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) 48246 (Completion Date 10/04/2024) and 44181 (Completion Date 07/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/04/2024 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-2660, WAC 388-78A-2660-1, WAC 388-78A-2660-2, WAC 388-78A-2450, WAC 388-78A-2450-1, WAC 388-78A-2450-1-a

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

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

Sincerely,

Cory Cisneros

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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia West
Provider Type: Assisted Living Facility

License/Cert.#: 2497
Intake ID: 137146
Compliance Determination #: 44181
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 07/16/2024 through 07/18/2024
Complainant Contact Date(s):

Allegation(s):

1. Physical Environment: Anonymous public report of cold water temperatures in resident showers.
2. Quality of Care/Treatment: Anonymous public report of facility management instructing staff to pour cold water over a resident after the water pressure and temperature decreased during a shower.
3. Administration/Personnel: Anonymous public report of facility management instructing staff to pour cold water over a resident after the water pressure and temperature decreased during a shower.

Investigation Methods:

Sample:
Total residents: 41
Resident sample size: 5
Closed records sample size: 0

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

Interviews:
Identified resident
Family members
Nursing staff
Management

Record Reviews:
Facility policies
Negotiated Service Plans
Staff Schedules
Shower Documentation

Investigation Summary:

1. Physical Environment: Facility currently out of compliance with water temperatures. See Statement of Deficiencies dated 06/26/2024 for more details.

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2. Quality of Care/Treatment: Claims substantiated. Facility found to pour cold water over resident, causing them to yell out in discomfort after they lost water pressure, and temperature during a resident shower, and confirmed staff were following instructions of management staff through multiple staff interviews. Failed practice identified.
3. Administration/Personnel: Claims substantiated. Facility found to pour cold water over resident, causing them to yell out in discomfort after they lost water pressure, and temperature during a resident shower, and confirmed staff were following instructions of management staff through multiple staff interviews. Failed practice identified.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia West
Provider Type: Assisted Living Facility

License/Cert.#: 2497
Intake ID: 136782
Compliance Determination #: 44181
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 07/16/2024 through 07/18/2024
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Public report of low staffing in the community, which is affecting resident care.

Investigation Methods:

Sample:
Total residents: 41
Resident sample size: 5
Closed records sample size: 0

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

Interviews:
Identified resident
Family members
Nursing staff
Management

Record Reviews:
Facility policies
Negotiated Service Plans
Staff Schedules
Shower Documentation

Investigation Summary:
Quality of Care/Treatment: Claims substantiated. Facility failed to provide resident showers, as per the negotiated service agreement, due to lack of staff. This was confirmed through multiple staff interviews, observation and document review. Failed practice identified.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

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☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2497	Compliance Determination # 44181
Plan of Correction	Brookdale Olympia West	Completion Date
Page 1 of 12	Licensee: BKD Clare Bridge of Olympia LLC	07/18/2024

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 07/16/2024 and 07/18/2024 of:

Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following complaint number(s): 137146, 136782

The following sample was selected for review during the unannounced on-site visit: 5 of 41 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

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

Cory Cisneros
Residential Care Services

07/31/2024
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.

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Administrator (or Representative)

7/31/24
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the Assisted Living memory care Facility (ALF) failed to ensure that care and services provided to residents in the community maintained or enhanced each resident's dignity for 1 of 1 resident reviewed (Resident 1, R1). This failure caused R1 to experience physical discomfort, emotional distress, and placed R1 and all 41 residents who receive showers in the facility at risk of decreased quality of life.

Findings included ..

RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Review of department records showed a report of concern for resident well-being, dated 07/03/2024. It stated Staff D, a Caregiver, and Staff E, a Med Tech/Caregiver, were providing a shower to R1. During the shower it was reported that the shower malfunctioned, which caused the water pressure to weaken and the hot water to turn cold. Staff D and Staff E reported the malfunction to Staff C, the Resident Care Coordinator. It was reported that Staff C instructed Staff D and Staff E to fill a bucket of cold water from the shower room and pour it on the R1 to remove the soap and complete the shower. The report stated that Staff D refused to do this and requested Staff C to come to the shower room to assist. It was then reported that Staff C and Staff E filled a bucket with cold water and poured it on R1. The report stated that R1 was non-verbal, but stated R1 opened their eyes wide, made vocalizations, and that it was apparent that R1 was in distress and unhappy.

