residents were observed to be walking the hallways near the hall with the door alarming and residents began coming out of their rooms and inquiring about the alarm noise. At 10:03 AM Staff F, Medication Technician, was walking through the town square area into the Clare side of the building. At 10:04 AM, Staff F was observed to come check the alarming door and look to see if any residents had eloped. No staff came and checked the door for elopement of residents from 9:50 AM-10:04 AM. Further observation showed that at no time during or after the incident that staff did a head count to ensure no memory care resident had eloped.

In an observation on 02/15/2024 at 2:35 PM, the door alarm was triggered and alarmed near the "F court refreshment station". There was an un-named resident coming out of the F court refreshment station that was near the call system pull cord with the light illuminated red and alarm ringing. Staff Q, Care Staff, was observed to look at the wall of alarm lights and location and then walked away. Staff Q stated they were not sure where the alarm was triggered from. Staff Q was observed to walked to the end of a hallway and look around. Staff Q stated they thought the alarm was triggered at the end of the hallway. Staff Q was shown by the licensior where the alarm was triggered. Staff Q silenced the alarm at 2:41 PM.

In interview on 02/02/2024 at 2:17 PM, Staff C, Medication Technician, stated she worked the 2 PM-10 PM shift. Staff C stated there were not enough staff scheduled to meet all of the residents needs, especially those requiring two-person assistance. Staff C stated they had approximately four residents requiring two-person assistance in the building. Staff C stated in the case of a fire or emergency, they would not be able to safely evacuate or assist residents as there was not enough staff to stay with residents for supervision, assist two-person assistance residents, and also assist all other residents.

In interview on 02/02/2024 at 3:33 PM, when asked where the facility evacuation meeting place was, Staff A stated, she "did not know and would get it from the fire department."

In an interview on 02/02/2024 at 2:32 PM, Anonymous Staff 1 (AS1), care staff, stated that they were not able to meet all the residents needs due to not enough staff. AS1 stated that the staff were responsible for providing residents with ADL (Activities of Daily Living) care, showers, laundry, and all other care needs. AS1 stated it was impossible to meet all the residents needs with their current staffing. AS1 stated they were unable to provide showers



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due to not enough staff, and that R4 and another female resident had developed skin issues that had worsened from lack of showers. AS1 stated they did not believe the facility had enough staff to safely evacuate or meet residents needs in an emergency, including on day shift. AS1 stated laundry tasks had fallen to the caregivers and they were not able to keep up. AS1 stated families had been voicing lots of frustrations and complaints. AS1 stated that because they work in memory care, there tends to be an increase in resident behaviors in the evenings as they sundown.

In an interview on 02/02/2024 at 2:48 PM, Staff J, Care Staff, stated they typically worked evenings, and staffing consisted of one caregiver on each side of the building (Clara and Bridge), and one medication technician shared between the two sides of the building. Staff J stated sometimes there was only herself and a medication technician in the building. Staff J stated that last night she was on shift with a medication technician and herself. Staff J stated residents did not receive showers due to short staffing, and that they had to prioritize immediate care needs for residents. Staff J stated they felt they could not safely evacuate or meet residents needs in an emergency due to not enough staff.

In an observation on 02/02/2024 at 9:26 AM, the Bridge side laundry room was observed to have no soap in the dispenser, the soap inside had curdled and hardened and would not dispense. The handwashing sink was full of mop heads, resident clothing, soiled clothes, a red bucket, and a rubber door seal. The paper towel dispenser did not dispense towels. The door to the laundry room was unlocked and accessible to the memory care residents. In the unlocked cabinet above the washer was solid laundry detergent. There were no staff observed in the area.

In an observation on 02/02/2024 at 9:36 AM, the shower room by the F court wing had a shower chair speckled with brown matter. There was an adult incontinent brief sitting inside the bathtub. There were 2 large bags of linens and residents clothing on the floor by the wall with brown matter splattered across. The door to the toilet room was blocked with bags of soiled clothing and linens sitting on the floor in front of the door. There were items stored in the bathroom sink and in front of the toilet making the toilet room inaccessible.

In an observation on 02/02/2024 at 9:41 AM, the E court shower room was observed to have clothes on the floor blocking the door from opening. Inside the room there were towels and residents clothing strewn about on the floor and in bags piled against the wall.

