STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Emeritol Evergreen Lodge LLC
Brookdale Federal Way
31002 14th Ave S
Federal Way, WA 98003

RE: Brookdale Federal Way License # 2526

Dear Administrator:

This letter addresses Compliance Determination(s) 60015 (Completion Date 05/28/2025) and 56555 (Completion Date 04/03/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/28/2025 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-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3, WAC 388-78A-2130-4, WAC 388-78A-2130-5, WAC 388-78A-2130-5-a, WAC 388-78A-2130-5-b, WAC 388-78A-2130-5-c, WAC 388-78A-2130-5-d, WAC 388-78A-2130-5-e, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-1, WAC 388-78A-2150, WAC 388-78A-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2150-3, WAC 388-78A-2350-1, WAC 388-78A-2350-7, WAC 388-78A-2350-7-a, WAC 388-78A-2350-7-b

The Department staff who did the on-site verification:
Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager

Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 the unannounced on-site full inspection on 03/20/2025 and 03/26/2025 of:

Brookdale Federal Way
31002 14th Ave S
Federal Way, WA 98003

The following sample was selected for review during the unannounced on-site visit: 14 of 102 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licensor
Steven Garrett, LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2526	Compliance Determination #:55555
Plan of Correction	Brookdale Federal Way	Completion Date
Page 2 of 18	Licensee: Emeritol Evergreen Lodge LLC	04/03/2025

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.

Laurie Anderson — Residential Care Services

04/07/2025 — 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)

4/16/25 — Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 13 of 13 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13) assessments with the required full assessment components. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13 at risk for a decline in health and medical conditions from unidentified care needs and changes in condition.

Findings included...

RESIDENT 1
Review of Resident 1's information document showed the facility admitted Resident 1 on [redacted]/2023. The records showed Resident 1 admitted with a diagnosis of [redacted]

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.

Residential Care Services | 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-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 13 of 13 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13) assessments with the required full assessment components. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13 at risk for a decline in health and medical conditions from unidentified care needs and changes in condition.

Findings included…

RESIDENT 1
Review of Resident 1's information document showed the facility admitted Resident 1 on [redacted]/2023. The records showed Resident 1 admitted with a diagnosis of [redacted]

[redacted], and [redacted]

Review of Resident 1's assessment, dated 11/21/2024, showed no documentation the facility screened Resident 1 for signs and symptoms related to their depressive disorder or anxiety. There was no documentation of the type, frequency and duration of Resident 1's seizure activity. The assessment showed no documentation of Resident 1's current prescribed medications and any potential side effects of the medications.

RESIDENT 2
Review of Resident 2's information document showed the facility admitted Resident 2 on [redacted]/2023. The records showed Resident 2 admitted with a diagnosis of [redacted]

Review of Resident 2's assessment, dated 01/29/2025, showed the facility provided medication assistance which included ordering, storage, and assistance with taking medications. The assessment showed no documentation of Resident 2's current prescribed medications and any potential side effects of the medications.

RESIDENT 3
Review of Resident 3's information document showed the facility admitted Resident 3 on [redacted]/2024. Review of Resident 3's record showed diagnoses which included [redacted], and [redacted].

Review of Resident 3's Department of Social and Health Services assessment, dated 09/11/2024, showed a diagnosis of [redacted].

Review of Resident 3's facility assessment, dated 10/31/2024, showed that Resident 3 was independent with medications which included ordering, storage, and taking medications. The assessment showed no documentation of Resident 3's current prescribed medications and any potential side effects of the medications. The assessment showed no documentation of Resident 3's [redacted] diagnosis.

RESIDENT 4
Review of Resident 4's information document showed the facility admitted Resident 4

on [redacted]/2024.

Review of Resident 4's assessment, dated 10/23/2024, showed Resident 4 independently managed their medications, including ordering, storage, and administration. The assessment showed no documentation of Resident 4's current prescribed medications and any potential side effects of the medications.

RESIDENT 5
Review of Resident 5's information document showed the facility admitted Resident 5 on [redacted]/2017. The records showed Resident 5 admitted with a diagnosis of [redacted], and [redacted].

Review of Resident 5's assessment, dated 11/25/2024, documented that Resident 5 had a history of resistance to care, demonstrated chronic hoarding behaviors (a mental health condition characterized by persistent difficulty discarding possessions, regardless of their value, leading to excessive clutter and impairment in daily life), and verbally aggressive behaviors towards staff. The assessment showed no documentation that the facility assessed Resident 5 for any special needs or symptoms related to their hoarding and verbally aggressive behaviors. The assessment showed no documentation of Resident 5's current prescribed medications and any potential side effects of the medications.

