STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Allenmore AL (WA)
3615 S. 23RD STREET
TACOMA, WA 98405

RE: Brookdale Allenmore AL (WA) License # 1701

Dear Administrator:

This letter addresses Compliance Determination(s) 38872 (Completion Date 05/01/2024) and 32528 (Completion Date 11/17/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/01/2024 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-2600-1-b

The Department staff who did the on-site verification:
Nareet Bajwa, NCI-ALF Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

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 follow-up on 11/14/2023 and 11/14/2023 of:

Brookdale Allenmore AL (WA)
3615 S. 23RD STREET
TACOMA, WA 98405

This document references the following SOD dated: 11/17/2023

The following sample was selected for review during the unannounced on-site visit: 5 of 60 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Nareet Bajwa, NCI-ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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.

Residential Care Services

11/29/2023
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.

Statement of Deficiencies	License #: 1701	Compliance Determination # 32528
Plan of Correction	Brookdale Allenmore AL (WA)	Completion Date
Page 2 of 3	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	11/17/2023

Administrator (or Representative) — Date: 11.29.23

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 observations, interviews and record review, the Assisted Living Facility (ALF) failed to ensure they implemented their own policy on call system alerts for 2 of 2 sampled residents (Resident 1 & 2). This failure placed all 60 residents in the ALF at risk for serious negative health outcomes and poor quality of life.

Findings Included...

Record review of the Resident Call System and Door Alarm Response - SE-14 Last Revised 5/2023 stated that "when responding to resident call system alerts: (a) when an associate receives a resident call system alert, he or she should respond within a timely manner. (b) If the associate is unable to respond in a timely manner, he or she should request assistance from another associate."

During an interview on 11/17/2023 at 11:36am, Staff B, Clinical Specialist stated that staff is supposed to answer the call light in 5-10 minutes.

During an interview on 11/14/2023 at 12:55pm, R1 stated that he had an experience where he waited for more than an hour for staff to respond to the call light.

During an interview on 11/14/2023 at 1:38pm, R2 stated that staff never respond to the call light on time. R2 stated that she gave up on staff. R2 stated that when she talks to staff for taking too long to answer the call light, staff say that they are busy.

During an interview on 11/14/2023 at 2:22pm, Staff A, Administrator stated that staff is supposed to answer the call light as quickly as possible. Staff A was asked what you would do if staff responded to a call light after 40 minutes. Staff B stated that she would like to see staff responding to the call light quicker. Staff A stated that she would like residents to be more satisfied and if they are not satisfied then she would like to improve that.

Administrator (or Representative) 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 observations, interviews and record review, the Assisted Living Facility (ALF) failed to ensure they implemented their own policy on call system alerts for 2 of 2 sampled residents (Resident 1 & 2). This failure placed all 60 residents in the ALF at risk for serious negative health outcomes and poor quality of life.

Findings Included…

Record review of the Resident Call System and Door Alarm Response - SE-14 Last Revised 5/2023 stated that "when responding to resident call system alerts: (a) when an associate receives a resident call system alert, he or she should respond within a timely manner. (b) If the associate is unable to respond in a timely manner, he or she should request assistance from another associate."

During an interview on 11/17/2023 at 11:36am, Staff B, Clinical Specialist stated that staff is supposed to answer the call light in 5-10 minutes.

During an interview on 11/14/2023 at 12:55pm, R1 stated that he had an experience where he waited for more than an hour for staff to respond to the call light.

During an interview on 11/14/2023 at 1:38pm, R2 stated that staff never respond to the call light on time. R2 stated that she gave up on staff. R2 stated that when she talks to staff for taking too long to answer the call light, staff say that they are busy.

During an interview on 11/14/2023 at 2:22pm, Staff A, Administrator stated that staff is supposed to answer the call light as quickly as possible. Staff A was asked what you would do if staff responded to a call light after 40 minutes. Staff B stated that she would like to see staff responding to the call light quicker. Staff A stated that she would like residents to be more satisfied and if they are not satisfied then she would like to improve that.

Statement of Deficiencies	License #: 1701	Compliance Determination # 32528
Plan of Correction	Brookdale Allenmore AL (WA)	Completion Date
Page 3 of 3	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	11/17/2023

Observation on 11/14/2023 at 12:56pm showed that Resident 1 (R1) pressed the call light and waited for staff to respond. Staff came to answer call light after 40 minutes of pressing the call light button.