In an interview on 07/16/2024 at 9:50AM, Staff A, the Executive Director, was asked to explain if there was an issue with the water in the resident shower rooms. Staff A stated, "It is still ongoing. It is a mixing valve they are trying to have fixed. They came out and diagnosed it. They turned the temps [temperatures] up a little bit so we could get hot water. The hot water was kicking off, due to back-to-back showers. We have quoted it to be fixed and it is going to be around $4,000 to $13,000. it is authorized for

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repair." Staff A stated the water issue specifically is that "It is affecting pressure. It is affecting mix [of cold and hot water]. We have talked to [the staff] about it. We told them that if they notice there is a problem, they have to stop and then wait for water to heat up again. [Staff] have been moving residents to other shower room if there is an issue." Staff A was asked what staff are instructed to do if the water pressure dropped or went cold during a shower and the resident was still covered in soap. She stated, "I would recommend they use a washcloth and help that resident to the best of their ability… If they are soapy, we got to get them." Staff A was asked if the water pressure and temp is only affecting showers. "My understanding is that is in the showers, and it is not in the sinks."

Review of R1's Face Sheet showed that R1 was admitted to the facility on [redacted]/2013.

Review of R1's Personal Service Plan/PSP (Negotiated Service Agreement), dated 04/19/2024, showed that it was unsigned by facility representative and resident representative. Under the section titled, "Medications," it stated "[R1] is unable to tell staff if [they are] in pain. Monitor for grimacing, crying, decreased mobility, or irritability."

In an interview and observation on 07/16/2024 at 11:08AM, R1 was observed to be in their wheelchair. R1 appeared to be in clean clothing, but R1's hair appeared greasy, and unwashed. R1 was asked how they felt today, and if they recalled any incidents where cold water was poured onto their skin during a shower. R1 did not answer. It was observed that R1 was non-verbal, and unable to answer further questions.

In an interview on 07/15/2024 at 1:09PM, Staff D was asked if they had any information about the incident where cold water was poured onto R1. Staff D stated, "I was here that day. It was myself and my partner at the time which was [Staff E]. [Staff E] took [R1] into the shower room and called me in to assist. We turned it on and there was water pressure, and it was warm. We got [R1] undressed and in the shower chair. I left the room at that point. [R1] is a 2-person transfer but once [they are] in there, we can do it with one person. I got called back in when the water got cold, and [R1] was covered in soap and was asked to help. We decided to [take R1 and] go from C Court shower [room] to B Court shower [room]. It was the same issue, there was no water pressure, and the water was cold. I started to panic and called radio and asked management to assist. At the time that was [Staff C]. [Staff C] told us to get a bucket. [They] said to fill it up, and to dump water on [R1] to rinse her off." Staff D was asked where the water was obtained for the bucket. Staff D stated, "Next to the shower room is the laundry room with a sink. That water was also cold. I told [Staff C] it was cold also and asked [them] to come [and assist]. [Staff C] came, and [they] started to fill it up. I told [Staff C] again that it was cold, and [Staff C] said, "There is no other option at this point." I left the bathroom and I listened to them outside the door pour cold water on R1. [R1] is not able to speak or walk. There is no way for her to get away. There were no words, but [R1] was screaming out." Staff D was asked what exactly they heard. Staff D stated, "I heard her yelling, and hollering. It sounded distressful." "My personal opinion, how I feel inside, is that I have the right to refuse what you are asking me to do, and I refused. It brought me to tears. I can't comprehend that kind of thing."