RESDIENT 6
Review of Resident 6's information document showed the facility admitted Resident 6 on [redacted]/2023. The records showed Resident 6 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 6's assessment, dated 11/21/2024, showed no documentation the facility screened Resident 6 for signs and symptoms related to their seizures, including type, frequency and duration. The records showed no documentation of Resident 6's current prescribed medications and any potential side effects of the medications.

RESIDENT 7
Review of Resident 7's information document showed the facility admitted Resident 7 on [redacted]/2023. The records showed Resident 7 admitted with a diagnosis of [redacted], and [redacted].

Review of Resident 7's records showed a Basic Interview for Mental Status (BIMS) was completed on 10/31/2023. Review of the annual assessment, dated 11/11/2024, showed no documentation that a BIMS was completed as part of Resident 7's annual assessment.
The assessment showed documentation that Resident 7 had memory impairment which

included diminished time and place orientation. The records showed no documentation of Resident 7's current prescribed medications and any potential side effects of the medications.

RESIDENT 8
Review of Resident 8's information document showed the facility admitted Resident 8 on [redacted]/2011. The records showed Resident 8 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 8's assessment, dated 11/05/2024, showed no documentation the facility screened Resident 8 for signs and symptoms related to their depression disorder. There was no documentation of the type, frequency, and duration of Resident 8's seizure activity. The records showed no documentation of Resident 8's current prescribed medications and any potential side effects of the medications.

RESIDENT 9
Review of Resident 9's information document showed that the facility admitted Resident 9 on [redacted]/2025. The records showed Resident 9 admitted with a diagnosis of [redacted], and [redacted].

Review of Resident 9's records showed a BIMS was completed on 10/31/2023. Review of the assessment, dated 01/18/2025, showed no documentation that a BIMS was completed as part of Resident 9's initial assessment. The assessment showed that Resident 9 had memory impairment with diminished time and place orientation. The records showed no documentation of Resident 9's current prescribed medications and any potential side effects of the medications.

RESIDENT 10
Review of Resident 10's face sheet showed the facility admitted Resident 10 on [redacted]/2019. The sheet showed Resident 10 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 10's assessment, dated 02/16/2025, showed documentation that Resident 10 had memory impairment which included diminished time and place orientation. The assessment showed no documentation that the facility assessed Resident 10 for any special needs or symptoms related to their anxiety and memory loss. The records showed no documentation of Resident 10's current prescribed medications and any potential side effects of the medications.

RESIDENT 11
Review of Resident 11's face sheet showed the facility admitted Resident 11 on [redacted]/2020. The sheet showed Resident 11 admitted with diagnoses of [redacted]

[redacted], and [redacted]

Review of Resident 11's assessment, dated 11/11/2024, showed documentation that Resident 11 was not always oriented to place or time. The assessment showed no documentation that the facility assessed Resident 11 for any special needs or symptoms related to their [redacted] diagnosis. The records showed no documentation of Resident 11's current prescribed medications and any potential side effects of the medications.

RESIDENT 12
Review of Resident 12's information document showed the facility admitted Resident 12 on [redacted]/2008. The records showed Resident 12 admitted with a diagnosis of [redacted].

Review of Resident 12's assessment, dated 12/24/2024, showed no documentation the facility assessed Resident 12 for signs and symptoms related to their dementia. The records showed no documentation of Resident 12's current prescribed medications and any potential side effects of the medications.

RESIDENT 13
Review of Resident 13's face sheet showed the facility admitted Resident 13 on [redacted]/2015. The sheet showed Resident 13 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 13's assessment, dated 01/08/2025, documented that Resident 13 had a crisis plan for mental health issues and incidents. The assessment showed no instruction of what the crisis plan included. Review of Resident 13's assessment showed that facility staff coordinated care with Resident 13's mental health providers. The assessment instructed staff to notify Resident 13's mental health providers of any mood changes and behaviors. The assessment showed no documentation that Resident 13 was diagnosed with [redacted] with prescribed medication to manage the dementia. The assessment showed no documentation that the facility assessed Resident 13 for any special needs or symptoms related to their [redacted] diagnoses. The assessment showed no documentation of Resident 13's a change of condition related to new diagnosis of [redacted] in March 2025. The assessment showed no documentation of Resident 13's current prescribed medications and any potential side effects of the medications.

