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

Emeritol Fairhaven Estates LLC
Brookdale Fairhaven
2600 Old Fairhaven Parkway
Bellingham, WA 98225

RE: Brookdale Fairhaven License # 2525

Dear Administrator:

This letter addresses Compliance Determination(s) 10572 (Completion Date 06/30/2022) and 6533 (Completion Date 05/10/2022).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/30/2022 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-2630-1-a, WAC 388-78A-2630-1-b, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2

The Department staff who did the on-site verification:
Helen Fisher, Complaint Investigator

If you have any questions, please contact me at (360)651-6863.

Sincerely,

Jayne Hill

Jayne Hill, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Fairhaven
Provider Type: Assisted Living Facility
License/Cert.#: 2525
Compliance Determination #: 6533
Intake ID: 24517
Investigator: Karen Nodolf
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/09/2022 through 05/10/2022
Complainant Contact Date(s):

Allegation(s):

1) A named staff had a physical altercation with a named resident and verbally threatened the named resident.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 11 Closed records sample size:
Observations:	Resident appearance Staff to resident interactions
Interviews:	Executive Director Director of Nursing Caregiver staff Maintenance staff
Record Reviews:	Resident assessments Resident negotiated service agreements Incident and investigation reports progress notes

Investigation Summary:

1) The Assisted Living Facility (ALF) was informed of a named staff making inappropriate and disrespectful verbal statements to residents as well as inappropriate physical actions including attempting to "trip" residents with their foot when residents were walking by with walkers and disregarding resident dignity and privacy. The ALF did not investigate or report these allegations after multiple reports by residents and other staff of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.

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 Fairhaven
Provider Type: Assisted Living Facility
License/Cert.#: 2525
Compliance Determination #: 6533
Intake ID: 24103
Investigator: Karen Nodolf
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/09/2022 through 05/10/2022
Complainant Contact Date(s):

Allegation(s):

1) A named resident may have been physically abused by a named staff who was witnessed roughly handling residents and the facility did not take any action.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 11 Closed records sample size:
Observations:	Resident appearance Staff to resident interactions
Interviews:	Executive Director Director of Nursing Caregiver staff Maintenance staff
Record Reviews:	Resident assessments Resident negotiated service agreements Incident and investigation reports progress notes

Investigation Summary:

1) The Assisted Living Facility (ALF) was informed of a named staff making inappropriate and disrespectful verbal statements to residents as well as inappropriate physical actions including attempting to "trip" residents with their foot when residents were walking by with walkers and disregarding resident dignity and privacy. The ALF did not investigate or report these allegations after multiple reports by residents and other staff of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.

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 Fairhaven
Provider Type: Assisted Living Facility
License/Cert.#: 2525
Compliance Determination #: 6533
Intake ID: 22690
Investigator: Karen Nodolf
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/09/2022 through 05/10/2022
Complainant Contact Date(s):

Allegation(s):

1) A named staff has been physically and verbally abusive to residents and neglecting resident care needs.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 11 Closed records sample size:
Observations:	Resident appearance Staff to resident interactions
Interviews:	Executive Director Director of Nursing Caregiver staff Maintenance staff
Record Reviews:	Resident assessments Resident negotiated service agreements Incident and investigation reports progress notes

Investigation Summary:

1) The Assisted Living Facility (ALF) was informed of a named staff making inappropriate and disrespectful verbal statements to residents as well as inappropriate physical actions including attempting to "trip" residents with their foot when residents were walking by with walkers and disregarding resident dignity and privacy. The ALF did not investigate or report these allegations after multiple reports by residents and other staff of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.

