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) 41320 (Completion Date 05/16/2024) and 34739 (Completion Date 03/20/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/16/2024 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-2930-1-a-ii, WAC 388-78A-2930-1-b, WAC 388-78A-2450-2-e

The Department staff who did the on-site verification:
Hayley Pinkham, ALF Licensor

If you have any questions, please contact me at (253)312-1446.

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 #: 34739
Intake ID: 111280
Investigator: Hayley Pinkham
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 01/04/2024 through 03/20/2024
Complainant Contact Date(s):

Allegation(s):

1) The Named Resident (NR) sustained a significant injury during care at the Assisted Living Facility (ALF).
2) The ALF nursing staff is unsure if the Staff Member (SM) assisting the NR for care was properly credentialed to provide care.

Investigation Methods:

Sample:
Total residents: 30
Resident sample size: 2
Closed records sample size:

Observations:
Identified resident
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Identified staff
Nursing staff
Residents
Residents
Family members

Record Reviews:
Medical records
Incident investigation
Personnel files

Investigation Summary:

1) Interview with the NR showed the NR could not recall the incident. Observation and interview with sampled resident showed no concerns for care and/or safety issues. Record review showed the ALF investigated the injury, sought immediate medical attention, and notified the responsible party. Interview showed the family member was satisfied with the ALF's investigation and care of the NR.
2) Interview and record review showed the NR received assistance during care with subsequent injury from a SM not credentialed to provide care. Deficient 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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Statement of Deficiencies	License #: 1700	Compliance Determination # 34739
Plan of Correction	Brookdale Alderwood	Completion Date
Page 1 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	03/20/2024

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 01/04/2024 and 01/04/2024 of:

Brookdale Alderwood
18706 36th AVENUE WEST
LYNNWOOD, WA 98037

This document references the following complaint number(s): 112234, 111280

The following sample was selected for review during the unannounced on-site visit: 2 of 30 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

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

3/20/2024
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) Date 3/25/2024

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(ii) Resident living rooms and resident sleeping rooms; and

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure residents who did not wear call light pendants had means to call for assistance in living rooms and sleeping rooms in all the ALF apartments. This failure placed residents without call light pendants at risk for harm and unmet care needs.

Findings included...

Record review of the Facility Management Systems database showed the ALF is licensed for 60 beds. Record review of the ALF's undated characteristic roster showed the ALF provides care for 30 residents.

Record review of a letter from Guardian Senior Facility Communication System regarding the approved communication system by Department of Health's Construction Review Services (CRS) showed this was initially approved in 1999. The letter outlined the use of pendants in which the residents could use to call for assistance beyond the hardwired call light buttons.

Interview and observation, on 01/04/2024 at 1:44 PM, showed in the Cottage Hallway Unit, apartment 43 and apartment 45 did not have a means to call for assistance from staff in the sleeping area. Staff A (Health and Wellness Director) stated the ALF only had a call light system in the resident's bathroom. Staff A stated the residents on this unit do not wear pendants for summoning staff. Staff A stated none of the ALF apartments had call lights in the sleeping area.

In an interview, on 01/11/2024 at 12:37 PM, a representative from CRS, stated the letter from Guardian Senior Facility Communication System showed ALF committed that all

residents were to wear a pendant system. The CRS representative stated if the ALF had not provided all residents with a pendant system, then they are no longer in compliance with the Washington Administrative Code. The CRS representative stated the ALF cannot require a resident with dementia (a group of symptoms that affects memory, thinking and interferes with daily life) to wear a pendant, however if they did not wear a pendant the ALF would need to implement a call system in the living rooms and sleeping rooms.

In an interview, 01/26/2024 at 12:52 PM, Staff C (Executive Director) stated the residents on the Memory Care Unit do not wear the pendant system related to cognitive deficits. Staff C stated there is no other system to call for assistance from the caregivers from the resident living rooms and the resident sleeping rooms in any of the ALF apartments.

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) 04/30/2024.

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

Administrator (or Representative) Date 3/25/2024

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure sufficient trained and qualified staff were available to provide care for 1 of 1 residents (Resident 1). This failure resulted in an unqualified staff member providing care that may have contributed to Resident 1 sustaining a hand injury and placed other residents at risk of receiving care from staff who did not have the training and knowledge to perform care.

Findings included...

Review of a Face Sheet showed the ALF admitted Resident 1 on [redacted]/2020 with multiple medical conditions. Review of Resident 1's Negotiated Service Agreement (NSA), dated

07/21/2023, showed the resident required staff assistance with Activities of Daily Living (personal care needs that may include bathing/showering, dressing, getting out of bed). The NSA showed Resident 1 required oversight and cues from caregivers to use the restroom.

Record review of an ALF's undated investigative documentation, on 12/17/2023, showed Resident 1 had used the restroom and then transferred to back to her wheelchair. During the transfer, Resident 1 sustained a fracture (a partial or complete break in the bone) of her left hand. The investigative documentation showed Staff B (Activity Director) had been alone providing the oversight and cues for Resident 1's transfer to the wheelchair.

Record review showed Staff B did not have the required credentials or certifications to provide care to long-term care residents.

In an interview, on 01/04/2024 at 12:52 PM, Staff A (Health and Wellness Director) stated she was unsure if Staff B was credentialed to provide care for Resident 1's. Staff A stated Staff B assisted Resident 1 with toileting and transferring because the assigned caregivers were off the unit at the same time attending a meeting.

In an interview, on 01/04/2024 at 2:19 PM, Staff B stated he was on the unit by himself hosting an activity for eight residents. Staff B stated when Resident 1 needed to use the restroom he called the caregivers on the communication system to come and provide the care. Staff B stated no caregivers arrived to assist Resident 1. Staff B stated because no caregivers were available, he provided stand-by assistance while Resident 1 used the toilet and transferred to the wheelchair. Staff B stated he is not credentialed to provide care.

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) 04/30/2024.

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

Administrator (or Representative) — Date: 3/25/2024