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

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) 60498 (Completion Date 06/03/2025) and 56299 (Completion Date 04/11/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/03/2025 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-2210-2-a

The Department staff who did the on-site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (253)281-1245.

Sincerely,

Anthony Devito, Field Services Administrator
Region 2, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Arbor Place
Provider Type: Assisted Living Facility
License/Cert.#: 2278
Compliance Determination #: 56299
Intake ID: 167299
Investigator: Wesler Dumecquias
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 03/13/2025 through 04/11/2025
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) did not have medications available.

Investigation Methods:

Sample:
Total residents: 96
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Medication administration
Resident rooms

Interviews:
Identified resident
Nursing staff
Residents
Family members
Administrator

Record Reviews:
Incident investigation
Facility policies
care plan
MAR
Progress Notes
Medical records/hospital records
Staff statements
Faxes notifying PCP

Investigation Summary:
The Assisted Living Facility (ALF) identified and investigated the incident. The ALF failed ensure timely and proper communication was followed for the ALF to be able to secure and obtain the NR medications. The ALF staff did not ensure the NR's medications were reconciled and updated after the NR's hospitalizations. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A-2210 (2) (a) Medication services.

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 03/13/2025 of:

Brookdale Arbor Place
12806 BOTHELL EVERETT HWY
EVERETT, WA 98208

This document references the following complaint number(s): 167299, 167298, 170216

The following sample was selected for review during the unannounced on-site visit: 3 of 96 current residents and 0 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.

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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 1 Resident (Resident 1) received their medications according to the service plan. The failure resulted in Resident 1 not receiving several of their medications for the month January 2025 and placed Resident 1 at risk for medical complications and hospitalization.

Findings included…

Review of the ALF's policy titled "MEDICATION POLICY" dated 03/31/2022 showed the ALF would be responsible for obtaining newly ordered medication or refills for medication and treatment orders.

Review of Face sheet showed Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted]

[redacted].

Review of a Medical record dated [redacted]/2025 showed Resident 1 was admitted to the hospital on [redacted]/2025 through [redacted]/202 due to a fall.

Review of the Personal Service Plan dated 12/24/2024 showed Resident 1 need assistance with their medications. The ALF would order and coordinate medications between families, health care and pharmacy.

Review of the Medication Administration (MAR) record dated January 2025 showed Resident 1 had the following prescribed medications and the dates they were no longer available.

1. Cephalexin Oral Capsule 500 milligrams (mg), one capsule daily by mouth as prophylactic for infection. The medication was not given starting on 01/19/2025.
2. Cetirizine hydrochloride (HCL) Oral Tablet (tab) 10 mg, one tab once a day at bedtime by mouth.
3. Donepezil HCL oral tab 5 mg, one tab once a day at bedtime by mouth. The medication was not given starting 01/10/2025.
4. Fergon oral tab 240 mg, one tab once a day at bedtime by mouth.
5. Fish oil oral capsule 360 mg, one capsule daily by mouth. The medication was not given starting 01/04/2025.
6. Levothyroxine Sodium oral tab 100 microgram (mcg), one tab daily by mouth. The medication was not given starting 01/21/2025.
7. Melatonin Oral tablet 10 mg, one tab once a day at bedtime by mouth. The medication was not given starting 01/10/2025.
8. Quetiapine Fumarate oral tablet 25 mg, one tab once a day at bedtime by mouth. The medication was not given starting 01/01/2025.
9. Sertraline HCL oral tab 25 mg, one tab daily my mouth. The medication was not given starting 01/22/2025.
10. Trazodone HCL oral tab 50mg, one tab once a day at bedtime by mouth. The medication was not given starting 01/01/2025.
11. Simlandi (2 pen) subcutaneous auto-injection kit 40 mg/0.4 milliliter, inject every 14 days for rheumatoid arthritis.
12. Calcium Carbonate tab 600 mg, two tabs two times a day by mouth as antacid.
13. Fluticasone Propionate Nasal suspension 50 mg mcg, one spray in each nostril two times a day for allergy.
14. Nystatin External Powder 100,000 unit/gram, apply under the breast two times a day for rash and redness.
15. Senna Oral Tablet 8.6 mg, one tab two times a day by mouth for constipation.

Review of a Discharged Summary dated [redacted]/2025 showed Resident 1 was admitted to the hospital on [redacted]/2025 due to a fall and was treated for Urinary tract infection.

Review of a written statement from Staff G, Licensed Nurse, dated 02/10/2025 showed they were informed on 01/26/2025 by Staff H, Licensed nurse, that Resident 1 was out of all their medications. Staff G stated that they faxed Resident 1's medication list to

their Primary care physician (PCP) for signature on 12/19/2024 and refaxed again but could not remember the date.

On [redacted]/2025 at 2:23 PM, Staff A, Executive Director, stated that Resident 1 consumed all their medications, and the prescription orders were expired. Staff A stated that the care staff missed a lot of Resident 1's medications. Staff A stated that they were not informed immediately of the issue.

On [redacted]/2025 at 3:06 PM, Staff B, Medication Technician (Med Tech), stated that they faxed their facility pharmacy around end of December to January 2025 for a refill. The pharmacy informed the ALF that an updated prescription was needed. Staff B stated that beginning January 2025 Resident 1 had been acting out and was observed by staff yelling for help. Staff B stated that Resident 1 would not say what exactly they needed and would call out for help when the care staff approach them.

On [redacted]/2025 at 3:25 PM, Staff C, Med Tech, stated that Resident 1 started getting confused and screaming at the middle of the night. Staff C stated that the changes occurred when Resident 1 ran out of their medications.

On [redacted]/2025 at 4:01 PM, Staff F, Caregiver stated that Resident 1 had been anxious. Staff F stated that Resident 1 was always pressing their call button calling for help but would not let the staff know what help they needed.

On 04/02/2024 at 10:03 AM, Staff G, License nurse, stated that they were never informed Resident 1 ran out on some of their medication. Staff G stated that the Med Techs did not report to them about the medications running out.

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)_____ .

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

_____ _____

Administrator (or Representative) Date