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In an interview on 07/16/2024 at 10:06AM, Staff C was asked if they had any information about the cold water in the resident shower rooms. Staff C stated, “I know sometimes the water temperatures dip or the pressure. There is a valve they are going to be replacing that is causing that. But if they wait like 15-20 minutes the pressure and temp will come back up.” Staff C was asked if they had any information regarding an incident where cold water was poured onto R1. Staff C stated, “There was. The water went cold. They moved the resident to the other shower room. There is a bathroom in between the shower rooms. So, they brought the resident over there and finished the shower.” Staff C was asked if the water was warm in the other shower room. Staff C stated, “I think the water was still cold.” Staff C was asked if they could name which resident this happened to. Staff C stated, “[R1].” Staff C was then asked if a bucket was used to pour water onto the R1. Staff C stated, “If I remember correctly, they moved [R1] from one shower to another. It heated back up and then it dipped again. And they had to rinse [R1] with a bucket… “They called me on the walkie and told me what was happening. I told them that there was a bucket they could use. By the time I got there, they were done.” Staff C was asked if they could clarify what exactly staff did to complete R1’s shower. Staff C stated, “They put the water in a bucket and rinsed [R1] off. The pressure also dropped too.” Staff C was asked if they knew where the water was obtained for the bucket. Staff C stated, “I believe it was out of the same shower. I don’t know how cold it was. They rinsed [R1] off, so [they were] not soapy.” Staff C was asked if they thought the water used in the bucket was cold. Staff stated, “I don’t know that it was cold. They told me they lost pressure. I don’t know.” Staff C was asked which staff were present during R1’s shower. Staff C stated, “One was [Staff D], but I cannot remember who the other one was.” Staff C was asked if they felt that it was dignified to pour cold water onto a resident during a shower. Staff C stated, “No.”

In an interview on 07/16/2024 at 10:26AM, Staff B, the Health and Wellness Director, was asked if they were aware of the cold-water issue in the resident shower rooms and if they were aware of any residents who were affected by the malfunction. Staff B stated, “Yes, initially when the mixing valve broke, [staff] had to go to another shower room. Staff brought wash cloths, warmed them, and we got the resident shower completed as best we could. We space them [showers] out to ensure the water can heat back up. It seems to keep the temperature throughout. We try to work our best around the situations.” Staff B was asked if they were aware of the incident where cold water was poured onto R1. Staff B stated, “What I was told was that the water was not warm, but it was more moderate than they were getting out. I am not sure if the information got miscommunicated to me, but my understanding is that [staff] used washcloths and the bucket. I talked to [Staff E] about it.”

In an interview on 07/16/2024 at 10:45AM, Staff E was asked if they were aware of the cold- water temperatures in the resident shower rooms, and if they knew of any residents who were affected by the malfunction. Staff E stated the water became cold in middle of R1’s shower. Staff E was asked if they could name which resident this happened with. Staff E stated that it had happened multiple times, to multiple residents. Staff E was asked if they could name a resident that they remember this happening to. Staff E stated this occurred recently with R1. Staff E was asked to explain the incident. Staff E stated, “[In] D Court shower room, the water is cold. We have to use other shower rooms to finish sometimes. I discovered that the water got cold, and we had to cut [R1’s] shower short.” Staff E was asked if they could explain in greater detail what

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actions they took after discovering the water was cold. Staff E stated, "We had to use a bucket to rinse [R1] off... [We] gave her shower and, in the middle, while covered in soap, the water just stopped working, there was no water. We had to wheel [R1] through the bathroom into B Court showers. I got [R1] set up in there. Turned water on, and it was warm and fine, and then just stopped working again. Then I called over the walkie for some assistance and got a response from [Staff C] was to use a bucket that we have in the shower room. We went in and grabbed the bucket and filled it up from the laundry room sink and got water to help rinse [R1]." Staff E was asked if they recalled the temperature of the water. "It wasn't freezing, but it wasn't warm... We used the bucket and poured a little bit, by little bit to try and get the soap off." Staff E was asked if they could remember how R1 reacted to this pouring of the water onto their skin. "It was cold. [R1] screamed out and jumped for sure." Staff E was asked if they felt it was dignified to pour cold water onto a resident during a shower. "Absolutely not. I would be pissed off it was me."

This is a recurring deficiency previously cited on 04/21/2022.

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) 8/31/24.

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

Administrator (or Representative) — Date 7/31/24

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;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the Assisted Living memory care Facility (ALF) failed to provide sufficient staff persons to furnish the agreed upon care and services, for 5 of 5 residents reviewed, (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], and Resident 5 [R5]). This failure resulted in R1, R2, R3, R4, R5 not receiving care and services as per their signed Negotiated Service Agreement and placed all 41 of 41 residents who receive care and services in the facility at risk of unmet care needs and decreased quality of life.

