



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

EMERITUS CORPORATION
Brookdale Everett
11333 3RD PL W
EVERETT, WA 98204

RE: Brookdale Everett License # 2285

Dear Administrator:

This letter addresses Compliance Determination(s) 27591 (Completion Date 08/02/2023) and 23795 (Completion Date 06/05/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/02/2023 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-3090-1-a, WAC 388-78A-3090-1-c, WAC 388-78A-3090-1-d

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,

A handwritten signature in cursive script that reads "Kim Ripley".

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



Residential Care Services Investigation Summary Report

Provider/Facility: Brookdale Everett

Provider Type: Assisted Living Facility

License/Cert.#: 2285

Compliance Determination #: 23795

Intake ID: 80698

Investigator: Wesler Dumecquias

Region/Unit #: RCS Region 2 / Unit A

Investigation Date(s): 05/10/2023 through 06/05/2023

Complainant Contact Date(s):

Allegation(s):

1. There were no fruits and only occasional vegetables were being served.
2. The Named Resident (NR) missed lunch because it was not delivered.
3. The NR was given late breakfast and was served cold.
4. The NR was getting 2 baths a week despite having a bedsore.
5. The nurses had to help the kitchen prepare meals.
6. The Assisted Living Facility (ALF) had issues with housekeeping and cleanliness on 2 Sampled residents (SR). The NR and SR's room were cluttered with boxes, used clothes and linens in the bathroom. The sink had unwashed dishes in it. The laundry bin was full, the room smelled. There was dirty equipment, stained pillows, and an unchanged painting in the room. All contributing to safety hazard.

Investigation Methods:

Sample:	Total residents: 65 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Dining Resident rooms Kitchen Food preparation
Interviews:	Identified resident Nursing staff Residents Family members Housekeeping staff Kitchen staff
Record Reviews:	Facility policies Care plans Assessments Menu Call light logs

Investigation Summary:

1. Assisted Living facility (ALF) records showed that the ALF had a weekly menu that included fresh fruits and vegetables. Observation and interview showed that fruit was being served to residents. Residents were given copies of the menu for the day. Residents were able to order extra food and request available food choices.
2. Observation during un announced visit showed that the ALF had a system to cater to room tray services. The ALF was catering to all the residents eating in the dining room and then do food tray services. Residents were to fill up food tray services slips. the slips were taken by the caregivers which would be processed in the kitchen as tray service. The caregivers would start serving the trays on room services once the residents in the dining room were done. The Kitchen has a master list to make sure that all residents are served meals. Observation made during lunch time showed that the lunch was delivered within the time range for the ALF's tray services.
3. During an observation, the NR was served a with a warm breakfast at 8:54 in the morning. In an interview, the NR stated that the ALF had been serving warm food and was satisfied about it. The ALF encourages residents to come down for meals. The ALF delivers tray services right after catering to residents eating at the Dining room.
4. Interview and record review showed the NR had an increase in bathing frequency from 2 to 3 times a week on Sundays, Wednesdays and Fridays. The NR on interview stated that the ALF was cleaning and applying cream to their skin.
5. Interview showed that caregivers tasks include helping in food preparation for delivery and delivers food trays to residents room. Med Techs and care coordinator help answer call lights for residents.
6. Observation and interview showed that the Rooms of NR and SR were cluttered boxes, used clothes and linens in the bathroom, sink had unwashed dishes, laundry bin was full, room smells, dirty equipment, stained pillows and unhanged painting on SR exit door. All contributing to safety hazard and decreased quality of life. Failed Practice identified for noncompliance with WAC 388-78A-3090 Maintenance and housekeeping.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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Hand
6/23

Statement of Deficiencies	License #: 2285	Compliance Determination # 23795
Plan of Correction	Brookdale Everett	Completion Date
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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 05/10/2023 and 05/26/2023 of:

Brookdale Everett
11333 3RD PL W
EVERETT, WA 98204

This document references the following complaint number(s): 78029, 80698

The following sample was selected for review during the unannounced on-site visit: 3 of 65 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesley Dumecquias, 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 Ripley

Residential Care Services

06/13/2023

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.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2285	Compliance Determination # 23795
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Angela Kline
Administrator (or Representative)

6/23/2023
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and
- (d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observations and interviews the Assisted Living Facility (ALF) failed to provide basic housekeeping and maintenance services to keep resident living quarters in a safe and sanitary condition for 2 of 3 residents (Resident 1 and 2). This failure resulted in an unsanitary safety risk and diminished quality of life.

