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

SILVER LAKE ASSISTED LIVING LLC
Brookdale Arbor Place
12806 BOTHELL EVERETT HWY
EVERETT, WA 98208

RE: Brookdale Arbor Place License # 2278

Dear Administrator:

This letter addresses Compliance Determination(s) 29309 (Completion Date 09/11/2023) and 23148 (Completion Date 07/06/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/11/2023 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-2160

The Department staff who did the on-site verification:
Jodi Condyles, ALF Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Arbor Place
Provider Type: Assisted Living Facility
License/Cert.#: 2278
Compliance Determination #: 23148
Intake ID: 76479
Investigator: Wesler Dumecquias
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/27/2023 through 07/06/2023
Complainant Contact Date(s):

Allegation(s):
1. The Named Resident (NR) had a witnessed fall.
2. The Named Resident left the ALF on an ALF facilitated activity without taking their portable oxygen.

Investigation Methods:

Sample:
Total residents: 62
Resident sample size: 5
Closed records sample size: 1

Observations:
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Family members
Nursing staff
Residents
Administrators
Activities director

Record Reviews:
Incident investigation
Facility policies
Care plan
Temporary care plan
Vitals signs record
Medication administration records
Progress notes
After visit summary - Hospital records
Employee schedule
Resident rosters

Investigation Summary:
1. The Assisted Living Facility (ALF) investigated the incident and ruled out abuse and neglect. The Staff assessed the NR, called 911 and sent the NR to the hospital for evaluation and treatment. The NR was independent with most of his Activities of daily living including ambulation and use of oxygen except housekeeping, laundry and meal

preparation. The ALF failed to review, update and ensure the NR's negotiated service agreement identified the increased needs of the NR after a fall and failed to follow through with the daily check of the NR's vitals. Failed practice identified. WAC 388-78A-2160 Implementation of negotiated service agreement.
2. Interview and record review showed the NR was independent with their oxygen and does not use the oxygen all the time.

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 Arbor Place
Provider Type: Assisted Living Facility
License/Cert.#: 2278
Compliance Determination #: 23148
Intake ID: 76644
Investigator: Wesler Dumecquias
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 04/27/2023 through 07/06/2023
Complainant Contact Date(s):

Allegation(s):
The Named resident (NR) unexpectedly passed away.

Investigation Methods:

Sample:
Total residents: 62
Resident sample size: 5
Closed records sample size: 1

Observations:
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Family members
Residents
Nursing staff
Administrators

Record Reviews:
Incident investigation
Facility policies
Care plan
Temporary care plan
Vitals signs record
Medication administration records
Progress notes
After visit summary - Hospital records
Employee schedule
Resident rosters

Investigation Summary:
The Assisted Living Facility (ALF) investigated the incident. The NR was found unresponsive, pale, lips were blue, foam and bubbles coming out from the mouth and without breathing or pulse. The Staff assessed the NR and called 911. The ALF followed it's protocol and informed Law enforcement, Medical examiner, Primary care physician, and the Family. The NR had a fall with injury on 3/29/2023. The ALF failed to review, modify, and ensure a resident's negotiated service agreement was updated

after the NR's fall. Failed practice identified. WAC 388-78A-2160 Implementation of negotiated service agreement.

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

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 04/27/2023, 06/06/2023 and 06/06/2023 of:

Brookdale Arbor Place
12806 BOTHELL EVERETT HWY
EVERETT, WA 98208

This document references the following complaint number(s): 76479, 76644

The following sample was selected for review during the unannounced on-site visit: 5 of 62 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler 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

07/14/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) — Date: 07/17/2023

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.

This requirement was not met as evidenced by:

Based on Interviews and record reviews the Assisted Living Facility (ALF) failed to provide services as agreed upon in the Temporary Service Plan (TSP) for 2 of 2 residents (Resident 1 and 2) when the ALF failed to monitor Resident 1 and Resident 2's vitals and failed to ensure a resident's negotiated service agreement was updated for 1 of 2 Residents (Resident 1) when Resident 1's care needs changed after a fall. These failures place Resident 1 and 2 at risk of unmet care needs and a decreased quality of life.