In an interview and observation on 02/02/2024 at 9:44 AM, Staff K, Housekeeper, stated they did not normally do laundry but was doing it today. Staff K stated they started at the facility approximately three weeks prior. Staff K acknowledged that there was clean and soiled laundry intermixed in the laundry room. When asked where staff could wash their hands, Staff K stated they were unsure as the sink in the laundry room they were in had piles of clothes and baskets blocking access to the sink, the water did not turn on, there was no soap, and no trash bag in the trash can.

In an interview and observation on 02/02/2024 at 10:23 AM, of the laundry room by the B court, Anonymous Staff 2 (AS2) stated they were not working the floor today, and that they

due to not enough staff, and that R4 and another female resident had developed skin issues that had worsened from lack of showers. AS1 stated they did not believe the facility had enough staff to safely evacuate or meet residents needs in an emergency, including on day shift. AS1 stated laundry tasks had fallen to the caregivers and they were not able to keep up. AS1 stated families had been voicing lots of frustrations and complaints. AS1 stated that because they work in memory care, there tends to be an increase in resident behaviors in the evenings as they sundown.

In an interview on 02/02/2024 at 2:48 PM, Staff J, Care Staff, stated they typically worked evenings, and staffing consisted of one caregiver on each side of the building (Clare and Bridge), and one medication technician shared between the two sides of the building. Staff J stated sometimes there was only herself and a medication technician in the building. Staff J stated that last night she was on shift with a medication technician and herself. Staff J stated residents did not receive showers due to short staffing, and that they had to prioritize immediate care needs for residents. Staff J stated they felt they could not safely evacuate or meet residents needs in an emergency due to not enough staff.

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In an interview and observation on 02/02/2024 at 10:23 AM, of the laundry room by the B court, Anonymous Staff 2 (AS2) stated they were not working the floor today, and that they



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were just there to do laundry. The sink was observed to have a giant grey blanket in it, blocking access and use of the sink. The floors of the laundry room were covered in plastic bags of linens, resident clothing, and towels, creating a narrow pathway through the center of the narrow room. The bagged items on the floor were stacked from the floor to past the handle on the door (halfway up the wall). The door to the bathroom area from the laundry room was blocked by bags of soiled laundry stacked in front of the door. The trash can was observed to have a full trash bag stacked on top of the overflowing trash can. When asked how AS2 would wash their hands, AS2 stated she could not currently access the sink to wash her hands as it was full of clothing items and blocked from use. There was no hand sanitizer available in the room. AS2 stated she had not been able to provide four residents their showers she was assigned due to other tasks and assignments taking priority. AS2 stated the care staff scheduled on day and evening shift were to provide three to four scheduled resident showers. AS2 stated they would often be asked to complete more resident's showers as they were not provided on their scheduled day. AS2 stated it was often they would not be able to provide the residents their showers. AS2 stated they documented the residents shower that were completed on a skin check shower sheet. AS2 stated the skin check shower sheets were turned into the health and wellness director. AS2 stated they were not able to provide showers for the residents on their scheduled day shift on 01/13/2024 and 02/01/2024. AS2 stated they typically worked the day shift 8 AM until 2 PM. AS2 stated they had taken care of 23 residents with just a medication technician to help assist with resident care needs. AS2 stated they would not be able to physically get R1 or all of the residents out of the facility independently without a second staff member if they needed to evacuate the residents out of the facility in an emergency. AS2 stated the care staff were responsible to complete the resident's laundry during their shift. AS2 stated they would not have enough time to provide the care and services to their residents and complete the resident's laundry before the end of their shift at 2 PM.

In an interview on 02/02/2024 at 3:18 PM, Staff C, Medication Technician, stated they were the only medication technician on evening shift between the times 6 PM until 8:30 PM or 9:30 PM when Staff L, Health and Wellness Coordinator, came on shift. Staff C stated during the times that they were the only medication technician there were only one care staff for each side without a care staff to float.

In an interview on 02/02/2024 at 3:47 PM, Staff A stated when a resident's shower was completed, a care staff would fill out a skin check shower sheet. Staff A stated the shower sheets were turned in to Staff G. Staff A stated since Staff G left employment at the facility on 02/01/2023, Staff A had not received any skin check shower sheets for review. Staff A stated they had not seen the laundry room's conditions. Staff A stated family members had expressed concerns about residents laundry not being completed or long periods of them being not returned to the resident, and was aware of the concerns. Staff A stated they were aware care staff were staying over or coming in on their day off to complete resident laundry.