During an interview on 03/26/2025 at 2:20 PM, Staff A, Executive Director, stated that the facility utilized an electronic documentation system. Staff A stated that they were unaware the comprehensive elements required in resident assessments were not completed. Staff A stated that they thought the facility electronic documentation

systems used the required assessment comprehensive components.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) May 17, 2025

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

Administrator (or Representative) 4/16/25 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

(4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

system used the required assessment comprehensive components.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

(4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(c) Other individuals the resident wants included;

(d) The department's case manager, if the resident is a recipient of medicaid assistance, or any private case manager, if available; and

(e) Staff designated by the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 11 of 13 residents (Resident 1, Resident 2, Resident 3, Resident 5, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13) service agreements a plan to monitor and address interventions required to meet the current clinical needs. This failure placed Resident 1, Resident 2, Resident 3, Resident 5, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13 at risk for unmet care needs and potential harm.

Findings included…

RESIDENT 1
Review of Resident 1's information document showed the facility admitted Resident 1 on [redacted]/2023. Resident 1 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 1's Personal Service Plan (PSP: equivalent to the negotiated service agreement), dated 11/21/2024, showed no directions for care staff to monitor Resident 1 for signs and symptoms of depression or anxiety. The plan showed no instructions for staff about supportive actions needed when Resident 1 exhibited signs and symptoms of anxiety or depression.

RESIDENT 2
Review of Resident 2's information document showed the facility admitted Resident 2 on [redacted]/2023. The records showed Resident 2 admitted with a diagnosis of [redacted].

Review of Resident 2's February 2025 and March 2025 medication administration record (MAR) showed that Resident 1 received five milligrams (mg) of Eliquis (medication used to prevent blood clots), one tablet by mouth, twice a day, for prevention of blood clots.

Review of Resident 2's assessment and PSP, both dated 01/29/2025, showed staff provided Resident 2 full medication management assistance. Review of the assessment and PSP showed no documentation that Resident 2 received blood thinner medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of Eliquis. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 3
Review of Resident 3's information document showed the facility admitted Resident 3 on [redacted]/2024. The records showed Resident 3 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 3's Department of Social and Health Services assessment, dated 09/11/2024, showed a diagnosis of [redacted].

Review of Resident 3's February 2025 and March 2025 MAR showed that Resident 3 received 100 mg of Tegretol-XR (medication used to treat seizures).

Review of Resident 3's PSP, dated 09/30/2024, showed no documentation that Resident 3 received seizure control medications There was no documentation that provided the staff with guidance about the possible side effects from daily use of Tegretol-XR. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 5
Review of Resident 5's information document showed the facility admitted Resident 5 on [redacted]/2017. The records showed Resident 5 admitted with a diagnosis of [redacted], and [redacted].

Review of Resident 5's PSP, dated 11/25/2024, showed documentation that Resident 5 had a history of resistance to care, demonstrated chronic hoarding behaviors (a mental health condition characterized by persistent difficulty discarding possessions, regardless of their value, leading to excessive clutter and impairment in daily life), and verbally aggressive behaviors towards staff. The service plan showed no staff guidance to monitor Resident 5 for signs and symptoms related to resistance to care. The plan showed no instructions for staff about supportive actions needed when Resident 5 exhibited signs and symptoms of depression, anxiety, and verbally and physically aggressive behaviors. The plan showed documentation that Resident 5's service plan contained a crisis plan from an outside mental health provider that directed facility care staff to report incidences of depression, anxiety, and verbally and physically aggressive behaviors to the nurse and the mental health provider. Resident 5's Resident Service Plan showed no documentation of the crisis plan's guidance and instructions to be followed by the care staff.

RESIDENT 7
Review of Resident 7's information document showed the facility admitted Resident 7 on [redacted]/2023. The records showed Resident 7 admitted with a diagnosis of [redacted], and [redacted].

Review of Resident 7's February 2025 and March 2025 MAR showed that Resident 7 received 81 mg of Aspirin (medication used to as a blood thinner), one tablet by mouth, once a day, for prevention of blood clots; 500 mg of Naproxen (an anti-inflammatory with blood thinning qualities), one tablet, twice daily; and 25 mg of Seroquel (an antipsychotic medication that treats several kinds of mental health conditions), one tablet, twice daily.