Observation on 11/14/2023 at 1:39pm showed that Resident 2 (R2) pressed the call light and waited for staff to respond. At 2:03pm, no staff came to answer the call light.

This is an uncorrected deficiency cited on 08/17/2023.

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 Allenmore AL (WA) is or will be in compliance with this law and / or regulation on (Date) 11.17.23 .

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

Administrator (or Representative) — Date: 11.29.23

Observation on 11/14/2023 at 12:56pm showed that Resident 1 (R1) pressed the call light and waited for staff to respond. Staff came to answer call light after 40 minutes of pressing the call light button.

Observation on 11/14/2023 at 1:39pm showed that Resident 2 (R2) pressed the call light and waited for staff to respond. At 2:03pm, no staff came to answer the call light.

This is an uncorrected deficiency cited on 08/17/2023.

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 Allenmore AL (WA) 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.

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Allenmore AL (WA)
License/Cert.#: 1701
Compliance Determination #: 27333
Investigator: Nareet Bajwa
Investigation Date(s): 07/28/2023 through 08/17/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 84674
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
Fall with injury: AV on floor for 4 hours before discovered. Call light not working.

Investigation Methods:

Sample:	Total residents: Resident sample size: 10 Closed records sample size: 1
Observations:	call light response time General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors
Interviews:	Resident staff
Record Reviews:	Resident Characteristic Roster Staff records Staff progress notes Incident log / reports, Facility P & P care plan

Investigation Summary:
Per observation, record review, interviews with residents and staff, facility failed to follow their own policies to provide the necessary care and services for sampled resident. Failed facility practice identified. See Statement of Deficiency dated 08/17/2023.

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 Allenmore AL (WA)
License/Cert.#: 1701
Compliance Determination #: 27333
Investigator: Nareet Bajwa
Investigation Date(s): 07/28/2023 through 08/17/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 85114
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
AV waited too long for staff to answer call light and AV fell. Lack of care.

Investigation Methods:

Sample:	Total residents: Resident sample size: 10 Closed records sample size: 1
Observations:	call light response time General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors
Interviews:	Resident representative staff
Record Reviews:	Resident Characteristic Roster Staff records Staff progress notes Incident log / reports, Facility P & P care plan

Investigation Summary:
Per observation, record review, interviews with residents and staff, facility failed to follow their own policies to provide the necessary care and services for sampled resident. Failed facility practice identified. See Statement of Deficiency dated 08/17/2023.

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 Allenmore AL (WA)
Provider Type: Assisted Living Facility
License/Cert.#: 1701
Intake ID: 88370
Compliance Determination #: 27333
Region/Unit #: RCS Region 3 / Unit D
Investigator: Nareet Bajwa
Investigation Date(s): 07/28/2023 through 08/17/2023
Complainant Contact Date(s):

Allegation(s):
Facility had no nurse for evening shift on 07/04/2023. Nurse responsibilities given to med tech.

Investigation Methods:

Sample:	Total residents: Resident sample size: 10 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors
Interviews:	Residents Staff
Record Reviews:	Resident Characteristic Roster Medication administration records (MAR) Staff records Nurse delegation records'

Investigation Summary:
Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that staff have the required training (DSHS designated nurse delegation core training, “nurse delegation for nursing assistants & home care aides”) to perform blood sugar checks and administer insulin injections Failed facility practice identified. See Statement of Deficiency dated 08/17/2023.

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 Allenmore AL (WA)
Provider Type: Assisted Living Facility
License/Cert.#: 1701
Intake ID: 88456
Compliance Determination #: 27333
Region/Unit #: RCS Region 3 / Unit D
Investigator: Nareet Bajwa
Investigation Date(s): 07/28/2023 through 08/17/2023
Complainant Contact Date(s):

Allegation(s):

1. Facility had no nurse on 07/04/2023. Some residents have insulin checks before dinner.
2. Bed bugs in AV's room

Investigation Methods:

Sample:	Total residents: Resident sample size: 10 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors
Interviews:	Residents staff
Record Reviews:	Resident Characteristic Roster Medication administration records (MAR) Staff records Nurse delegation records' Facility P & P

Investigation Summary:

1. Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that staff have the required training (DSHS designated nurse delegation core training, “nurse delegation for nursing assistants & home care aides”) to perform blood sugar checks and administer insulin injections. Failed facility practice identified. See Statement of Deficiency dated 08/17/2023.
2. Per record review, interviews with residents and staff, there was not sufficient information to either support or refute this allegation.