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 Fairhaven
Provider Type: Assisted Living Facility
License/Cert.#: 2525
Compliance Determination #: 6533
Intake ID: 27498
Investigator: Karen Nodolf
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/09/2022 through 05/10/2022
Complainant Contact Date(s):

Allegation(s):

1) A named staff put their foot in front of a resident as they were walking - this action has been seen before with other residents. The named staff is not liked by other residents and does not ask permission to enter resident rooms.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 11 Closed records sample size:
Observations:	Resident appearance Staff to resident interactions
Interviews:	Executive Director Director of Nursing Caregiver staff Maintenance staff
Record Reviews:	Resident assessments Resident negotiated service agreements Incident and investigation reports progress notes

Investigation Summary:

1) The Assisted Living Facility (ALF) was informed of a named staff making inappropriate and disrespectful verbal statements to residents as well as inappropriate physical actions including attempting to "trip" residents with their foot when residents were walking by with walkers and disregarding resident dignity and privacy. The ALF did not investigate or report these allegations after multiple reports by residents and other staff of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.

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 Fairhaven
Provider Type: Assisted Living Facility
License/Cert.#: 2525
Compliance Determination #: 6533
Intake ID: 27772
Investigator: Karen Nodolf
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/09/2022 through 05/10/2022
Complainant Contact Date(s):

Allegation(s):

1) A named staff was verbally abusive to a named resident.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 11 Closed records sample size:
Observations:	Resident appearance Staff to resident interactions
Interviews:	Executive Director Director of Nursing Caregiver staff Maintenance staff
Record Reviews:	Resident assessments Resident negotiated service agreements Incident and investigation reports progress notes

Investigation Summary:

1) The Assisted Living Facility (ALF) was informed of a named staff making inappropriate and disrespectful verbal statements to residents as well as inappropriate physical actions including attempting to "trip" residents with their foot when residents were walking by with walkers and disregarding resident dignity and privacy. The ALF did not investigate or report these allegations after multiple reports by residents and other staff of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.

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 Fairhaven
Provider Type: Assisted Living Facility
License/Cert.#: 2525
Compliance Determination #: 6533
Intake ID: 19642
Investigator: Karen Nodolf
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/09/2022 through 05/10/2022
Complainant Contact Date(s):

Allegation(s):

1) A named staff has been physically and verbally abusive to residents and may have neglected care.

Investigation Methods:

Sample: Total residents: 49
Resident sample size: 11
Closed records sample size:

Observations: Resident appearance
Staff to resident interactions

Interviews: Executive Director
Director of Nursing
Caregiver staff
Maintenance staff

Record Reviews: Resident assessments
Resident negotiated service agreements
Incident and investigation reports
progress notes

Investigation Summary:

1) The Assisted Living Facility (ALF) was informed of a named staff making inappropriate and disrespectful verbal statements to residents as well as inappropriate physical actions including attempting to "trip" residents with their foot when residents were walking by with walkers and disregarding resident dignity and privacy. The ALF did not investigate or report these allegations after multiple reports by residents and other staff of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.

Conclusion / Action:

☒ 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 Fairhaven
Provider Type: Assisted Living Facility
License/Cert.#: 2525
Compliance Determination #: 6533
Intake ID: 28335
Investigator: Karen Nodolf
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 02/09/2022 through 05/10/2022
Complainant Contact Date(s):

Allegation(s):

1) A named staff had a physical and verbal altercation with a named resident and a physical altercation with another named resident. Both incidents were reported to the administration and nothing was done about it.
2) The named staff harassed other staff at the facility with no action taken by the administration.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 11 Closed records sample size:
Observations:	Resident appearance Staff to resident interactions
Interviews:	Executive Director Director of Nursing Caregiver staff Maintenance staff
Record Reviews:	Resident assessments Resident negotiated service agreements Incident and investigation reports progress notes

Investigation Summary:

1) The Assisted Living Facility (ALF) was informed of a named staff making inappropriate and disrespectful verbal statements to residents as well as inappropriate physical actions including attempting to "trip" residents with their foot when residents were walking by with walkers, hitting residents on the head with a paper and disregarding resident dignity and privacy. The ALF did not investigate or report these allegations after multiple reports by residents and other staff of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.
2) Staff reported issues regarding a named staff's inappropriate behaviors at the ALF. The ALF did not investigate or report these allegations after multiple reports of concerns related to the named staff. See Statement of Deficiencies dated 04/27/2022.