Review of Resident 7's PSP, dated 11/11/2024, showed staff provided Resident 7 with medication management assistance. The plan showed no documentation that Resident 7 received blood thinner medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of blood thinning medications. There was no documentation that provided the staff with guidance about the possible side effects from daily use of antipsychotic medications. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 8
Review of Resident 8's information document showed the facility admitted Resident 8 on [redacted]/2011. The records showed Resident 2 admitted with a diagnosis of [redacted] and [redacted].

Review of Resident 8's January 2025, February 2025, and March 2025 MAR's showed Resident 8 received 200 mg of Carbamazepine (medication used to treat seizures), by mouth, one tablet twice daily and two tablets in the evening; 250 mg Levetiracetam (medication used to treat seizures), by mouth, one tablet twice daily; 400 mg Gabapentin (medication used to treat seizures), by mouth, one capsule three times daily; 20 mg Citalopram (medication used to treat depression), by mouth, one tablet daily; and 50 mg Trazodone (medication used to treat depression), by mouth, one tablet daily.

Review of Resident 8's assessment and PSP, both dated 11/05/2024, showed staff provided Resident 8 full medication management assistance. There was no documentation that provided staff guidance to monitor Resident 8 for signs and symptoms related to depressive disorder or seizures. The plan showed no instructions for staff about supportive actions needed when Resident 8 exhibited signs and symptoms of depression or seizures. There was no documentation that provided staff with guidance about possible side effects from daily use of Carbamazepine, Levetiracetam, Gabapentin, Citalopram, and Trazodone.

RESIDENT 9
Review of Resident 9's information document showed the facility admitted Resident 9 on [redacted]/2025. The records showed Resident 9 admitted with a diagnosis of [redacted].

Review of Resident 9's PSP, dated 01/18/2025, showed that Resident 9 had memory impairment with diminished time and place orientation.

Review of Resident 9's February 2025 and March 2025 MAR showed that Resident 9 received 81 mg of Aspirin, one tablet by mouth, once a day, for prevention of blood clots.

Review of Resident 9's service plan, dated 01/18/2025, showed staff provided Resident 9 with full medication management assistance. There was no documentation that provided the staff with guidance about the possible side effects from daily use of Aspirin. There were no instructions for staff about what actions were needed for such side effects.

RESIDENT 10
Review of Resident 10's Face Sheet showed the facility admitted Resident 10 on [redacted]/2019. The sheet showed Resident 10 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 10's assessment, dated 02/16/2025, showed documentation that Resident 10 had memory impairment with diminished time and place orientation.

Review of Resident 10's PSP, dated 02/05/2025, showed no staff guidance to monitor Resident 10 for signs and symptoms related to anxiety. The plan showed no instructions for staff about supportive actions needed when Resident 10 exhibited signs and symptoms of anxiety.

RESIDENT 11
Review of Resident 11's face sheet showed the facility admitted Resident 11 on [redacted]/2020. The sheet showed Resident 11 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 11's assessment, dated 11/11/2024, showed documentation that Resident 11 was not always oriented to place or time.

Review of Resident 11's PSP, dated 02/05/2025, showed no staff guidance to monitor Resident 11 for signs and symptoms related to schizoaffective disorder. The plan showed no instructions for staff about supportive actions needed when Resident 11 exhibited signs and symptoms of hallucinations and delusions.

RESIDENT 12
Review of Resident 12's information document showed the facility admitted Resident 12 on [redacted]/2008. The records showed Resident 12 admitted with a diagnosis of [redacted].

Review of Resident 12's January 2025, February 2025, and March 2025 MARs showed Resident 12 received five mg Memantine (medication used to treat dementia), by mouth, one tablet daily.

Review of Resident 12's assessment and PSP, both dated 12/24/2024, showed staff provided Resident 12 full medication management assistance. The plan showed no staff guidance to monitor Resident 12 for signs and symptoms related to vascular dementia, and the use of Memantine. The plan showed no instructions for staff about behaviorally based supportive actions needed when Resident 12 exhibited signs and symptoms of dementia. There was no documentation that provided the care staff with guidance about the possible side effects from daily use of Memantine.

RESIDENT 13
Review of Resident 13's face sheet showed the facility admitted Resident 13 on [redacted]/2015. The sheet showed Resident 13 admitted with diagnoses of [redacted], and [redacted].

Review of Resident 13's March 2025 MAR showed that Resident 13 was prescribed five mg of donepezil hydrochloride (medication used to treat dementia), by mouth, one tablet at bedtime and 150 mg of bupropion (medication used to treat depression), by mouth, one tablet twice daily.

