STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

EMERITUS CORPORATION
Brookdale Monroe
15465 179TH AVE SE
MONROE, WA 98272

RE: Brookdale Monroe License # 2284

Dear Administrator:

This letter addresses Compliance Determination(s) 29043 (Completion Date 09/06/2023) and 23898 (Completion Date 07/13/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/06/2023 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-2240, WAC 388-78A-2350-1, WAC 388-78A-2350-7-b

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Monroe
Provider Type: Assisted Living Facility
License/Cert.#: 2284
Compliance Determination #: 23898
Intake ID: 80954
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/12/2023 through 07/13/2023
Complainant Contact Date(s):

Allegation(s):

1. The Assisted Living Facility (ALF) failed to follow physician's orders, when the Named Resident (NR) had a blood sugar higher than the parameters.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident rooms
Interviews:	Identified resident Nursing staff
Record Reviews:	Resident Records

Investigation Summary:

1. Interview and record review showed the ALF staff failed to notify the NR's physician when the resident had a high blood sugar reading. The Registered Nurse stated that the physician should have been notified.

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 Monroe
Provider Type: Assisted Living Facility
License/Cert.#: 2284
Compliance Determination #: 23898
Intake ID: 81937
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 05/12/2023 through 07/13/2023
Complainant Contact Date(s):

Allegation(s):

1. The Executive Director (ED) was making changes to the resident's living conditions without notifying the residents or the resident representatives of the Assisted Living Facility (ALF).
2. The ED was bullying and isolating residents at the ALF.
3. The ALF failed to re-order the Named Residents (NR)'s medications, resulting in missed medications for one week.
4. The ALF increased the NR's care and rent.
5. The NR's apartment was not cleaned or garbage emptied.

Investigation Methods:

Sample:	Total residents: 54 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	Resident Records

Investigation Summary:

1. In an interview, the interim executive director stated that changes had been made to rearrange the furniture for decor. The Health and Wellness Director stated that rearranging the furniture was for residents safety. Observation showed multiple seating options in the common areas to accomodate resident socialization.
2. In an interview, the interim executive director stated that he had not bullied or isolated any of the residents. Sampled residents reported no concerns with being bullied or isolated.
3. Interview and record review showed the ALF staff failed to esnure the NR had medications availabe as prescribed by their primary care physician.
4. In an interview, the NR's family representative stated that they had received written

notice prior to the rate increase. The interim executive director stated that the ALF has an annual rent increase. The residents and their family representatives were given a 30 day written notice prior to the rent increase.
5. Observation and interview showed the NR's apartment was cleaned and garbage was emptied. The NR stated that their apartment was cleaned weekly. Sampled residents had no concerns with the housekeeping.

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
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2284	Compliance Determination # 23898
Plan of Correction	Brookdale Monroe	Completion Date
Page 1 of 4	Licensee: EMERITUS CORPORATION	07/13/2023

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 05/12/2023, 05/12/2023 and 07/07/2023 of:

Brookdale Monroe
15465 179TH AVE SE
MONROE, WA 98272

This document references the following complaint number(s): 79003, 80954, 81937

The following sample was selected for review during the unannounced on-site visit: 4 of 54 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

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

7/17/2023
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 7/18/2023

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure medications were available for 1 of 2 sampled residents (Resident 2). This failure placed Resident 2 at risk for health complications.

Findings included...

Record review showed the ALF admitted Resident 2 on [redacted]/2021 with multiple medical diagnoses. A Personal Service Plan (PSP is equivalent Negotiated Service Agreement), dated 05/05/2023, showed the ALF staff managed Resident 2's medication and were to do an inventory of medications every Sunday evening, reordering any medications that were down to the last two weeks supply.

In an interview, on 05/12/2023 at 11:40 AM, Staff A (Registered Nurse) stated a note that read, "16 pharmacy action required" in a Medication Administration Record (MAR) indicated that a medication was not available, had not been received from the pharmacy, and was not given to a resident.

Record review of the April 2023 MAR showed Resident 2 had a physician's order for PreserVision AREDS 2 Capsule (multiple vitamins-mineral supplement) give one capsule by mouth two times a day. The MAR showed the ALF staff had documented under PreserVision "16 pharmacy action required" on 04/04/2023 through 4/7/2023. Resident 2 had a physician's order for Guaifenesin Extended-Release 12 hour (used to help clear mucus from the chest when you have congestion) 600 milligrams give one tablet by mouth two times a day. The MAR showed the ALF staff had documented under Guaifenesin, "16 pharmacy action required" on 04/01/2023 through 04/19/2023 and 04/25/2023 through 04/29/2023. Resident 2 had a physician's order for Tiotropium Bromide Monohydrate (used to prevent bronchospasm (tightening of the muscles) caused by Chronic Obstructive Pulmonary Disease) 18 micrograms give one capsule orally one time a day. The MAR showed the ALF staff documented "16" to show pharmacy action required on 04/28/2023 and 04/29/2023.

Statement of Deficiencies	License #: 2284	Compliance Determination # 23898
Plan of Correction	Brookdale Monroe	Completion Date
Page 3 of 4	Licensee: EMERITUS CORPORATION	07/13/2023

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 Monroe is or will be in compliance with this law and / or regulation on (Date) 8/15/2023

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

Administrator (or Representative) Date 7/19/2023

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify 1 of 2 sampled residents (Resident 1) physician about a high blood sugar result. This failure placed Resident 1 at risk for health complications.

Findings included...

Review of a Personal Service Plan (PSP-equivalent to a Negotiated Service Agreement), dated 05/05/2023, showed Resident 1's Primary Care Physician (PCP) ordered the ALF to check Resident 1's blood sugar every Monday, Wednesday, and Friday morning and instructed the ALF to call the PCP if the blood sugar result was less than 80 or greater than 300.

Record review of the April 2023 Medication Administration Record (MAR) showed on 04/19/2023, Resident 1 had a blood sugar reading of 353.

In an interview, on 05/12/2023 at 11:25 AM, Staff A (Registered Nurse) stated that she did not have documentation to show that Resident 1's PCP had been notified about the blood sugar result of 353 on 04/19/2023. Staff A stated that the PCP should have been notified.

Statement of Deficiencies	License #: 2284	Compliance Determination # 23898
Plan of Correction	Brookdale Monroe	Completion Date
Page 4 of 4	Licensee: EMERITUS CORPORATION	07/13/2023

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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 Monroe is or will be in compliance with this law and / or regulation on (Date) 8/15/2023

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

Administrator (or Representative) Date 7/19/2023