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 Allenmore AL (WA)
Provider Type: Assisted Living Facility
License/Cert.#: 1701
Intake ID: 89266
Compliance Determination #: 27333
Region/Unit #: RCS Region 3 / Unit D
Investigator: Nareet Bajwa
Investigation Date(s): 07/28/2023 through 08/17/2023
Complainant Contact Date(s):

Allegation(s):

1. AV fell and was on floor for 3 hours. call light not working.
2. slow response time.

Investigation Methods:

Sample:	Total residents: Resident sample size: 10 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors
Interviews:	Residents staff
Record Reviews:	Resident Characteristic Roster Staff records Staff progress notes Incident log / reports, Facility P & P care plan

Investigation Summary:

1. Per record review, interviews with residents and staff, there was not sufficient information to either support or refute this allegation.
2. Per observation, record review, interviews with residents and staff, facility failed to follow their own policies to provide the necessary care and services for sampled resident. Failed facility practice identified. See Statement of Deficiency dated 08/17/2023.

Conclusion / Action:

☒ 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 Allenmore AL (WA)
Provider Type: Assisted Living Facility
License/Cert.#: 1701
Intake ID: 90496
Compliance Determination #: 27333
Region/Unit #: RCS Region 3 / Unit D
Investigator: Nareet Bajwa
Investigation Date(s): 07/28/2023 through 08/17/2023
Complainant Contact Date(s):

Allegation(s):

1. Call light pressed, wait time is too long.
2. understaff, No ED in facility.

Investigation Methods:

Sample:	Total residents: Resident sample size: 10 Closed records sample size: 1
Observations:	Call light response time General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors
Interviews:	Residents staff
Record Reviews:	Resident Characteristic Roster Staff records Staff progress notes Facility P & P care plan

Investigation Summary:

1. Per observation, record review, interviews with residents and staff, facility failed to follow their own policies to provide the necessary care and services for sampled resident. Failed facility practice identified. See Statement of Deficiency dated 08/17/2023.
2. Per record review, interviews with residents and staff, there was not sufficient information to either support or refute this allegation.

Conclusion / Action:

[X] Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

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 07/28/2023 and 07/28/2023 of:

Brookdale Allenmore AL (WA)
3615 S. 23RD STREET
TACOMA, WA 98405

This document references the following complaint number(s): 84674, 85114, 88370, 88456, 89266, 89728, 90496

The following sample was selected for review during the unannounced on-site visit: 10 of 0 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nareet Bajwa, NCI-ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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.

Residential Care Services

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

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 observations, interviews and record review, the Assisted Living Facility (ALF) failed to implement their policies and procedures to respond to residents' call for help for 2 of 4 sampled residents (Resident 1 and 2). This failure resulted in residents call for assistance not being responded to in a timely manner and placed all 56 residents in the ALF at risk for serious negative health outcomes and poor quality of life.

Findings Included…

Record review of the Resident Call System and Door Alarm Response - SE-14 Last Revised 05/2023 policy stated that "when responding to resident call system alerts: (a) when an associate receives a resident call system alert, he or she should respond within a timely manner. (b) If the associate is unable to respond in a timely manner, he or she should request assistance from another associate."

Observation on 07/28/2023 at 1:01pm showed that Resident 1 (R1) pressed the call light and waited for staff to respond, no staff came to answer the call light after 40 minutes of pressing the call light button.

Observation on 07/28/2023 at 1:32pm showed that Resident 2 (R2) pressed call light and waited for staff to respond until 1:50pm, no staff came to answer the call light.

During an interview on 07/28/2023 at 12:49pm, R1 stated "care staff is good, it is just a management issue." R1 stated that his left leg is not in good shape and needed help with transfers. R1 stated that he had an experience where staff responded to the call light button being pressed after 5 hours of waiting.

