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

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

RE: Brookdale Olympia West License # 2497

Dear Administrator:

This letter addresses Compliance Determination(s) 41429 (Completion Date 05/17/2024) and 38232 (Completion Date 03/26/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/17/2024 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-2630-1-a

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

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

Sincerely,

Cory Cisneros

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia West
Provider Type: Assisted Living Facility
License/Cert.#: 2497
Compliance Determination #: 38232
Intake ID: 119315
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/13/2024 through 03/26/2024
Complainant Contact Date(s):

Allegation(s):
1) allegation that there were incidents that involved a staff member that were allegation of abuse & neglect

Investigation Methods:

Sample:
Total residents: 42
Resident sample size: 3
Closed records sample size: 1

Observations:
Identified resident
Residents
Resident rooms
Staff to resident interactions

Interviews:
Identified resident
Identified staff
Nursing staff
Residents

Record Reviews:
Medical records
State reporting log
Incident investigation
Facility policies
Personnel files

Investigation Summary:
1) after record review and interviews the facility failed to report two incidents to the State complaint resolution unit when allegations of abuse were reported to the facility.

Conclusion / Action:

- [x] 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 # 38232
Plan of Correction	Brookdale Olympia West	Completion Date
Page 1 of 4	Licensee: BKD Clare Bridge of Olympia LLC	03/26/2024

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 03/13/2024 and 03/26/2024 of:

Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following complaint number(s): 119315

The following sample was selected for review during the unannounced on-site visit: 3 of 42 current residents and 1 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

04/03/2024
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.

Administrator (or Representative) 4/12/24 Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report allegations of abuse and neglect for 2 of 3 sampled residents (Resident 1[R1] and Resident 2 [R2]). This failure placed all residents who were involved in allegations or incidents of abuse at risk of unmet care and services due to the departments inability to investigate the incident.

Findings included...

Record review of the facility's policy titled, "BAIRS Incident Reporting Policy", dated 01/2024 (no day documented), showed "in the event that a resident or visitor experiences an occurrence, the associate reporting the incident must either complete the preliminary draft notes of a reported incident or enter the incident into the facility's automated incident reporting system ("BAIRS") in accordance with this policy". In the event that a resident or visitor experiences an occurrence such as, but not limited to fall, alleged aggressive behavior, abuse, and neglect, the associate reporting the incident along with the supervisor or management representative, must either complete the preliminary draft notes of a reported incident ("draft incident notes") or enter the incident into the BAIRS during the shift on the day of the incident. The policy does not replace the Reportable Events Policy. The Executive Director, or designee, should notify the appropriate leadership above the community of occurrences according to the reportable events policy and procedure and the reportable events categories/reporting time frames grid.

Record review of the Department of Social and Health Services, "Assisted Living Guide Book", dated February 2018, Chapter one, showed facilities were required to report 24 hours a day, seven days a week to the departments Complaint Resolution Unit (CRU) hotline via phone or online for any reasonable cause to believe violations involving abuse or neglect. Under the section "What to Report to The Department", stated where there was reasonable cause to believe violations had occurred involving abuse and neglect.

Record review of R2's progress note, dated 02/20/2024 at 7:39 PM, showed R2 was out of character, upset, and had a difficult morning. R2 reported that a night shift caregiver was

"rough" with their personal care. R2 told Staff E, Health & Wellness Coordinator/Licensed Practical Nurse, that the night caregiver was "verbally mean" and was not gentle with their personal care. The executive director (Staff A) was aware of R2's complaints.

Record review of Staff C's, Caregiver", "Corrective Action", dated 02/15/2024, showed "on 02/05/2024 [Staff C] were observed to not speak kindly with residents [R2], also it was reported that you left residents wet or unchanged and that you intentionally placed call light cords out of reach of your resident [R1]... because they call for no reason or cannot remember why they called. These actions are not conducive to good resident care and are in violation of the [facility] guidelines for appropriate conduct... this not only affects our residents; it affects your ability to work together with peers". The corrective action was related to incidents involving Resident 1 and Resident 2.

Record review of the facility's "Incident Log", dated 03/13/2024, showed it was a log of all the incidents that occurred with the residents for date range 02/01/2024 through 03/06/2024. The log showed there were no allegations of abuse or neglect by staff recorded or documented for R2 or R1.

Record review of the Departments database showed there were no reported incident on or around 02/06/2024 for possible allegation of abuse or neglect against Staff C from R1. The database showed there were no reported incident for the possible allegation of abuse or neglect against Staff C from R2.

In an interview on 02/15/2024 at 11:04 AM, Staff D, Medication Technician, stated on 02/06/2024 during the night to day shift walking rounds in R1's room, R1's pull cord for their call light was taped on the wall out of R1's reach. Staff D stated Staff C had been terminated from employment at the facility. Staff D stated Staff F, District Director of Clinical Service, and Staff A, Executive Director were notified about the call light. Staff D stated Staff E, Health & Wellness Coordinator, saw the call light taped up on the wall where R6 was unable to reach. Staff D was unaware if the incident had been reported to the Department.

In an interview on 03/13/2024 at 1:55 PM, Staff B, Regional Clinical Services Director, stated there were only incident reports dated 02/27/2024, 02/18/2024, and 01/27/2024 recorded for R1. Staff B stated none of the incident's listed were related to when R1's call light was taped up on the wall out of the reach of R1's use. Staff B stated that incident did place R1 at jeopardy and an incident report should have been completed with an investigation. Staff B stated the incident should have been reported to the Department. Staff B stated the allegation of abuse incident with R2 and Staff C was not reported to the Department.

In an interview on 03/13/2024 at 2:36 PM, Staff A, Executive Director, stated they were unsure if the incidents with Staff C that R1, and R2 were involved with were reported to the Departments CRU hotline number.

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In an interview on 03/25/2024 at 10:22 AM, Staff A stated the incidents of allegation of abuse against Staff C that R2 reported and was observed in R1's room were not reported to the Departments CRU hotline number.

This is a recurring deficiency that was previously cited on 07/28/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Olympia West is or will be in compliance with this law and / or regulation on (Date) 5/10/24.

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

Administrator (or ~~Representative~~) Date 4/12/24