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
3906-172nd St NE, Suite #100, Arlington, WA 98223

05/13/2022

CERTIFIED MAIL

HQ notice

Licensee: Emeritol Fairhaven Estates LLC
Brookdale Fairhaven
2600 Old Fairhaven Parkway
Bellingham, WA 98225

RE: Brookdale Fairhaven License # 2525

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 05/10/2022 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

• Wrote the enclosed Statement of Deficiencies (SOD) report; and
• May take licensing enforcement action based on any deficiency listed on the enclosed report; and
• May inspect the facility to determine if you have corrected all deficiencies.

You Must:

• Begin the process of correcting the deficiency or deficiencies immediately;
• Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

• Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  o Sign and date the enclosed report;
  o For each deficiency, indicate the date you have or will correct each deficiency;
  o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  o Mail the Plan/Attestation Statement and report with original signatures to:

Jayne Hill, Field Manager
Residential Care Services
Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (360)651-6863.

Sincerely,

Jayne Hill, Field Manager
Region 2, Unit A
Residential Care Services

Enclosure

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

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 02/09/2022 and 03/23/2022 of:

Brookdale Fairhaven
2600 Old Fairhaven Parkway
Bellingham, WA 98225

This document references the following complaint number(s): 24517, 24103, 22690, 27498, 27772, 19642, 28335

The following sample was selected for review during the unannounced on-site visit: 11 of 49 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Karen Nodolf, Community Complaint Investigator
Helen Fisher, Complaint Investigator

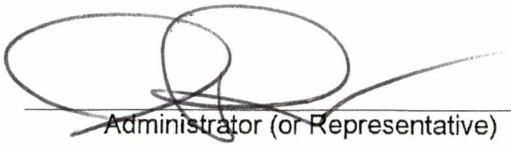
From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Jayne Hill
Residential Care Services

5/12/2022
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)

6/6/2022
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to report to the department, incidents of verbal and/or physical abuse by one of one ALF staff (Staff C) to four of four current residents (Resident 3, 4, 8 and 11) and one of one former residents (Resident 1). This failure resulted in some residents being afraid of Staff C and Staff C being rude and not respecting Resident's 1, 3, 4, 8 and 11 right to dignity.

Findings included...

Review of the ALF policy and procedure on abuse titled, "Abuse, Neglect & Exploitation Policy" dated 10/2001 with last revision dated 05/2021, showed it was the policy of the ALF to report to the Washington State Department of Social and Health Services when there is reasonable cause to believe that abuse, neglect or exploitation has occurred..

In an interview on 02/09/2022 at 2:30 PM, Resident 8 stated that Staff C, a former caregiver at the ALF had been rude to residents, didn't respect resident privacy and some residents were afraid of Staff C. Resident 8 stated that they had informed Staff A, the Executive Director and Staff B, the Director of Health and Wellness of these concerns specific to Staff C and he continued to work at the facility with no action taken.

In an interview on 02/09/2022 at 2:25 PM, Resident 3 and Collateral Contact 1, Resident 3's representative, stated that a few weeks prior, Staff C had put their foot out blocking Resident 3's walker when they were walking in the facility. Collateral Contact 1 stated that the ALF staff know how Staff C treats some residents and they don't report the incidents and the ALF management is aware and overlook the issue.

In an interview on 02/09/2022 at 1:10 PM, Staff B, the Health and Wellness Director stated that there had been no incidents of staff to resident abuse or any issues with staff behavior. Staff B stated that some residents reported concerns regarding Staff C exhibiting rude behavior to residents and not respecting their privacy. Staff B stated Resident 4 and Resident 8, "gang up on staff." Staff B stated that Resident 4 had reported issues with Staff C but stated that Resident 4 had "behavior issues." Staff B stated that Resident 8 had also notified Staff B of their concerns regarding Staff C but stated that Resident 8 did not like Staff C because he wears his pants too tight. Staff B stated that they did not investigate either of the resident concerns related to Staff C or document any incidents regarding Staff C. Staff C continued to work with the residents without any further investigation, supervision, or a report to the Department.

