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) 38333 (Completion Date 04/25/2024) and 30186 (Completion Date 11/09/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/25/2024 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-2630-1, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Allenmore AL (WA)
Provider Type: Assisted Living Facility
License/Cert.#: 1701
Intake ID: 99694
Compliance Determination #: 30186
Region/Unit #: RCS Region 3 / Unit D
Investigator: Nareet Bajwa
Investigation Date(s): 09/27/2023 through 11/09/2023
Complainant Contact Date(s):

Allegation(s):
AV being abused by AP

Investigation Methods:

Sample:	Total residents: Resident sample size: 1 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors Care equipment hotline contact for reporting abuse poster
Interviews:	Residents, including the named resident Staff
Record Reviews:	Resident Characteristic Roster Staff records Staff progress notes Incident log / reports, Facility P & P Safety plan

Investigation Summary:
Per record review, interviews with resident and staff, facility failed to call law enforcement agency and Complaint Resolution Unit (CRU) hotline as a mandatory reporter for resident on an incident of suspected sexually abuse. Failed facility practice identified. See Statement of Deficiency dated 11/09/2023.

Conclusion / Action:

☒ 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

Statement of Deficiencies	License #: 1701	Compliance Determination # 30186
Plan of Correct on	Brookdale Allenmore AL (WA)	Completion Date
Page 1 of 3	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	11/09/2023

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 09/27/2023 and 09/27/2023 of:

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

This document references the following complaint number(s): 99694

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

Cory Cisneros
Residential Care Services

11/13/2023
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) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74 34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to call law enforcement and Complaint Resolution Unit (CRU) hotline as a mandatory reporter for 1 of 1 sampled resident (Resident 1) on an incident of suspected sexually abuse. This failure placed all 56 residents in the ALF at risk for potential abuse.

Findings Included...

Record review of the Abuse, Neglect & Exploitation Policy- WA-1 Last Revised 5/2021 stated "(3) Internal Reporting: (a) Employee obligations (General): Any employee who witnesses or has reasonable cause to believe that a resident has been the subject of suspected or alleged abuse neglect, or exploitation, should immediately report such incident to Executive director or supervisor on duty and to the Washington State Department of Social and Health Services (Department) hotline at 1-800-562-6078 without retaliation from licensee or administrator. (4) Response to Incident: (a) Protection of resident: (1a) Take necessary steps to protect the resident, which may include removing the resident or removing the other resident/ associate/ 3rd part provider/ visitor immediately from the situation or summoning additional help "

During an interview on 09/27/2023 at 1:01pm, Resident 1 (R1) stated that Staff C, Caregiver, laid n his bed for a little bit. R1 stated that Staff D (Medication Technician) came into the room and saw Staff C lying with him. R1 stated that he doesn't understand why they fired Staff C. R1 stated that it was the only time it happened.

During an interview on 09/27/2023 at 12:10pm, Staff B, Resident Care Coordinator stated that on 09/25/2023, around 4.30am she received a call from Staff D working that shift that she witnessed Staff C lying in bed with R1 Staff B stated that she told staff D to write a

statement. Staff B was asked if Staff C was in the facility after the incident. Staff B stated that Staff C was working in the facility with other residents after the incident and left when her shift ended. Staff B was asked who was notified. Staff B stated that she tried to call the Administrator (Staff A), but the call didn't go through.

During an interview on 09/27/2023 at 12:20pm, Staff A stated that the incident happened on 09/25/2023 early morning at 4:30am. Staff A stated that she was notified at 11:30am on 09/25/2023 by Staff B. Staff A stated that as soon as she was notified about the incident, she started an investigation and notified the state hotline (CRU), police, regional nurse, Department of Health license, family/POA, and doctor. Staff A stated that she told Staff B that this needed to be addressed immediately. Staff A stated that if she was notified at the time of incident then she would have told Staff C to wait in her car until she arrived. Staff A was asked if Staff C was in the facility after the incident. Staff A stated that Staff C was working in the facility with other residents for approximately 90 minutes after the incident and punched out at 06:01am when her shift ended.

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) 10.9.23.

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

Ann Marie Natali
Ann Marie Natali — 11.20.23

Administrator (or Representative) Date