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Findings included...

Review of department records showed a report of concern, dated 07/01/2024. The report stated there was a lack of staff, which was alleged to affect resident care. In the report, it stated concerns of the facility being understaffed. The report stated that the facility was utilizing an Agency to staff the building but has since pulled/removed Agency support as of July 2024. Reporter stated that they felt residents are unsafe due to insufficient staffing in the facility.

In an interview on 07/16/2024 at 9:50AM, Staff A, the Executive Director, was asked to explain what optimal staffing would look like in the facility. Staff A stated, “It is based on acuity. The program [used to calculate the acuity of residents] dictates 30 staffing hours as safety. Then each shift has more or less depending on whatever the [resident] tasks are. We staff according to that. And people either call out or they don’t. We try and hire people, two-weeks to be professional.” Staff A was asked what they meant by ‘two-weeks to be professional.” Staff A stated they were talking about on-boarding staff giving their previous positions/facilities notice before starting work. Staff A was asked with today’s facility census how many staff were scheduled on shift. Staff A stated, “Today we got two Med Techs (Medication Technicians), and 4 care staff on the floor. Staff A stated that on each of the two wings of the facility (Clare and Bridge), there is one Med Tech, and two caregivers. “We have the RCC (Resident Care Coordinator) here, two nurses here. They are not counted in that. But they are supposed be counted in the acuity numbers. This weekend we had call outs, and the nurse was here working the floor. We have stopped agency as of the 6th (July). The goal was to be done by this date.” Staff A was asked if they had concerns of staffing issues in the facility. “We are not perfect. But we are really, really close. Staff always feel like they do not have enough. It is hard for staff to understand that we are using acuity to base staffing needs.” Staff A was asked if they felt that all the care needs of residents could be met as per the agreement today with the census and staff present on the floor. Staff A stated, “If all residents had perfect behavior and had no problems, then yes.” Staff A was asked if they were aware of any residents not getting the care they agreed upon, due to staffing issues. “I am not aware of them. They may be slower to get there. But not, not being met.” Staff A was asked generally how many staff were scheduled to work on the floor. Staff A stated there are times where the RCC can run both carts, which could free the Med Techs to assist with resident care on the floor. Staff A stated there are usually 3 to 4 caregivers scheduled to work on the floor. “Med Techs jump off the cart to the floor. Also having the nurse available to come help as well. This week has been tight. We are waiting that 2-week period for staff to be on boarded. We had a wave of 3 or 4 hires, and they are giving notice from [their previous facilities]. It is making it difficult.”

In an interview with Collateral Contact 1 (CC1) a former facility caregiver, on 07/17/2024 at 12:04PM, CC1 was asked if they had any concerns with insufficient staffing at the facility. CC1 stated, “One thing for sure is they are always very low staffed. They put you on one [wing], with 13-15 residents and it is just not something that one caregiver can handle. They [management] do not care. If someone doesn’t show up to work, they don’t really care. They just go about their day and don’t help on the floor.” CC1 stated that their biggest concern was when Staff A was pulling agency

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out of the building when “we didn’t even have enough staff to cover on a regular basis.” CC1 was asked exactly how many staff were usually on the floor. CC1 stated, “One day it was just 2 caregivers, one on each side; One med cart person, and maybe another caregiver.” CC1 stated again that if they were unable to complete resident tasks as per the resident agreement, due to lack of staffing. CC1 stated, “There would be times where we can’t get to certain residents. It is just such a big load that it takes all day long. Showers would get missed.” CC1 was asked how often this would occur. CC1 stated, “It would happen very often. Not every day, but it would be because we did not have enough people to do what we needed to do, and to add showers on top of that? No way… Residents there are absolutely not getting showered like they are supposed to.”

In an interview with Staff F, a Med Tech, on 07/15/2024 at 12:47PM, Staff F was asked if they had any concerns with insufficient staffing at the facility. Staff F stated, “Oh Yeah! Right now, they are working with one Med Tech and one Caregiver on each side. I will help care staff, but there certain are Med Techs that will not get off the med cart to help.” Staff F was asked if these concerns were ever brought up with management. Staff F stated, “Management is not doing anything.” Staff F was asked if there are any specific incidents that they can recall where resident care was impacted due to staffing issues. Staff F stated, “When we are short staffed, we cannot do showers.” Staff F was asked if they remember the last time they personally were not able to complete a resident shower due to staffing. Staff F stated, “Last weekend.”