In an interview and observation on 02/09/2022 at 2:40 PM, Resident 4 stated that Staff C enters resident rooms without knocking and is abrupt and rude. Resident 4 stated that they had been on the toilet in their room and Staff C had entered their room without knocking and then stood outside the open bathroom door facing Resident 4 while they were on the toilet. Resident 4 stated that Staff C made no attempt to respect their privacy or dignity and that she was very uncomfortable with Staff C standing there. During the interview with Resident 4, Staff C was observed entering Resident 4's room at 2:43 PM on 02/09/2022 without knocking.

In an interview on 02/09/2022 at 2:45 PM, Staff C stated that they liked to work with the residents and loved the work at the ALF. Staff C identified Resident 4 as a difficult resident and stated, "she (Resident 4) hates my guts" and laughed. Staff C stated that they thought Resident 4 did not like him because of his long hair. Review of the ALF incident log for dates 01/09/2022 through 02/09/2022 found no incidents involving Staff C and other residents in the ALF.

In an interview on 03/25/2022 at 3:40 PM, Collateral Contact 3, a resident representative stated that Resident 11 had reported Staff C had been walking by the resident saying he was going to kill (Resident 11's) cat. Collateral Contact 3 stated that Resident 11 had spoken with the ALF about their concerns related to Staff C but no action had been taken.

Review of a report of an incident dated 03/16/2022 at 3:40 PM, showed Resident 11 came out of a common living area to ask staff for help for another resident. Resident 11 and Staff C got into a verbal altercation. Staff D, the ALF receptionist, who witnessed the altercation, reported Staff C told Resident 11 to, "get out of here." Staff C was told by Staff E, the Business Office Coordinator, not to speak to the resident that way and Staff C said Resident 11 was, "up in my space." Staff C left the ALF following the altercation and did not return. Following the incident, Resident 11 reported they felt threatened by Staff C. Resident 11 reported Staff C had stated something frightening to him during the altercation, but Staff D could not recall what they had been told that Staff C had said to Resident 11. Staff D stated that Resident 11 was concerned that he was causing trouble. Review of the Department's reporting records found there had been no report from the ALF regarding this staff to resident altercation.

In an interview on 03/23/2022 at 2:45 PM, Staff B stated that there had been "a couple of ladies" that had complained of Staff C being disrespectful. Staff B stated that Staff C had

tried to connect with residents and felt some residents had made Staff C a target. Staff A and Staff B stated that they had conducted resident and staff interviews related to the verbal altercation on 03/16/2022 but did not report it to the Department. Staff A and B stated that there were no investigations related to other resident concerns and Staff B and could not provide documentation of any incidents regarding Staff C. Staff C continued to work with the residents without any further investigation, supervision, or a report to the Department until the day they left the job voluntarily on 03/16/2022.

In an interview on 05/10/2022, Collateral Contact 5, stated that they had observed Staff C at the ALF on multiple occasions acting inappropriate with residents including both physical and verbal abuse. Collateral Contact 5 stated that Staff C had been observed hitting Resident 1 on the head with a rolled up paper and pretending to trip residents ambulating with walkers as well. The incidents were reported by Collateral Contact 5 and other ALF staff to Staff A and Staff B. No action was taken regarding this information including no report to the Department or investigation of the incidents. Collateral Contact 5 stated that Staff C was "intimidating" and stood over staff staring at them.

Review of an email communication sent to Staff A and Staff B dated 11/28/2022 at 10:48 AM showed Staff A and B were notified of, "multiple concerns regarding colleague (Staff C's) behaviors." The email documented incidents including Staff C telling a resident' "I'm sick of you too" and pretending to trip another resident who was ambulating in the hall with a walker and telling the resident to, "move!" The email communication showed ALF staff reported feeling unsafe and uncomfortable related to Staff C's behavior. No report was made by the ALF to the Complaint Resolution Unit (CRU) related to these reported incidents.

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 Fairhaven is or will be in compliance with this law and / or regulation on (Date) 6/6/2022 .