Resident 1

Resident 1 was admitted on [redacted]/2021 with multiple diagnoses including [redacted] and [redacted].

Record review of an incident report dated 04/15/2023 showed Resident 1 had a fall on 03/30/2023. Resident 1's progress notes dated 04/27/2023 showed the fall happened on 03/29/2023. The ALF called 911 and Resident 1 was sent to the hospital.

Review of After-Visit-Summary (AVS) dated 03/29/2023 showed Resident 1 was advised by the hospital doctor to keep off the left leg as much as possible, to use a wheelchair to get around, need to elevate the affected leg, put a pillow under the injured leg when sitting, support the injured leg so it's above heart (first 2 days) and put ice pack 3 to 4 x day.

Review of a TSP dated 03/30/2023 showed care associates were to take full vital signs for 3 days and to use caution when assisting Resident 1 with ambulation. The TSP failed to identify and include the increased assistance Resident 1 required in the activities of daily living; transferring, mobility, toileting, and staff delivering meals to the room. The TSP did not include the advice from the hospital's AVS or the Clinical Specialist's recommendation for Resident 1 to use oxygen at all times.

Review of Resident 1's clinical weights and vitals dated 06/13/2023 showed there was only one complete set of vital signs that was entered for 03/30/2023 at 1:16 PM. There were no other entries on all other shifts.

On 06/08/2023 at 11:26 AM, Staff B, Clinical Specialist stated that they were at the ALF on 03/30/2023 to assess Resident 1. Resident 1 was off baseline after coming back from the hospital because their oxygen saturation was low and needed to always use their Oxygen. Staff B stated that Resident 1 was not always using their oxygen and staff had to remind them. Staff B stated that Resident 1's increased use of oxygen should have been included in the TSP.

On 06/12/2023 at 11:47, Staff K, Med Tech stated that Resident 1 was independent with all activities of daily living. Staff K stated that after the fall, Resident 1 was 1 person assist for all his activities of daily living which includes transferring, bathroom use, staff delivering meals in his room and mobility.

On 06/22/2023 at 11:AM, Staff L, LPN stated that the Resident 1 was independent with activities of daily living before the fall except meal preparation; laundry and housekeeping. Staff L stated that Resident 1, after the fall was not able to ambulate, needed help with transferring and needed to call for help.

Resident 2

Resident 2 was admitted on [redacted]/2018 with multiple diagnoses including [redacted].

Review of facility's incident report dated 04/19/2023 showed Resident 2 had an unwitnessed fall on 04/19/2023 at 12:25 PM.

Review of Resident 2's Temporary Service Plan (TSP) dated 04/19/2023 showed Care Associates were to take daily vital signs for 3 days.

Review of Resident 2's clinical weights and vitals showed vital signs were taken only on 04/19/2023 at 12:35 AM. There were no other records that showed the vital signs were and documented for the other two days from the time of the incident and recorded in the ALF's PCC.

On 06/07/2023 at 10:33 AM, Staff G, Health and Wellness Coordinator stated that the caregivers do the vital signs then provide the information to the nurses to record it in the computer. Staff G stated that she cannot find a record that full vital signs were taken and monitored for 3 days.

On 06/12/2023 at 11:47 AM, Staff K, Med Tech stated that the caregivers monitor the vital signs and then then provide the information to the nurses to record it in the computer.

On 06/22/2023 at 11:00 AM, Staff L, LPN stated that the TSP included an instruction for care staff to check Resident 2's vital signs. Staff L stated that the vital signs taken were to be recorded in the ALF's Point Click Care (PCC) which was the ALF's computer documentation system. Staff L stated that she read Resident 1's after-visit- summary and she believed the instructions were in the Temporary care plan (TCP).

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 Arbor Place is or will be in compliance with this law and / or regulation on (Date) 8/18/2023 .

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

Administrator (or Representative) — Date: 7/17/2023