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

Belamour, INC.
Premier Senior Living Brush Prairie
PO Box 1772
Battle Ground, WA 98604

RE: Premier Senior Living Brush Prairie # 755606

Dear Provider:

This document references Compliance Determination 28722 (09/14/2023), which included complaint number(s) 93744.

The Department completed a complaint investigation of your Adult Family Home on 09/14/2023 and found that your home does not meet the Adult Family Home Licensing requirements.

The department staff who did the inspection and provided consultation:

Robert Hennig, NCI ALF Complaint Investigator

A licensor may consult with a provider when a violation of the Washington Administrative Code (WAC) or Revised Code of Washington (RCW) is found, but it is not cited in the Statement of Deficiencies. Violations may not be cited when it is a first-time violation of statute or rule with minimal or no harm to residents. A consult does not require a follow-up visit.

Consultation:

WAC 388-76-10225 Reporting requirement.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

(c) The resident's health care provider;

(e) Persons identified in the negotiated care plan; and

(f) The resident's case manager if the resident is a department client.

A consultation was completed with the Provider regarding the delay in reporting a fall with head injury to the family and physician, as stated in the policy for resident falls with injury. Provider was aware of incident and has since re-educated all staff on the importance of following the policy and ensuring family is notified in a timely manner.

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately; and
• Complete correction as soon as possible.

You Are Not:
• Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
• Inspect the home to determine if you have corrected all deficiencies.

You May:
• Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
• Ask questions and provide written information to help clarify or dispute the deficiencies.

• Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:
• Please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit F
Residential Care Services

INFORMAL DISPUTE RESOLUTION [RCW 70.128]

You May:
Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an **'IDR Request Form'** for **each**

citation or enforcement you plan to dispute. You can find this form and directions on the IDR Adult Family Home web page at: https://www.dshs.wa.gov/altsa/idr

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Provider Process for Choosing a Panel or Traditional IDR:

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a **Panel IDR**, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDR**s the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

Send your request and supporting documents to the address below or email to rcsidr@dshs.wa.gov:

Adult Family Home IDR Program
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

Residential Care Services
Investigation Summary Report

Provider/Facility: Premier Senior Living Brush Prairie
Provider Type: Adult Family Home
License/Cert.#: 755606
Intake ID: 93744
Compliance Determination #: 28722
Region/Unit #: RCS Region 3 / Unit F
Investigator: Robert Hennig
Investigation Date(s): 08/29/2023 through 09/14/2023
Complainant Contact Date(s): 08/29/2023, 09/14/2023

Allegation(s):

Resident/Patient/Client - Neglect - Facility did not respond appropriately to a Resident fall with head injury in a timely manner.

Investigation Methods:

Sample:	Total residents: 6 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions
Interviews:	Identified resident Identified staff Residents Administrator Caregiver
Record Reviews:	Incident report Incident investigation Facility policies Negotiated Care Plan

Investigation Summary:

Resident/Patient/Client - Neglect - Facility did not respond appropriately to a Resident fall with head injury in a timely manner. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intake. Based on interviews, observations, and record reviews, no failed facility practice was substantiated in relation to original reported allegations, however, a consultation was completed based on evidence of reporting requirements in the case of a fall with head injury not reported appropriately. Additional residents reviewed for safety, care and services, with no concerns.

Conclusion / Action:

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