In an interview with Staff D, a Caregiver, on 07/15/2024 at 1:09PM, Staff D was asked if they had any concerns with insufficient staffing at the facility. Staff D stated, “I do… We have expressed concerns to management and there is nothing done… “We can’t give residents full care, because if we take 15 minutes with a resident, that is 15 minutes that I can’t watch the other residents.” Staff D was asked if by stating this that they meant they were the only staff scheduled on the floor to care for and monitor residents. Staff D confirmed this was accurate. Staff D was asked if the Med Tech could assist with care, or monitoring. Staff D stated, “The Med Tech is there, and they can assist, but I was told that I cannot rely on them.” Staff D was asked if they had any specific incidents that they can recall where resident care was impacted due to staffing issues. “There have been more falls because of the staffing. wanderers or exit seekers. If I am in resident care, and then I cannot watch residents exit seeking. We cannot monitor. Sometimes showers don’t get done.” Staff D was asked if there were any times where they specifically did not follow a resident’s care plan due to insufficient staffing. Staff D stated, stated for [R1], “I would leave [R1] in bed if I don’t have a second person to help me get [them] up. [R1] has medical reasons as to why [they] can’t stay in bed after eating food. [R1] is supposed to be up after meals because of [their] GERD (Gastro Esophageal Reflux Disease).”

In an interview with Staff C, the Resident Care Coordinator, on 07/16/2024 at 10:06AM, Staff C was asked if they had any concerns with insufficient staffing at the facility. Staff C stated, “Yes. My concerns are that I have to cover everybody’s shift. Once Agency left, it started problems. We don’t have enough employees yet to cover all shifts. I am working the floor every day. I have been working the cart.” Staff C was asked if they felt there were enough caregivers to accomplish all resident tasks. Staff C stated “It depends on the day. Right now, I have four Caregivers on the floor.” Staff C was asked if they could remember a time where there was critical, or low staffing. Staff C stated,

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"The lowest I remember is when we had one Med Tech, and one Caregiver on each side [wing of the facility]. It is not always the whole shift. We might get some help cover, stay longer. Sometimes I can get someone to come in a bit early." Staff C was asked if there were any times where they specifically did not follow a resident's care plan due to insufficient staffing. Staff C stated, "Showers will not get done. We try to toilet residents, and they are waiting longer than I'd like them to." Staff C was asked if provided showers were documented. Staff C stated that they are documented "On our staffing task sheets," which were kept in the Health and Wellness Director's (HWD) Office.

In an interview with Staff E, a Med Tech, on 07/16/2024 at 10:45AM, Staff E was asked if they had any concerns with insufficient staffing at the facility. Staff E stated, "Absolutely. We don't have enough. Usually over the weekends and Mondays we have only 1 care staff for each side for evening shift. Staff E was asked if they ever were unable to complete resident task due to staffing issues. Staff E stated, "Showers are not getting done. The laundry sometimes does not get completed. The details of actual caregiving, like nail care, shaving. Things they deserve and that they pay for; they are not getting done. We had Agency and that was helping us out a lot, but corporate cut out Agency on the 6th of this month (July). Since then, it has been a real struggle." Staff E was asked if they could recall any specific dates where they did not complete the assigned resident showers or provide care as per the resident agreement due to insufficient staffing. Staff E stated, "Yesterday. (07/15/2024). None of the residents yesterday got showers on dayshift on my side. That was due to staffing." Staff E stated that during dayshift on 07/15/2024, "we had me [Med Tech], one caregiver, and a float caregiver [on their wing of the facility.]

During an interview with Staff B, the Health and Wellness Director, on 07/16/2024 at 10:26AM, Staff B was asked to explain the process for staff providing resident showers, and documentation of those showers. Staff B stated that as far as documentation that they only keep one week of shower records. Staff B stated, "I track refusals that way… For shower refusals, I train the staff to have 3 attempts. If they are still unable, they get me involved. If it is an actual refusal, it is just a refusal. They are getting better at keeping me in the loop." Staff B was asked if staff were to document resident refusals, or any other reasons a shower was not given on the staffing task sheet. Staff B confirmed that the staff should be documenting all missed showers, and the reasons for any missed showers on the bottom of staffing task sheet (shower sheet).