Review of Resident 13's PSP, dated 01/08/2025, documented that Resident 13 had a crisis plan for mental health issues and incidents. There was no documentation of the crisis plan details. The plan showed no guidance for staff about how to coordinate care and notify mental health providers of Resident 13's mood and behaviors. The plan showed that Resident 13 was diagnosed with [redacted] and prescribed medication to manage the dementia.

Review of Resident 13's PSP, dated 02/05/2025, showed no staff guidance to monitor Resident 13 for signs and symptoms related to anxiety, depression, and dementia. The plan showed no instructions for staff about supportive actions needed when Resident 13

exhibited signs and symptoms of anxiety, depression, and dementia. There was no staff guidance about the possible side effects from daily use of Memantine.

During an interview on 03/26/2025 at 2:20 PM, Staff A, Executive Director, stated that the facility utilized an electronic documentation system. Staff A stated that they were unaware the comprehensive elements required in resident service plans were not completed. Staff A stated that they thought the facility electronic documentation system included the required service plan comprehensive components.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) May 17, 2025

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

Administrator (or Representative) — Date: 4/16/25

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

(3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 14 of 14 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, and Resident 14) or their representatives, the resident's case manager, or a facility representative signed their Personal Service Plan (equivalent to the negotiated service agreement) at least annually. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, and Resident 14 at risk of being uninformed about their assessed care and services and having unmet care needs.

Findings included...

exhibited signs and symptoms of anxiety, depression, and dementia. There was no staff guidance about the possible side effects from daily use of Memantine.

During an interview on 03/26/2025 at 2:20 PM, Staff A, Executive Director, stated that the facility utilized an electronic documentation system. Staff A stated that they were unaware the comprehensive elements required in resident service plans were not completed. Staff A stated that they thought the facility electronic documentation system included the required service plan comprehensive components.

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 Federal Way is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

(3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 14 of 14 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, and Resident 14) or their representatives, the resident’s case manager, or a facility representative signed their Personal Service Plan (equivalent to the negotiated service agreement) at least annually. This failure placed Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, and Resident 14 at risk of being uninformed about their assessed care and services and having unmet care needs.

Findings included…

Record Review of the Department's, "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a citation for this regulation on 10/19/2023. The facility signed an attestation statement that stated the facility would have the deficiency corrected by 12/15/2023.

RESIDENT 1
Review of Resident 1's information document showed the facility admitted Resident 1 on [redacted]/2023. Review of Resident 1's latest Personal Service Plan (PSP), dated 11/21/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 2
Review of Resident 2's information document showed the facility admitted Resident 2 on [redacted]/2023. Review of Resident 2's latest PSP, dated 01/29/2025, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 3
Review of Resident 3's information document showed the facility admitted Resident 3 on [redacted]/2024. Review of Resident 3's latest PSP, dated 10/31/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 4
Review of Resident 4's information document showed the facility admitted Resident 4 on [redacted]/2024. Review of Resident 4's latest PSP, dated 10/23/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 5
Review of Resident 5's information document showed the facility admitted Resident 5 on [redacted]/2017. Review of Resident 5's latest PSP, dated 11/25/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 6
Review of Resident 6's information document showed the facility admitted Resident 6 on [redacted]/2023. Review of Resident 6's latest PSP, dated 11/21/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 7
Review of Resident 7's information document showed the facility admitted Resident 7

on [redacted]/2023. Review of Resident 7's latest PSP, dated 11/11/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 8
Review of Resident 8's information document showed the facility admitted Resident 8 on [redacted]/2011. Review of Resident 8's latest PSP, dated 11/05/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 9
Review of Resident 9's information document showed the facility admitted Resident 9 on [redacted]/2025. Review of Resident 9's latest PSP, dated 01/18/2025, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 10
Review of Resident 10's information document showed the facility admitted Resident 10 on [redacted]/2019. Review of Resident 10's latest PSP, dated 02/16/2025, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 11
Review of Resident 11's information document showed the facility admitted Resident 11 on [redacted]2020. Review of Resident 11's latest PSP, dated 11/11/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 12
Review of Resident 12's information document showed the facility admitted Resident 12 on [redacted]/2008. Review of Resident 12's latest PSP, dated 12/24/2024, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 13
Review of Resident 13's information document showed the facility admitted Resident 13 on [redacted]/2015. Review of Resident 13's latest PSP, dated 01/08/2025, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

RESIDENT 14
Review of Resident 14's information document showed the facility admitted Resident 14 on [redacted]/2024. Review of Resident 14's latest PSP, dated 02/04/2025, showed no signature from the facility representative, the resident, the resident's representative, or the resident's case manager.

