



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Yakima
4100 W ENGLEWOOD
YAKIMA, WA 98908

RE: Brookdale Yakima License # 1695

Dear Administrator:

This letter addresses Compliance Determination(s) 33473 (Completion Date 12/06/2023) and 31081 (Completion Date 10/17/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/06/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

The Department staff who did the on-site verification:
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

A handwritten signature in cursive script, appearing to read "S. Jenks".

Stephanie Jenks, Field Manager
Region 1, Unit G
Residential Care Services



Residential Care Services Investigation Summary Report

Provider/Facility: Brookdale Yakima

Provider Type: Assisted Living Facility

License/Cert.#: 1695

Compliance Determination #: 31081

Intake ID: 100777

Investigator: Felicia Cantu

Region/Unit #: RCS Region 1 / Unit G

Investigation Date(s): 10/16/2023 through 10/17/2023

Complainant Contact Date(s):

Allegation(s):

A named resident had a unstageable pressure sore to their sacral area (under lumbar spine and above the tailbone).

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size:
Observations:	Residents Resident care equipment Resident rooms Facility environment Staff to resident interactions
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Hospital records State reporting log Resident records(face sheets, care plans, assessments, chart noted, doctor notes)

Investigation Summary:

Interviews and record review showed that care staff discovered unstageable pressure sore to the named resident's sacral area, The facility failed to investigate the cause of the pressure injury. Failed practice identified WAC 388-78A-2371 reference Statement of Deficiencies dated 10/23/2023.

Conclusion / Action:

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

☐ N/A

11:31:10 a.m. 10-30-2023

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WATECH

10.30.2023 09:32:04

State of Washington



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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 1695	Compliance Determination # 31081
Plan of Correction	Brookdale Yakima	Completion Date
Page 1 of 3	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	10/17/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 10/16/2023 and 10/16/2023 of:

Brookdale Yakima
4100 Englewood Ave
Yakima, WA 98908

This document references the following complaint number(s): 100777, 99261

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1, Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher
Residential Care Services

10/30/2023

Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

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

11:31:10 a.m. 10-30-2023

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WA TECH

10.30.2023 09:32:04

State of Washington

Statement of Deficiencies	License #: 1695	Compliance Determination # 31081
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Administrator (or Representative)

11/13/23

Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

- (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living (ALF) failed to investigate, document investigative actions to determine the circumstances of a significant injury of an unknown source, develop preventative measures, and protect the resident's health and wellbeing for 1 of 3 residents (Resident 1). This failure resulted in a skin pressure injury (wound that occurs from prolonged pressure to skin) from an unknown cause to Resident 1 and placed other residents at risk of harm and decline in their health.

Findings included...

Review of Department of Social and Health Services "Assisted Living Facility Guidebook" dated February 2018, showed that substantial injuries of an unknown source must be investigated immediately and thoroughly to determine how it occurred and to make necessary changes to protect residents and prevent reoccurrence. Substantial injuries may include but are not limited abrasions, deep lacerations/wounds bruises of deep color and depth.

Review of the ALF's policy titled "Abuse, Neglect and Exploitation Policy" revised 05/01/2021 showed that the ALF is committed to maintaining a safe environment for each resident, and allegations of neglect should be treated seriously and must be reported in accordance with this policy for investigations and appropriate follow-up. An internal investigation should be conducted and initiated as soon as the facility has become aware of the incident. The Executive Director or designee should maintain a written record of the investigation.

Resident 1

Review of Resident 1's face sheet showed that they were admitted to the ALF on

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██████/2023 and did not have a diagnosis that included skin conditions or wounds.

Review of Resident 1's chart note dated 09/28/2023 showed that staff discovered wound to sacral area.

Review of Resident 1's doctor visit note dated 09/28/2023 showed that Resident 1 had stage 4 pressure ulcer (deep sore characterized by severe tissue damage that can appear black) to sacral area that radiated out to right buttocks with full thickness of skin loss. The pressure ulcer is described as dark purple, small amount of black over sacral area measuring 6cmx1cm, depth unknown.

On 10/16/2023 at 10:37 AM Staff A, Administrator stated that the pressure injury was discovered by a caregiver on 09/28/2023 and she was unsure when and how the injury occurred. Resident 1 was sent to the hospital on 10/02/2023 for worsening symptoms to wound. Staff A stated that there was not an investigation to the incident on file.

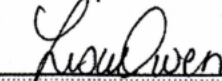
On 10/16/2023 at 10:50 AM Staff B, Health and Wellness Director expressed that the incident happened so fast. Staff B confirmed that she did not investigate the incident to rule out abuse and neglect.

This is a recurring deficiency previously cited on 07/28/2022 subsection (2).

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 Yakima is or will be in compliance with this law and / or regulation on (Date) 11/13/23.

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



Administrator (or Representative)

11/13/23

Date