Review of R1's Face Sheet, dated 07/16/2024, showed that R1 was admitted to the facility on [redacted]/2013.

Review of R1's Personal Service Plan/PSP (Negotiated Service Agreement), dated 04/19/2024, showed that it was unsigned by facility representative and resident representative. Under the section titled, "Showering or Bathing" it stated that R1 was to have shower days on Mondays, and Thursdays, with a preference time of 10AM-11AM. Under the "Comments" section, it stated, "[R1] is full assist with showering. [R1] will need 2 care staff to help assist [them] into the shower chair and out of the shower chair using a hoyer (lift). [R1] will need only one care staff while showering for full assist." Under the "Bathroom Assistance" section, it stated, "[R1] is incontinent of both

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bowel and bladder. [R1] is full assist by 2 care staff." Under the section titled, "Two Person or Mechanical Lift," it stated, "[R1] is full assist with transferring by 2 care staff, using hoyer (lift).

In an interview and observation with R1, on 07/16/2024 at 11:08AM, R1 was observed to be in their wheelchair. R1 appeared to be in clean clothing, but R1's hair appeared greasy, and unwashed. R1 was asked how they felt today. R1 did not answer. It was observed that R1 was non-verbal, and unable to answer further questions.

Review of R2's Face Sheet, dated 07/16/2024, showed that R2 was admitted to the facility on [redacted]/2021.

Review of the R2's PSP, dated 05/09/2024, showed that the R2 was to have shower days on Mondays, and Thursdays, with a preference time of 10AM-11AM. Under the "Bathroom Assistance" section, it stated, "[R2] is incontinent of bladder and bowel and is full assist with toileting." Under the section titled, "Two Person or Mechanical Lift," it stated, [R2] is a one-person pivot transfer."

Review of R3's Face Sheet, dated 07/16/2024, showed that R3 was admitted to the facility on [redacted]/2023.

Review of the R3's PSP, which was signed by facility rep and resident representative on 04/12/2024, showed that the R3 was to have shower days on Mondays, and Fridays, with a preference time of 9AM-10AM. Under "Comments" it stated, "[R3] is stand by assist with showering. Staff to be available to assist [them] with any aspects of the task that [they] are unable to complete." Under the "Two Person or Mechanical Lift" section, it stated, [R3] is a one person assist."

Review of R4's Face Sheet, dated 07/16/2024, showed that R4 was admitted to the facility on [redacted]/2023.

Review of the R4's PSP, which was signed by facility rep and resident representative on 04/23/2024, showed that the R4 was to have shower days on Mondays, and Fridays, with a preference time of 11AM-12PM. Under the "Comments" section, it stated, "[R4] likes to take showers and only requires set up with shampoo and body soap. [R4] can sit on a shower bench and shower [their self] only needing stand by assistance for safety…"

Review of R5's Face Sheet, dated 07/16/2024, showed that R5 was admitted to the facility on [redacted]/2022.

Review of the R5's PSP, which was signed by facility rep and resident representative on 01/08/2024, showed that the R5 was to have shower days on Sunday, and Thursdays, with a preference time of 11AM-12PM. Under the "Comments" section, it stated, "[R5] is

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able to shower [themselves] independently... Staff are to open the shower room up, assist with setting up [their] supplies and step out for privacy." Under the section titled, "Two Person or Mechanical lift," it stated, "[R5] is independent with all transfers."

Review of the provided facility staff schedule showed on 07/15/2024 for dayshift, 5 employees were listed to work. These employees were Staff E, Staff G, a Med Tech, Staff D, Staff H, a Caregiver, and Staff I, a Caregiver.

