STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Silver Lake
2015 LAKE HEIGHTS DR
EVERETT, WA 982086034

RE: Brookdale Silver Lake License # 1703

Dear Administrator:

This letter addresses Compliance Determination(s) 25446 (Completion Date 06/15/2023) and 20123 (Completion Date 04/06/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/15/2023 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-2600-2-f

The Department staff who did the on-site verification:
Christine Banta, Community Complaint investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Silver Lake
Provider Type: Assisted Living Facility
License/Cert.#: 1703
Compliance Determination #: 20123
Intake ID: 68357
Investigator: Christine Banta
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/27/2023 through 04/06/2023
Complainant Contact Date(s):

Allegation(s):

It was alleged...
The Named Resident (NR) had an injury fall in the Assisted Living Facility (ALF).

Investigation Methods:

Sample: Total residents: 42
Resident sample size: 3
Closed records sample size: 2

Observations: Environment
Residents
Staff-resident interactions

Interviews: Executive Director
Residents
Others not associated with the ALF.

Record Reviews: Resident records
ALF records
Medical records

Investigation Summary:

It was determined...
The NR was sitting on the edge of the bed, leaned to the left, and fell to the floor with the blanket and rolled to the right side. The med tech was alerted by the Safely You alert system and watched the Safely You video of the NR's fall. The med tech assumed the NR had a controlled fall. The NR was sleeping on the floor of their room which set off the Safely You alarm. The NR was moved into another room so they could continue to sleep on the floor. At 10:00 AM the NR was found on the floor in pain. The Director of Nursing called 911 to have the NR taken to the emergency department. The ALF failed to follow their policy for falls. Citation for WAC 388-78A-2600 Policies and Procedures.

Conclusion / Action:

☒ 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 #: 1703	Compliance Determination # 20123
Plan of Correction	Brookdale Silver Lake	Completion Date
Page 1 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	04/06/2023

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 02/27/2023, 02/27/2023, 03/15/2023 and 03/15/2023 of:

Brookdale Silver Lake
2015 LAKE HEIGHTS DR
EVERETT, WA 982086034

This document references the following complaint number(s): 68357, 71289

The following sample was selected for review during the unannounced on-site visit: 3 of 42 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Christine Banta, Community Complaint investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Rios
Residential Care Services

4-20-2023
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.

X _____ Administrator (or Representative)

X 5.10.2023 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to follow their policy and procedure for 1 of 2 sampled residents (Resident 1) when Resident 1 fell out of bed and did not receive a nursing assessment. This failure resulted in a delay of treatment.

Findings included...

Review of the ALF's policy dated 02/2023, "Falls Management Policy" showed their definition of a fall is an unintentional coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. The policy showed when a fall occurs:
A. In Assisted Living:

(1) Assist the resident and provide first aid or call 911 as indicated and follow the directions of the 911 operator.

(2) Notify the Health and Wellness Director (HWD)/nurse/designee and ED.

(3) Notify the resident's physician/healthcare provider (HCP) for evaluation, care and treatment if indicated and document in the resident record.

(4) Notify the resident's family /responsible party and document in the resident record.

(5) Document the resident fall/injuries, resident response, and interventions taken in the PointClickCare (PCC).

Resident 1 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted].

Record review of an incident report dated 02/01/2023 showed an unwitnessed fall occurred on 01/29/2023 at 5:55 PM. The report stated that the Safely You system captured Resident 1 sitting on the side of the bed and fall to the floor onto their left side,

then flipping over to the right side. Caregivers responded then placed a pillow under Resident 1's head and a blanket over them. There was no documentation that an assessment was done in the incident report.

In interview on 03/14/2023 at 2:03 PM, Staff D, Caregiver, stated that they answered the call from Safely You to check on Resident 1. Staff D stated that they found Resident 1 laying on the floor then put a pillow under Resident 1's head. Staff D stated that Resident 1 liked sleeping on the floor. Staff D stated that they were unaware that the Resident 1 had slipped out of bed at that time. Staff D stated that they called Staff G, Caregiver, and Staff C, Medication Technician, to assist Resident 1 off the floor and onto the wheelchair as directed by Staff B, Director of Nursing. Staff D stated that Resident 1 looked like they were in pain during the transfer. Staff D stated that Resident 1 was yelling as they were lifted into the wheelchair. Staff D stated that they took Resident 1 to the Nursery Room and transferred them onto a mattress that was placed on the floor. Staff D stated that they were "more careful" with this transfer compared to the initial one. Staff D admitted that they did not know if the on-call nurse had been notified.

