STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

EMERITUS CORPORATION
Brookdale Montclair Poulsbo
1250 NE Lincoln Rd
Poulsbo, WA 98370

RE: Brookdale Montclair Poulsbo # 2274

Dear Administrator:

This document references Compliance Determination 32742 (12/08/2023), which included complaint number(s) 100484, 97514.
The Department completed a complaint investigation of your Assisted Living Facility on 12/08/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Regenia Coleman, ALF NCI CI

Consultation:

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

Review of resident's personal service plans revealed the facility had two sets of service plans for each resident. One master set was kept in the resident's hard chart, in the Health and Wellness Director's office. That service plan was updated after a care conference, a change in resident condition, or when new interventions were put in place. The second set of personal service plans were located at the nursing station of each unit. These were the

service plans the direct care staff had immediate access to. These personal service plans were not updated with the newest resident care information or the newest interventions for each resident. This left the direct care staff without the information needed to provide the personal care for each resident, as negotiated in their personal service plans. Failed practice was identified. Consultation was provided since care plans have been updated.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the facility to determine if you have corrected all deficiencies.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

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 (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Montclair Poulsbo **Provider Type:** Assisted Living Facility

License/Cert.#: 2274
Intake ID: 97514
Compliance Determination #: 32742
Region/Unit #: RCS Region 3 / Unit D
Investigator: Regenia Coleman
Investigation Date(s): 11/13/2023 through 12/08/2023
Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility did not provide quality of care when a resident was found on the floor after a fall and required medical treatment for their injury.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 5 Closed records sample size: 1
Observations:	Resident to resident interactions Staff to resident interactions Identified resident Residents Resident rooms
Interviews:	Nursing staff Residents Family members Leadership Health and Wellness Director Direct Care Staff
Record Reviews:	Grievance log State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:

Quality of Care/Treatment: Resident found on the floor of their room with a injury to the head. Resident sent to the hospital for further evaluation and treatment. Facility investigation (video review) determined resident sat in their chair, leaned forward, and fell, striking their head on the corner of a cabinet. Notifications were made to required individuals. Upon return from the hospital, resident placed on alert charting and was

monitored and treated for pain. Review of resident care plan revealed the direct care staff did not have access to the most current interventions in place for the resident. Failed practice was identified. Consultation provided.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A