Review of "Bridge" side wing Staffing Task Sheet for Monday, 07/15/2024 on Dayshift showed that there were 3 staff listed to work the floor, one of which was floating between the "Bridge" side, and "Clare" side. Under "Med Tech" it listed Staff G. Under "Caregiver," it listed Staff H. Under "Float" it listed Staff D." Under the section titled "Shower List" it listed R2, R3, and R4 to be given showers during that shift.
• R2: Under "Shower," "N" was circled.
• R3: Under "Shower," "N" was circled.
• R4: Under "Shower," "N" was circled.
Under the "Document refusals: 3 interventions" section, there was no indication notated as to why the resident showers were not given.

Review of "Clare" side wing Staffing Task Sheet for Monday, 07/15/2024 on Dayshift showed that there were 3 staff listed to work the floor, one of which was floating between the "Bridge" side, and "Clare" side. Under "Med Tech" it listed Staff E. Under "Caregiver," it listed Staff I. Under "Float" it again listed Staff D." Under the section titled "Shower List" it listed R1, and R5 to be given showers during that shift.
• R1: Under "Shower," "N" was circled.
• R5: Under "Shower," "N" was circled.
On the bottom of this document, in the "Document refusals: 3 interventions" section, a handwritten note stated, "[R5], [R1] Tomorrow 07/16 showers."

Review of the facility provided document titled "Condensed Employee Time Detail" with a time period of 05/15/2024 to 07/16/2025 showed clock in and out times for each employee on each respective day.
• Review of Time Detail for Staff G on 07/15/2024 confirmed a clock in time of 6:03AM, and a clock out time of 4:20PM.
• Review of Time Detail for Staff D on 07/15/2024 confirmed a clock in time of 7:13AM, and a punch out time of 2:40PM.
• Review of Time Detail for Staff E on 07/15/2024 confirmed a clock in time of 6:00AM, and a clock out time of 2:57PM.
• Review of Time Detail for Staff I on 07/15/2024 confirmed a clock in time of 6:17AM, and a clock out time of 2:40PM.
• Review of Time Detail for Staff H on 07/15/2024 confirmed a clock in time of 7:05AM, and a clock out time of 2:41PM.
Further review of Time Details for all employees confirmed there were no additional care staff working on 07/15/2024 during dayshift hours.

During an interview with Staff B on 7/16/2024 at 1:08PM, Staff B was asked why R5's shower on the Staffing Task Sheet did not reflect what was indicated for showers on the

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PSP. Staff B stated they are in the process of shifting residents to their requested days as per the PSP. Staff B stated that as of now, care staff are trained to give showers as per the Staffing Task Sheet. Staff B confirmed that as of now, R5 was to receive a shower on Monday. Staff B was asked what it meant if a "N" was circled. Staff B stated that it meant that the resident's shower was not given for some reason. Staff B was asked why there was no indication noted on the bottom of the sheet for the Staffing Task List for Dayshift, 07/15/2024. Staff B stated again that staff should have documented the reason.

In an interview with Staff A, and Staff B on 07/16/2024 at 2:03PM, Staff A and B were asked how residents with increased fall risk, elopement risk, and behavioral issues could be adequately monitored when all staff are busy providing care. Staff A and Staff B both expressed understanding of this concern. Staff A and B were informed of the multiple staff reports of being unable to provide residents with showers as agreed upon, stating insufficient staffing as the reason. Staff B stated that they were not in the facility on 07/15/2024 and that if they were, they would not have accepted so many missed showers. Staff B stated that Staff J, the Health and Wellness Coordinator, was present that day and stated they were still in training. Notified Staff B that per the WAC (Washington Administrative Code) 388-78A-2450 it stated that the 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." Staff B was made aware that in their absence there must be "sufficient, trained staff persons" to complete resident tasks, or to ensure their completion by other staff. Staff B stated they understood this, however Staff B stated that they do not feel that this one day of missed showers was an accurate representation of showers given in the facility. Staff B stated they would ensure that the residents who missed their showers would receive one (on 07/16/2024) and provide proof/documentation of completion to the Department for review. Staff B stated that they would also like to provide additional shower documentation for review. The Department requested that these documents be submitted for review by 07/17/2024 at 12:00PM. Staff B stated they would send the documents over by 07/16/2024 in the evening.

As of 07/17/2024 at 3:00PM, no documents had been provided by the facility for review.

This is a recurring deficiency previously cited on 02/21/2024.

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)_____ .

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

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

Administrator (or Representative)

7/31/24
Date

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