STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Alderwood
18706 36th AVENUE WEST
LYNNWOOD, WA 98037

RE: Brookdale Alderwood License # 1700

Dear Administrator:

This letter addresses Compliance Determination(s) 31156 (Completion Date 11/09/2023) and 24112 (Completion Date 08/23/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/09/2023 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-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3, WAC 388-78A-2600-1-b, WAC 388-78A-2160

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Alderwood
Provider Type: Assisted Living Facility
License/Cert.#: 1700
Compliance Determination #: 24112
Intake ID: 81480
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/17/2023 through 08/23/2023
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) had an untreated deep wound, resulting in sepsis, and death at the Assisted Living Facility (ALF).
2. The ALF did not notify the NR's family about the change of condition.

Investigation Methods:

Sample:	Total residents: 36 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Home Health Nurse
Record Reviews:	Facility policies Resident records

Investigation Summary:

1. Record review and interview found the facility noted the wound, contacted the physician and obtained home health for wound care. Record review and interview showed the NR had a significant decline and change in condition developing a wound. The ALF failed to update the NR's Negotiated Service Agreement of the change of condition and skin status and failed to implement their policy on wound documentation.
2. Record review and interview showed the ALF documented noting the wound and notifying the family.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Alderwood
Provider Type: Assisted Living Facility
License/Cert.#: 1700
Compliance Determination #: 24112
Intake ID: 82632
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/17/2023 through 08/23/2023
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) had nine documented pressure injuries and an unstageable wound on their left hip at the Assisted Living Facility (ALF).

Investigation Methods:

Sample:	Total residents: 36 Resident sample size: 2 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions Resident skin
Interviews:	Identified resident Nursing staff Family members Hospice Staff
Record Reviews:	Resident records

Investigation Summary:

Observation, interview and record review showed that the NR had multiple pressure injuries and an unstageable to their left hip. Observation and record review showed the ALF failed to implement the NR's personal service plan by not repositioning or providing incontinence care for the resident every two hours. This failure may have contributed to the NR having pressure injuries and an unstageable wound.

Conclusion / Action:

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

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20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 1760	Compliance Determination # 24112
Plan of Correction	Brookdale Alderwood	Completion Date
Page 1 of 6	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	08/23/2023

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 05/17/2023, 05/18/2023, 05/29/2023 and 05/18/2023 of:

Brookdale Alderwood
18705 36th AVENUE WEST
LYNNWOOD, WA 98037

This document references the following complaint number(s): 81480, 82632

The following sample was selected for review during the unannounced on-site visit: 2 of 36 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Meglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

8/23/2023
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.

Administrator (or Representative) 8/24/2023 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed ensure the Negotiated Service Agreement (NSA) for 1 of 2 sampled residents (Resident 1) was updated after a change of condition and wound development. The failure placed Resident 1 at risk of not receiving the needed care and services and may have contributed to the development of an unstageable wound.

Findings included...

Record review of a Face sheet showed the ALF admitted Resident 1 on [redacted]2020 with multiple medical diagnoses including [redacted] Review of Resident 1's Personal Service Plan (PSP-equivalent to a Negotiated Service Agreement), dated 11/30/2022, showed Resident 1 was independent with ambulation without a mobility device, independent with feeding, and had occasional incontinence.

In an interview, on 07/20/2023 at 9:00 AM, Collateral Contact 3 (CC3-Home Health Registered Nurse) stated that Resident 1 was on home health services from 01/23/2023 through 03/20/2023 for physical therapy. CC3 stated that at the time of discharge from home health service Resident 1's care and service needs matched those documented on the 11/30/2022 PSP and Resident 1 had no skin issues.

Record review of a Client Episode Coordination Note (CECN) written by Collateral Contact 1 (CC1-Home Health Registered Nurse), dated 04/28/2023, showed Resident 1 was re-admitted to home health 39 days after she had been discharged. The CECN showed Resident 1 had a significant decline in function since she was previously discharged from home health. The CECN state Resident 1 was no longer able to stand or ambulate, was wheelchair bound, required one on one feeding, and completely incontinent. The CECN stated Resident 1 was completely dependent on the ALF caregivers for all Activities of daily living (ADLs- a term used in healthcare to refer to people's daily self-care activities such as

bathing, grooming, ambulation, etc.). The CECN documented Resident 1 was observed to have an unstageable pressure injury on the right lower buttock. The pressure injury was completely covered in soft black eschar (a collection of dry, dead tissue within a wound, commonly seen with pressure ulcers), very malodorous with drainage (wound odor indicating infection), that measured 3.0 centimeters (cm) X 4.6 CM.

