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) 57877 (Completion Date 05/02/2025) and 54934 (Completion Date 02/26/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/02/2025 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-2210-1-b, WAC 388-78A-2210-2-b, WAC 388-78A-2650-3

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, Allied Health Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Allenmore AL (WA)
License/Cert.#: 1701
Compliance Determination #: 54934
Investigator: Nareet Bajwa
Investigation Date(s): 01/14/2025 through 02/26/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 161197
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
AV was sent to hospital and later diagnosed as [redacted]

Investigation Methods:

Sample:	Total residents: 51 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 Medication administration
Interviews:	Staff ED
Record Reviews:	Resident Characteristic Roster Medication administration records (MAR) Staff records Staff progress notes Incident log / reports, Facility P & P service plan

Investigation Summary:
Per record review, interviews with staff, Assisted Living Facility (ALF) failed to ensure that residents received their medication as ordered and failed to report a medication error to the department's Complaint Resolution Unit (CRU). Failed facility practice identified. See Statement of Deficiency dated 02/26/2025.

Conclusion / Action:

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

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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 01/14/2025 of:

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

This document references the following complaint number(s): 161197

The following sample was selected for review during the unannounced on-site visit: 1 of 51 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

Statement of Deficiencies	License #: 1701	Compliance Determination # 54934
Plan of Correction	Brookdale Allenmore AL (WA)	Completion Date
Page 2 of 5	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	02/26/2025

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: 02/27/2025

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: 2/28/2025

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to ensure that 1 of 1 resident (Resident 1 [R1])received their medication as ordered. This failure placed Resident 1 and all other 51 residents in the ALF at risk for poor health outcomes.

Findings included...

Review of R1's facility records showed that R1 was admitted to the ALF on [redacted]2024 with the diagnosis to include [redacted]. Review of R1's [redacted]2024 and January 2025 Medication Administration Records (MARs) showed an order of insulin glargine (diabetic medication) starting from [redacted]2024, scheduled twice a day at 8am and 8pm. There was no record of administration of insulin glargine at 8:00am on 12/09/2024, 12/11/2024, 12/13/2024, 12/14/2024, 12/16/2024, 12/17/2024, 12/18/2024. There was no record for blood sugar check at 8:00am from

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

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Administrator (or Representative)

Date

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Findings included…

Review of R1's facility records showed that R1 was admitted to the ALF on [redacted]/2024 with the diagnosis to include [redacted] ([redacted]). Review of R1's [redacted] 2024 and January 2025 Medication Administration Records (MARs) showed an order of insulin glargine (diabetic medication) starting from [redacted]/2024, scheduled twice a day at 8am and 8pm. There was no record of administration of insulin glargine at 8:00am on 12/09/2024, 12/11/2024, 12/13/2024, 12/14/2024, 12/16/2024, 12/17/2024, 12/18/2024. There was no record for blood sugar check at 8:00am from

12/05/2024 to 12/20/2024. There was no record of insulin administration and blood sugar checks at 8:00pm on [redacted]/2024, 12/05/2024, 12/06/2024, 12/09/2024, 12/16/2024 and 12/17/2024. There was no record of blood sugar check at 8:00am on 01/01/2025, 01/02/2025, 01/03/2025, 01/04/2025.

During an interview on 01/14/2025 at 12:46pm, Staff B, Clinical Service Specialist stated that on 12/17/2024 she was informed that R1 had missed a few of her doses of insulin since she had just moved into the facility. Staff B stated that she investigated and noted that R1 had missed four evening and five morning doses of her glargine insulin on random days. Staff B stated that it was documented as waiting for refill delivery, and she did not know the medication was in the cart. Staff B stated that when she asked Staff C, Medication Technician and Staff D, Medication Technician, regarding insulin not being administered, they stated that they were not aware of the insulins brand name verse its generic name. Staff B stated that all staff were informed to notify the nurse immediately if they were out of an insulin and were having difficulty getting a medication as this is a life-threatening error. Staff B stated that R1 was placed on alert for missing medications and to monitor for possible side effects of missing medication. Staff B stated that Staff C and Staff D were written up. Staff B was asked if R1's blood sugar was being checked. Staff B stated that blood sugar was not checked for some days.

During an interview on 02/21/2025 at 1:07pm, Staff A, Administrator stated that every time before giving insulin, staff is supposed to check blood sugars as mentioned in the MARs. Staff A stated that R1 did missed some insulin doses and blood sugar checks. Staff A stated that Staff C and Staff D did not administer the insulin medication to R1. Staff A stated that Staff C, Staff D got written up and re-trained.

During an interview on 02/25/2025 at 2:10pm, Staff A stated that staff normally reorder medication four - five days before medication running out for R1. Staff A stated that all staff were aware, but they were not reordering medication on time. Staff A stated we are working on that, and she is monitoring medication cart herself and doing cart audit once a month.

Statement of Deficiencies	License #: 1701	Compliance Determination # 54934
Plan of Correction	Brookdale Allenmore AL (WA)	Completion Date
Page 4 of 5	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	02/26/2025

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) 2/28/25 .

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

Administrator (or Representative) 2/28/25 Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to report a medication error to the department's Complaint Resolution Unit (CRU) as required for 1 of 1 resident (Resident 1[R1]). This failure placed residents in the ALF at risk for poor health outcomes.

Findings included...

Review of R1's facility record showed that R1 was admitted to the ALF on [redacted] 2024 with the diagnosis to include [redacted]. Review of R1's [redacted] 2024 and January 2025 Medication Administration Records (MARs) showed medication error incident on 12/17/2024.

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During an interview on 02/26/2025 at 12:24pm, Staff A stated that when any incident happens, we notify the district nurse and then they tell us who to notify. Staff A was asked if CRU was notified of the incidents. Staff A stated that no, it was not reported.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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Staff A stated that she is good about reporting, but she forgot.

Plan/Attestation Statement

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

Katie Kemp
Administrator (or Representative)

2|28|25
Date

Staff A stated that she is good about reporting, but she forgot.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date