During an interview on 03/26/2026 at 11:15 AM, Staff G, Health & Wellness Director II, stated that they were unaware the PSP required signatures from the facility staff, residents, the resident's representative or resident's case managers at least annually and when a resident experienced a change in their condition. Staff G stated that they were aware that some of the PSP's were not signed and dated by facility staff, residents, or resident representatives or case managers, as required.

This is a recurring deficiency previously cited on 10/19/2023 for WAC 388-78A-2150, subsections (1)(2)(3).

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 Federal Way is or will be in compliance with this law and / or regulation on (Date) May 17, 2025.

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

Administrator (or Representative) — Date: 4/16/25

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:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(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 facility failed to coordinate care and services with 2 of 14 residents' (Resident 2 and Resident 13) healthcare providers. This failure placed Resident 2 and Resident 13 at risk for potential health complications and diminished care and services for medical diagnoses related to changes in conditions.

Finding included...

During an interview on 03/26/2025 at 11:15 AM, Staff G, Health & Wellness Director II, stated that they were unaware the PSP required signatures from the facility staff, residents, the resident's representative or resident's case managers at least annually and when a resident experienced a change in their condition. Staff G stated that they were aware that some of the PSP's were not signed and dated by facility staff, residents, or resident representatives or case managers, as required.

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_____ _____

Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to coordinate care and services with 2 of 14 residents' (Resident 2 and Resident 13) healthcare providers. This failure placed Resident 2 and Resident 13 at risk for potential health complications and diminished care and services for medical diagnoses related to changes in conditions.

Finding included…

RESIDENT 2
Review of Resident 2's information document showed the facility admitted Resident 2 on [redacted]/2023. The records showed Resident 2 admitted with a diagnosis of [redacted]. The records showed staff provided Resident 2 full medication management assistance.

Review of Resident 2's February 2025 and March 2025 treatment administration records (TAR's) showed the facility staff monitored Resident 2's morning blood pressure. The record showed that staff were to notify Resident 2's physician if the systolic (upper blood pressure number) reading was greater than 150 millimeters of mercury (mm Hg). The February 2025 and March 2025 TAR's showed 10 incidences when the systolic BP reading was greater than 150 mm Hg.

Review of Resident 2's record showed no documentation the facility staff notified the physician of Resident 2's systolic BP readings over 150 mm Hg.

Review of electronic mail (email) correspondence from Staff G, Health & Wellness Director II, on 03/27/2025 at 12:29 PM, showed no documentation facility staff attempted to communicate with Resident 2's physician regarding Resident 2's systolic BP readings over 150 mmHg.

RESIDENT 13
Review of Resident 13's face sheet showed the facility admitted Resident 13 on [redacted]/2015. The sheet showed Resident 13 admitted with diagnoses of [redacted].

Review of Resident 13's March 2025 Medication Administration Record (MAR) showed that Resident 13 was prescribed Lisinopril (medication used to treat high blood pressure). The MAR showed Resident 13 received two tablets, 20 mg each, by mouth one time a day, for blood pressure management. The MAR showed the medication was held when the systolic reading was 100 millimeters of mercury (mm Hg) or heart rate less than 60 beats per minute.

Review of Resident 13's March 2025 MAR showed that facility staff recorded Resident 13's blood pressure each time the Lisinopril was given. Review of the MAR showed no documentation that facility staff took Resident 13's heart rate each time the Lisinopril was given to Resident 13.

Review of email correspondence from Staff G, Health & Wellness Director II, on 03/27/2025 at 1:25 PM, showed no documentation staff took Resident 13's daily heart rate. The email showed no documentation facility staff communicated with Resident 13'

s physician that Resident 13's heart rate was not checked by facility staff when Lisinopril was given.

During an interview on 03/26/2025 at 3:18 PM, Staff G, Health & Wellness Director II, stated that they were unaware that the blood pressure and heart rate values in Resident 2 and Resident 13's diagnoses related care and services, were not communicated to their healthcare providers.

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 4/16/25

s physician that Resident 13's heart rate was not checked by facility staff when Lisinopril was given.

During an interview on 03/26/2025 at 3:15 PM, Staff G, Health & Wellness Director II, stated that they were unaware that the blood pressure and heart rate values in Resident 2 and Resident 13's diagnoses related care and services, were not communicated to their healthcare providers.

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_____ _____

Administrator (or Representative) Date