In interview on 03/17/2023 at 11:56 AM, Staff C stated that their duties also included handling resident falls, calling the nurse, or calling 911. Staff C stated that they received the alert from Safely You immediately following the fall and checked the video footage shortly after. Staff C stated that the video showed Resident 1 sitting on the edge of the bed and had braced themselves as they went down to the floor. Staff C stated that they saw Resident 1 sitting up on the floor. Staff C stated that they did not finish watching the recording after they had been interrupted by another resident. Staff C stated that the caregivers had reported that Resident 1 was in pain. Staff C stated Resident 1 was screaming as Staff C asked Resident 1 where the pain was. Staff C stated Resident 1 pointed to their hip after asking where it hurt. Staff C stated that they then proceeded to get Resident 1 onto the wheelchair to transfer to the Nursery Room. Staff C stated that they administered a dose of acetaminophen (pain medication). Staff C stated that they did not report to the on-call nurse that Resident 1 had any pain.

Review of Resident 1's Medication Administration Record (MAR) for January 2023 did not show acetaminophen was listed as one of the prescribed medications. There was no documentation that acetaminophen was administered.

In a phone interview on 03/15/2023 at 03/15/2023 at 2:53 PM, Staff B stated that there was no fall situation with Resident 1 since they "never saw a fall". Staff B stated that Resident 1 liked to put themselves on the floor. Staff B stated that when Resident 1 was on the floor, the Safely You system would continuously alert them every 30 minutes. Staff B stated that if the alert went unanswered, the call would escalate to Staff B's phone. Staff B stated that they called Staff C and gave instructions to transfer Resident 1 onto the wheelchair then transferred onto the Nursery Floor. Staff B stated that the Safely You system is not connected to the Nursery Room and that it had a window where staff can check on Resident 1. Staff B stated that an assessment was not done since Staff B was not aware Resident 1 had slipped out of bed. Staff B stated that there was no report Resident 1 was in any pain. Staff B stated that when Staff B arrived at work that next morning, the AM caregiver alerted them that Resident 1 had been in a lot of pain due to their leg and was yelling out. Staff B stated that Resident 1's family representative arrived

around 10:00 AM, the same time Staff B was notified of the resident's pain. Staff B stated Resident 1's family representative requested to have 911 called and transport Resident 1 to the Emergency Department (ED). Staff stated that they were not able to do an assessment before paramedics arrived.

In a phone interview 03/07/2023 at 11:00 AM, Collateral Contact 1, CC1, Resident 1's family representative, stated that they had walked into the ALF on 1/30/2023 at 10:30 AM (the morning after Resident 1 fell out of bed) and saw Resident 1 laying on the floor in the Nursery Room. CC1 stated that Resident 1 was upset and told them they cold not get off the floor. CC1 stated Staff B had denied Resident 1 had a fall and had made the decision to move Resident 1 to the Nursery room to keep the alarms from going off. CC1 stated that they observed Resident 1 screaming in pain when the care staff attempted to change Resident 1's brief. CC1 stated that they went to Staff A, Executive Director, and requested 911 be called. CC1 stated that Resident 1 passed away on [redacted]/2023. CC1 stated that when Resident 1 went to the hospital they diagnosed them with a [redacted]. Surgery was recommended but was told it may be too much for him. Hospice was recommended and opted to have hospice care at their private home.

Review of Resident 1's hospital records, dated [redacted]/2023 showed Resident 1 went to the ED on [redacted]/2023 and was admitted to the hospital on [redacted]/2023 for a right femur fractures and was not a good candidate for surgery. Resident 1 was discharged on home hospice services on 02/03/2023.

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 Silver Lake is or will be in compliance with this law and / or regulation on (Date) X 5/31/2023.

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

X _____ X 5-10-2023

Administrator (or Representative) Date