In an interview on 02/02/2023 at 10:23 AM, AS2 stated they were the only caregiver that worked from 6 am until 2 PM on 01/23/2024. AS2 stated they were unable to complete all of the resident's showers that were scheduled. AS2 stated there were four residents that required two-person assistance for care related to transfers and behaviors. AS2 stated they had to provide care to residents that required two-person assistance independently.



were just there to do laundry. The sink was observed to have a giant grey blanket in it, blocking access and use of the sink. The floors of the laundry room were covered in plastic bags of linens, resident clothing, and towels, creating a narrow pathway through the center of the narrow room. The bagged items on the floor were stacked from the floor to past the handle on the door (halfway up the wall). The door to the bathroom area from the laundry room was blocked by bags of soiled laundry stacked in front of the door. The trash can was observed to have a full trash bag stacked on top of the overflowing trash can. When asked how AS2 would wash their hands, AS2 stated she could not currently access the sink to wash her hands as it was full of clothing items and blocked from use. There was no hand sanitizer available in the room. AS2 stated she had not been able to provide four residents their showers she was assigned due to other tasks and assignments taking priority. AS2 stated the care staff scheduled on day and evening shift were to provide three to four scheduled resident showers. AS2 stated they would often be asked to complete more resident's showers as they were not provided on their scheduled day. AS2 stated it was often they would not be able to provide the residents their showers. AS2 stated they documented the residents shower that were completed on a skin check shower sheet. AS2 stated the skin check shower sheets were turned into the health and wellness director. AS2 stated they were not able to provide showers for the residents on their scheduled day shift on 01/13/2024 and 02/01/2024. AS2 stated they typically worked the day shift 6 AM until 2 PM. AS2 stated they had taken care of 23 residents with just a medication technician to help assist with resident care needs. AS2 stated they would not be able to physically get R1 or all of the residents out of the facility independently without a second staff member if they needed to evacuate the residents out of the facility in an emergency. AS2 stated the care staff were responsible to complete the resident's laundry during their shift. AS2 stated they would not have enough time to provide the care and services to their residents and complete the resident's laundry before the end of their shift at 2 PM.

In an interview on 02/02/2024 at 3:18 PM, Staff C, Medication Technician, stated they were the only medication technician on evening shift between the times 6 PM until 8:30 PM or 9:30 PM when Staff L, Health and Wellness Coordinator, came on shift. Staff C stated during the times that they were the only medication technician there were only one care staff for each side without a care staff to float.

In an interview on 02/02/2024 at 3:47 PM, Staff A stated when a resident's shower was completed, a care staff would fill out a skin check shower sheet. Staff A stated the shower sheets were turned in to Staff G. Staff A stated since Staff G left employment at the facility on 02/01/2023, Staff A had not received any skin check shower sheets for review. Staff A stated they had not seen the laundry room's conditions. Staff A stated family members had expressed concerns about residents laundry not being completed or long periods of them being not returned to the resident, and was aware of the concerns. Staff A stated they were aware care staff were staying over or coming in on their day off to complete resident laundry.

In an interview on 02/02/2023 at 10:23 AM, AS2 stated they were the only caregiver that worked from 6 am until 2 PM on 01/23/2024. AS2 stated they were unable to complete all of the resident's showers that were scheduled. AS2 stated there were four residents that required two-person assistance for care related to transfers and behaviors. AS2 stated they had to provide care to residents that required two-person assistance independently.



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In an interview on 02/02/2024 at 1:45 PM, Staff E, Medication Technician, stated for one side of the building the facility staffed one medication technician and one caregiver. Staff E stated they would not safely be able to get all the residents out of the facility in an event of emergency and evacuation with the current staffing ratio.

In an interview on 02/02/2024 at 2:28 PM, Anonymous Staff 3 (AS3), Care Staff, stated they often worked on one side of the facility during evening shift, as they were the only scheduled care staff. AS3 stated they "absolutely not" be able to safely evacuate residents if they needed to in an emergency. AS3 stated three residents required two staff members assistance with transfers and because of behaviors for all care.

In an interview on 02/02/2024 at 2:32 PM, AS1 stated they often worked with one care staff and one medication technician for one side of the facility. AS1 stated it was a lot work for the two staff members. AS1 stated they were responsible to pass medications for all of the residents on the side they were scheduled on and for any delegated tasks on the other side of the facility as they were the only nurse delegated medication technician. AS1 stated it was often that they were unable to provide residents their scheduled showers and laundry. AS1 stated R4 had a red rash that had an odor under both of their breasts and groin. AS1 stated the area continued to get worse when care staff were unable to provide R4 their scheduled shower. AS1 stated they would not be able to safely or had enough staff on shift to evacuate the residents in an emergency. AS1 stated the residents experienced more behaviors on the evenings that required the care staff to redirect and observe the residents closely.