Record review of a Progress Note (PN) written by Staff A (Floor Nurse), dated 04/06/2023, showed ALF staff reported to Staff A that Resident 1 needed more staff assistance. The PN gave no further details of the assistance Resident 1 required.

In an interview, on 07/21/2023 at 2:09 PM, Staff A confirmed that Resident 1 had a significant change of condition, developed an unstageable pressure wound, required home health and then hospice (end of life) care. Staff A stated that although he was aware of Resident 1's change of condition he did not update the PSP or put interventions in place to prevent potential pressure injuries.

Record review of Resident 1's PSP, dated 11/30/2023, showed it was not updated to reflect the changes in Resident 1's care needs. The PSP did not show Resident 1 required assistance with all ADLs including feeding, that she was no longer ambulatory and wheelchair bound or that she required interventions to reduce risks of skin breakdown. The PSP was not updated to reflect Resident 1 had a wound, or the plan to care for the wound. The PSP was not updated to reflect Resident 1 was receiving home health or hospice and how to coordinate care.

This deficiency was previously cited on 09/22/2022.

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 Alderwood is or will be in compliance with this law and / or regulation on (Date) 10/01/2023.

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

Administrator (or Representative) 08/21/2023 Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special

needs;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to implement their policy and of documenting an unstageable wound for 1 of 1 sampled resident (Resident 1). This failure may have contributed to Resident 1 not receiving the appropriate medical interventions and resulted in the facility having no documentation of the wound.

Findings included…

Record review of the ALF's policy, "Open Area Documentation", dated 03/2022, showed the ALF staff were to complete a Brookdale Automated Incident Reporting System (BAIRS) Report for a staged 3, 4, or unstageable pressure injury, deep tissue injury, or if skin issues were a result of an incident, injury or fall.

Record review of a Face Sheet showed the ALF admitted Resident 1 on [redacted]/2020 with multiple medical diagnoses including [redacted]

Record review of a Client Episode Coordination Note (CECN) written by Collateral Contact 1 (CC1- Home Health Registered Nurse), dated 04/28/2023, showed Resident 1 was observed to have an unstageable pressure injury on the right lower buttock. The pressure injury was completely covered in soft black eschar (a collection of dry, dead tissue within a wound, commonly seen with pressure ulcers), very malodorous with drainage (wound odor indicating infection), that measured 3.0 centimeters (cm) X 4.6 CM.

Record review showed Staff A (Floor Nurse) notified Resident 1's physician via fax, on 04/23/2023, the ALF noted Resident 1 had a wound. A Progress note, dated 04/27/2023, noted another wound was found

and home health had provided care. There was no BAIRS report or other documentation about the unstageable wound.

In an interview, on 05/18/2023 at 4:13 PM, Staff A that the ALF did not have documentation for Resident 1's wound. Staff A stated the ALF had not followed the "Open Area Documentation" policy.

This deficiency was previously cited on 01/09/2023

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 Alderwood is or will be in compliance with this law and / or regulation on (Date) 10/01/2023 .

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

Administrator (or Representative) 08/29/2023 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed implement the Negotiated Service Agreement (NSA) and provide the agreed upon care and services for 1 of 2 sampled resident (Resident 2). This failure may have contributed to Resident 2 having nine pressure injuries.

Findings included...

Record review of a Face sheet showed the ALF admitted Resident 2 on [redacted] 2022 with

multiple medical diagnoses including [redacted] Review of a Personal Service Plan (PSP - equivalent to an NSA), dated 05/16/2023, showed Resident 2 had pressure ulcers and required ALF staff to turn and reposition him on his right side or back every two hours and keep skin clean and dry.

Observation, on 06/29/2023 at 12:39 PM, showed Resident 2 lying in his bed on his back. Resident 2 had dry feces on his legs and right heel. On the wall above Resident 2's bed there was a sign stating," Reposition every two hours when in bed. Reposition only on his back and right side."

In an interview, on 06/29/2023 at 12:47 PM, when asked the last time Resident 2 was cleaned or repositioned, Staff C (Caregiver) stated that Resident 2 had not been cleaned or repositioned since breakfast at 7:30 AM that morning.

Every two hour care outlined in the NSA had not been provided in five hours. The PSP for turning and repositioning every two hours and ensuring Resident 2's skin was clean and dry had not been implemented.

In an interview, on 06/29/2023 at 12:39 PM, Staff A (Floor Nurse) stated Resident 2 should have been cleaned and turned, "hours ago."

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 Alderwood is or will be in compliance with this law and / or regulation on (Date) 10/01/2023

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

Administrator (or Representative) 08/29/2023 Date