During an interview on 07/28/2023 at 1:25pm, R2 stated that she was in bed asleep and the next thing she knew was that she had fallen to the floor. R2 stated that it took 4 - 5 hours to be found on the floor. R2 stated that pendant system was not working. R2 stated

that staff was supposed to come and check on her every 2 hours, but no one came until the next shift. Staff came to see her at 5:00am to say hello and she was discovered on the floor. R2 stated that the nurse and medication technician took over. She had injuries on both legs where she got bruises from the fall. R2 stated that Dispatch Health was called to treat her wounds.

During an interview on 07/28/2023 at 2:17pm, Staff C, Medication Technician, stated that when residents press the call light, it goes to the care staffs' pagers and after 10-15 minutes it goes to the medication technicians' and the nurses' walkie talkie. Staff C stated that sometimes residents call front desk when help is needed. Staff C stated that she cannot answer the question about the call light response time. Staff C stated that some caregivers don't answer the call light because they don't like that resident.

During an interview on 07/28/2023 at 2:17pm, Staff B, Clinical Specialist, stated that staff is supposed to answer the call light in 5 - 10 minutes. Staff B was asked what you would do if staff responded to the call light after 5 hours. Staff B stated, "she would assess the resident for injuries, investigate the reason for not responding and write up the staff on shift, notify family, check pendants and if not working then replace it." Staff B stated that it is not okay if staff is not responding to the call light in a timely manner. Staff B stated that staff needs to be trained, and we are hiring new staff and doing a lot of inservice education.

This is a recurring deficiency previously cited on 10/22/2022.

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 Allenmore AL (WA) 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.

_____ _____

Administrator (or Representative) Date

WAC 388-112A-0550 Who is required to complete nurse delegation core training and nurse delegation specialized diabetes training and by when?

(1) Before performing any delegated nursing task, long-term care workers in adult family homes and assisted living facilities must:

(a) Successfully complete the DSHS designated nurse delegation core training, "nurse delegation for nursing assistants & home care aides";

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 1 of 6 sampled staff (Staff D) were delegated before checking residents' blood sugars or administering insulin for 1 of 4 sampled residents. This failure resulted in Resident 3 receiving care from unqualified staff and placed the resident at risk for serious negative health consequences, inadequate/poor disease management and poor quality of life.

Findings Included...

Record review of Medication Administration Record (MAR) on 07/04/2023 showed that Resident 3 (R3's) blood sugar was checked at 4:00pm and 8:00pm by the Medication Technician (Staff D).

Record review of staff records on 08/09/2023 showed that Staff D did not have the required training (DSHS designated nurse delegation core training, "nurse delegation for nursing assistants & home care aides") to perform blood sugar checks and administer insulin injections (medication for diabetes; high levels of blood sugar).

During an interview on 07/28/2023 at 2:17pm, Staff B, Clinical Specialist, stated that if a nurse calls in sick, then the District Director of Clinical Services (Staff A) or Staff B will cover. Staff B stated that sometimes Staff A delegates the medication technicians. In a separate interview on 08/11/2023 at 1:25pm, Staff B stated that Staff A delegated Staff D to perform blood sugar checks and to administer insulin injections on 07/04/2023. Staff D did blood sugar checks for R3. Staff B stated that no blood sugar checks, and insulin administration was done by staff D for Resident 4 (R4), Resident 5 (R5) and Resident 6 (R6) because they were out of the facility with their family. Staff B stated that when residents go out with family, they give all scheduled medicines to family to administer to residents.

During an interview on 08/09/2023 at 6:34pm, Staff A stated that on 07/04/2023 she was told by the previous nurse and the associate at the building that Staff D had the correct training needed for nurse delegation. Staff A stated that she went through the delegated task which is only insulin and blood sugars. Staff A stated that Staff D acknowledged that she could do the nurse delegation task. Staff A stated that associates in the building thought that one of the previous nurses had taught Staff D to do insulin administration and was trained. Staff A was asked if Staff D had the required nurse delegation core training. Staff A stated that Staff D does not have the required nurse delegation core training but is currently going to be taking the delegation classes. Staff A stated that this was the only day Staff D did these tasks.

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 Allenmore AL (WA) 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.

_____ _____

Administrator (or Representative) Date