In an interview on 02/15/2024 at 11:27 AM, Staff D, Medication Technician, stated on 02/11/2024 for day shift 8 AM until 2 PM, they worked with the medication technician. Staff D stated at 2 PM, they worked as the medication technician for Bridge. Staff D stated a care staff walked off the job leaving Staff D working alone for Bridge side of the building. Staff D stated there was one medication technician and one care staff that worked on Clare side. Staff D stated they were told Staff M, Care Staff, had stayed over from day shift to work for evening shift to help. Staff D stated when they called for help or would ask where Staff M was at, Staff M would not answer or was not where to be found on Bridge side of the building. Staff D stated staff M had left the facility without telling anyone sometime on the evening shift. Staff D stated they were unable to transfer and provide care to R5 and R6 from 2 PM until 6 PM, as Staff D was acting as both the medication technician and caregiver by themselves. Staff D stated they did not provide any showers or complete any laundry for any residents that day. Staff D stated they were passing medications and providing personal care for all 23 residents on Bridge side of the building. Staff D stated "it was so unsafe" for them to be the only care staff. Staff D stated R4's daughter brought in new medication that they stated was for R4's skin. Staff D stated they did not have time to review the medication in the bag and had placed the bag into the medication cart. Staff D stated Resident 7 (R7) was exit-seeking. R7 had activated the furnace door alarm that required Staff D to redirect R7 and ensure they did not leave the facility, leaving all other residents unattended in the dining room. Staff D stated there were two other residents that were experiencing an increase in behaviors during that time that required more of Staff D's attention. Staff D stated they had to leave the residents unattended in the dining room to get the residents dinner plates. Staff D stated they had to leave residents in the dining room while eating unattended to go to the kitchen to get the residents desserts.



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In an interview on 02/15/2024 at 11:44 AM, Staff J, Care Staff, stated they had come into the facility on 02/11/2024 at 3 PM to see if the residents were getting ready for the super bowl party. Staff J stated a new staff member was having a panic attack being on the floor by themselves. Staff J stated Staff C informed them that the new staff member left the facility and did not return. Staff J stated they were asked to come in at 6 PM to help as they did not have enough staffing. Staff J stated they were unsure who they relived when they came in at 6 PM that day.

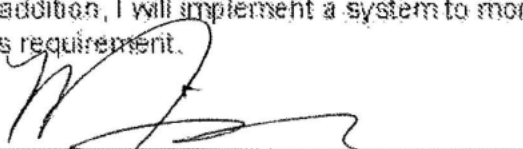
In an interview on 02/15/2024 at 12:45 PM, Staff I, Care Staff, stated on 02/11/2024 they were the only care staff during the time period, 2 PM until 10 PM, and was training a new staff member. Staff I stated the trainee and themselves were the only care staff scheduled for that shift. Staff I stated the new staff member had gotten overwhelmed and left the facility around 3 PM. Staff I stated at 7 PM they had gone to Bridge side of the facility and helped Staff J lay R6 down for bed and out of their wheelchair. Staff I stated R6's brief was heavily soiled and had leaked causing R6's clothes to be wet with urine. Staff I stated R6 had a strong odor of urine when they provided care to them. Staff I stated they also had assisted Staff J lying R5 down for bed from their wheelchair. Staff I stated R5's brief was heavily soiled with urine. Staff I stated there was no management that had come into the building to help with the staffing shortage that day. Staff I stated they did not have the time to provide any showers or laundry services for any residents that day.

Record review of the facility's document, titled, "Condensed Employee Time Detail [time card punches]", dated 01/19/2024 through 02/05/2024, showed on 02/11/2024 for evening shift there were two medications technicians and one care staff from 2 PM until 3:15 PM when another care staff clocked on shift. At 4:30 PM one care staff ended their shift leaving two medication technicians and one care staff for 47 residents across the two separate units until 6 PM. Comparison of the time card punches to the clinical schedule, showed the facility did not staff to the levels they indicated were necessary and documented.

**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, 3/10/24).

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

  
\_\_\_\_\_  
Administrator (or Representative)

3/10/24  
\_\_\_\_\_  
Date

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

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\_\_\_\_\_  
Administrator (or Representative)

\_\_\_\_\_  
Date