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) 30029 (Completion Date 09/28/2023) and 26309 (Completion Date 07/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/28/2023 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-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-2

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 #: 26309
Intake ID: 85430
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 07/07/2023 through 07/27/2023
Complainant Contact Date(s):

Allegation(s):

1. The Assisted Living Facility (ALF) failed to properly transcribe physician's orders for the Named Resident (NR), resulting in missed medications.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident
Record Reviews:	Resident Records Incident Investigations

Investigation Summary:

1. Interview and record review showed the ALF failed to follow the physician's order to only discontinue the parameters for a medication. The ALF nurse discontinued the prescribed medication in error. Interview and record review showed the NR's physicina discovered the error and notified the ALF . The medication being discontinued in error resulted in the NR missing several doses of the medication.

Conclusion / Action:

- [x] 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 #: 2284	Compliance Determination # 26309
Plan of Correction	Brookdale Monroe	Completion Date
Page 1 of 3	Licensee: EMERITUS CORPORATION	07/27/2023

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

Brookdale Monroe
15465 179TH AVE SE
MONROE, WA 98272

This document references the following complaint number(s): 85430

The following sample was selected for review during the unannounced on-site visit: 2 of 48 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

7/31/2023
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-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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(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 interview and record review, the Assisted Living Facility (ALF) failed to follow the physician orders for 1 of 1 resident (Resident 1). This failure resulted in Resident 1's missing several doses of a blood pressure medication when it was discontinued in error.

Findings included...

Record review of a Face sheet showed the ALF admitted Resident 1 on [redacted]/2021 with multiple medical diagnoses to include [redacted] and [redacted]. Record review of a Personal Service Plan (PSP is equivalent to a Negotiated Service Agreement), dated 06/13/2023, showed the ALF staff managed Resident 1's medications.

Review of Resident 1's records showed a signed physician's order, dated 05/31/2023, that instructed "DC [discontinue] lisinopril parameters."

In interview, 07/10/2023 at 4:40 PM Staff A (Health and Wellness Director) stated that on 05/31/2023 the ALF received a physician's order to discontinue parameters (when to hold medication related to blood pressure readings) for lisinopril (a medication used treat high blood pressure and heart failure). Staff A stated the ALF discontinued the entire lisinopril medication order in error, not just the parameters. The error was noted when Resident 1's physician reviewed their active medication list.

Statement of Deficiencies	License #: 2284	Compliance Determination # 26309
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Record review of the June Medication Administration Record (MAR) showed Resident 1's lisinopril was not given as ordered from 06/01/2023 through 06/09/2023.

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) 9/10/2023

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

Administrator (or Representative) 8/1/2023 Date