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

Adminstrator (or Representative) — Date: 6/6/2022

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Report to the local law enforcement agency and the department any individual threatening bodily harm or causing a disturbance, that threatens any individual's welfare and safety;

(2) Identify, investigate, and report incidents involving residents according to department established assisted living facility guidelines;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to investigate incidents of verbal and/or physical abuse by one of one ALF staff (Staff C) to four of four (Resident 3, 4, 8 and 11) and one of one former residents (Resident 1) at the ALF. This failure resulted in Residents 3, 4, 8 and 11 and former resident (Resident 1) being at risk for continued abuse.

Findings included...

In an interview on 02/09/2022 at 1:10 PM, Staff B, the Director of Health and Wellness stated that there had been no incidents of staff to resident abuse or any issues with staff behavior. Staff B stated that some residents reported concerns regarding Staff C exhibiting rude behavior to residents and not respecting their privacy. Staff B stated that two of the residents who had brought concerns regarding Staff C were residents who, "gang up on staff." Staff B stated that one of the residents had "behavior issues" and the other resident did not like Staff C because he wears his pants too tight. Staff B stated that they had not investigated the reported concerns regarding Staff C. Staff B stated that they felt some residents had made Staff C, "a target" and they did not investigate concerns related to Staff C or document any incidents regarding Staff C. Staff C continued to work with the residents without any further investigation or supervision.

In an interview on 02/09/2022 at 2:25 PM, Resident 3 and Collateral Contact 1, Resident 3's representative, stated that Staff C, a former caregiver had not treated residents with respect and gave an example of seeing Staff C put their foot out blocking Resident 3's walker as they were walking. Collateral Contact 1 stated that the ALF staff knew how Staff C treated some residents and the ALF management was aware and overlooked the issue.

In an interview on 02/09/2022 at 2:30 PM, Resident 8 stated that Staff C had been rude to residents, did not respect resident privacy and some residents were afraid of Staff C. Resident 8 stated that they had informed Staff A, the Executive Director and Staff B, of these concerns specific to Staff C and he had continued to work at the facility with no action taken.

In an interview and observation on 02/09/2022 at 2:40 PM, Resident 4 stated that Staff C enters resident rooms without knocking and is abrupt and rude. Resident 4 stated that they had been on the toilet in their room and Staff C had entered their room without knocking and then stood outside the open bathroom door facing Resident 4 while they were on the toilet. Resident 4 stated that Staff C made no attempt to respect their privacy or dignity and that she was very uncomfortable with Staff C standing there.

Review of the ALF incident logs for dates 01/09/2022 through 02/09/2022 found no incidents involving Staff C and other residents in the ALF.

In an interview on 02/09/2022 at 1:10 PM, Staff B stated that some residents had reported concerns regarding Staff C exhibiting rude behavior to residents and not respecting their

privacy.

In an interview on 03/25/2022 at 3:40 PM, Collateral Contact 3, a resident representative stated that Resident 11 had reported that Staff C had been walking by the resident saying he was going to kill (Resident 11's) cat. Collateral Contact 3 stated that Resident 11 had spoken with the ALF about their concerns related to Staff C but no action had been taken.

In an interview on 05/10/2022 at 2:40 PM, Collateral Contact 5 stated that Staff C had a altercation with Resident 11 at the front desk of the ALF. Collateral Contact 5 stated that Staff C was speaking to Resident 11 inappropriately and was told by another staff not to talk to a resident like that. Collateral Contact 5 stated that Staff C told the other staff not to speak unless spoken to. Collateral Contact 5 stated that they observed the incident and felt afraid of Staff C who they described as "intimidating" and "looming" over staff. Collateral Contact 5 stated that the incident was reported to Staff A and Staff B and no investigation or further action to protect residents was done. Collateral Contact 5 stated that Staff A and Staff B were informed of multiple incidents regarding Staff C's inappropriate behavior with residents at the ALF including hitting Resident 1 and other residents on the head with rolled up paper and pretending to trip residents as they were walking and no action was taken. Collateral Contact 5 stated that ALF staff felt, "powerless" because nothing was done to protect the residents.

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 Fairhaven is or will be in compliance with this law and / or regulation on (Date) 6/6/2022 .

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

Adminstrator (or Representative) — Date: 6/6/2022