Findings included:

Resident 1

*Collected 6/1/2023
Angela Kline*

Resident 1 was admitted [REDACTED] 2021 with multiple diagnoses including [REDACTED]

On 05/10/2023 at 1:00PM, Resident 1's living quarters were observed to have unwashed dishes in the sink and a plastic wrapper on the floor. The room was full of clutter and only a small space for the resident to move or maneuver their wheelchair. There were clothes piled up and stack up high on a chair. There were 2 small tables beside Resident 1's bed, one full of kitchen condiments and the other was full of personal stuff such as lotions and creams. By the foot part of the bed were brown boxes stack up together and stockpiles of depends. The wheelchair was by the left foot part of the bed with a folded walker near it.

In an interview on 05/10/2023 at 1:00 PM, Resident 1 stated that nobody washes her dishes, nobody cleans the floor except once a week and when they come to remove the trash. Resident 1 stated she does her best to clean her room, but it was hard for her.

In an interview on 05/10/2023 at 2:22 PM, Staff E, caregiver, stated that she did not know of the unwashed dishes because she was not assigned to the resident. Staff E stated that

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housekeeping was done by the housekeeper once a week and all other days are done by caregivers.

On 05/26/2023 at 8:57 AM, Resident 1's room was observed to have a smell. The room was still cluttered and unorganized with clothes on the chair, boxes laying on top each other near the kitchen and her bed. There were spoons on the floor, a pen and 2 small bottles. There was a Styrofoam food container marked "Extra" laying on top of a small divider by the kitchen. The laundry bin was full and overflowing of used incontinence linens and clothes.

In an interview on 05/26/2023 at 8:59 AM, Resident 1 stated that even her laundry is full, staff will only come at nighttime to get it. Resident 1 stated that she told a staff to remove the food box, but the staff did not come back to remove it. Resident 1 stated that she told staff to remove the spoons on the floor, but staff did not.

In an interview on 05/26/2023 at 9:07 AM, Staff J, Caregiver, stated that staff should have put the laundry bin in the closet and not just exposed in the open. Staff J stated that the night shift should have brought the bin to the laundry room and washed it because it was full, and staff should not wait for her laundry day.

Resident 2

Resident 2 was admitted [REDACTED] 2016 with multiple diagnoses including [REDACTED] and [REDACTED].

On 05/10/2023 at 2:43 PM, Resident 2's shirt was observed to have some white crumbs or flakes. Resident 2 was using a discolored white pillow without a pillowcase. The pillow was stained with brown and green marks from dried fluids. Resident 2's right recliner arm was stained and wet from dried food and fluids. Resident 2's bathroom had a large amount of used clothing from after showering that were on top of the shower chair. The room had stacks of 4 big brown boxes beside the head part of his bed. There was a big rectangular painting on the floor leaning on the wall by the right side of Resident 2's exit room. The resident was sitting in a wet pants.

In an interview on 05/10/2023 at 2:53 PM, during a visit in Resident 2's room, Staff F, Wellness Nurse, commented that they usually put a pillowcase on the pillow. Staff F did not say anything why there was no pillowcase but stated they will put one. Staff F stated that the armchair that was stained and wet appeared to be from a soda. Staff F upon looking at the used clothes in Resident 2's bathroom stated that they will remove it.

On 05/26/2023 at 9:11AM, with Staff J, Caregiver, on a visit to Resident 2's room, it was observed that Resident 2's room entrance was filled with huge boxes blocking the door and access into Resident 2's room.

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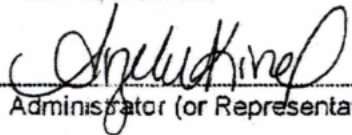
In an interview on 05/26/2023 at 9:11 AM, Staff J stated that Resident 2 was at the hospital. Staff J stated that the large boxes were supplies and were placed at Resident 2's entrance to be sorted out.

In an interview on 05/26/2023 at 9:13 AM, Staff K, housekeeping, stated that she was working alone. Staff K stated that she removes trash, cleans the sink and the bathroom only on residents' specific cleaning and housekeeping schedule. Staff K stated that the caregivers will do the housekeeping and cleaning on all other days.

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 Everett is or will be in compliance with this law and / or regulation on (Date) 7/15/2023.

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


Administrator (or Representative)

6/22/2023
Date