



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

EMERITUS CORPORATION
Brookdale Vancouver Stonebridge
7900 NE Vancouver Mall Dr
Vancouver, WA 98662

RE: Brookdale Vancouver Stonebridge License # 2308

Dear Administrator:

This letter addresses Compliance Determination(s) 49099 (Completion Date 10/23/2024) and 46833 (Completion Date 09/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/23/2024 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, WAC 388-78A-2630-1, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b, WAC 388-78A-2630-2

The Department staff who did the on-site verification:
Richard Westom, NCI, ALF Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services



Residential Care Services Investigation Summary Report

Provider/Facility: Brookdale Vancouver
Stonebridge

License/Cert.#: 2308

Compliance Determination #: 46833

Investigator: Michael Burdick

Investigation Date(s): 09/09/2024 through 09/12/2024

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 143952

Region/Unit #: RCS Region 3 / Unit I

Allegation(s):

1. Quality of care/Treatment. Resident to resident altercation

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Family members Administrator
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

1. Quality of care/Treatment. Facility investigated but failed to report to DSHS for 20 days.
Failed practice.

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 Vancouver
Stonebridge

License/Cert.#: 2308

Compliance Determination #: 46833

Investigator: Michael Burdick

Investigation Date(s): 09/09/2024 through 09/12/2024

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 143464

Region/Unit #: RCS Region 3 / Unit I

Allegation(s):

1. Quality of care/Treatment. Resident to resident altercation.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Family members Administrator
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

1. Quality of care/Treatment. Facility investigated but failed to notify state of incident for 13 days. Failed practice.

Conclusion / Action:

- ☒ 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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2308	Compliance Determination # 46833
Plan of Correction	Brookdale Vancouver Stonebridge	Completion Date
Page 1 of 4	Licensee: EMERITUS CORPORATION	09/12/2024

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 09/09/2024 and 09/12/2024 of:

Brookdale Vancouver Stonebridge
7900 NE Vancouver Mall Dr
Vancouver, WA 98662

This document references the following complaint number(s): 144895, 143952, 143464

The following sample was selected for review during the unannounced on-site visit: 4 of 68 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Richard Westom, NCI, ALF Complaint Investigator
Michael Burdick, AFH Nurse Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

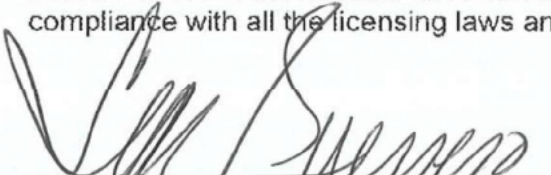
09/17/2024

Date

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Statement of Deficiencies	License #: 2308	Compliance Determination # 46833
Plan of Correction	Brookdale Vancouver Stonebridge	Completion Date
Page 2 of 4	Licensee: EMERITUS CORPORATION	09/12/2024

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-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.
- (2) The assisted living facility must prominently post so it is readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident abuse and neglect.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report suspected abuse to the Washington state department of social and health services (DSHS) for 3 of 3 sampled residents (Resident 1/ R1), (Resident 2 /R2), and (Resident 3/ R3). This failure prevented the department from being able to investigate potential instances of abuse and to evaluate systems that were in place to protect residents.

Finding included...

During an unannounced visit on 09/09/2024 a review of facility policy titled Abuse Neglect & Exploitation Policy dated 10/2001 Stated, any employee who witnesses or "has reasonable cause to believe" that a resident has been the subject of suspected or alleged abuse, neglect or exploitation, should immediately report such incident to the Executive Director or supervisor on duty and to the Washington State department of Social and Health Services.

Record review of R1's face sheet, dated 07/10/2024, shows R1 was admitted to the facility on /20224.

Record review of R 2's face sheet, dated 09/10/2024, shows R 2 was admitted to the facility

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██████/2023.

Record review of R 3's face sheet dated 09/10/2024, shows R 3 was admitted to the facility on ██████/2024.

On 09/09/2024 a review of a facility online incident report to the state, stated R 1 was found in R 2's room with his pants down on 07/29/2024. This intake was reported to state on 08/22/2024.

On 09/09/2024 a review of facility online incident report to the state, stated R 1 and R 3 were in a physical altercation on 08/01/2024. This was reported to the state on 08/16/2024.

In an interview on 09/09/2024 at 11:29 AM Staff D, Medication Technician (MT) says the number for the state hotline is posted in the breakroom. They stated all abuse and neglect should be reported within 24 hours. They stated, "I don't report, I don't know how".

In an interview on 09/09/2024 at 11:43 AM Staff E, Care giver stated, "I don't report to state".

In an interview on 09/09/2024 at 11:50 AM Staff F, Care giver stated, "I don't call state, I've never been trained to call state".

In an interview on 09/09/2024 at 11:50 AM Staff G, MT stated "I don't call the state, I assume the supervisor will call. They stated I have not been trained to call state".

In an interview on 09/09/2024 at 12:05 PM Staff H, MT stated "I don't call state, I think the nurses do". "I was never told to call state".

In an interview on 09/09/2024 at 12:22 PM Staff B Health and wellness coordinator stated, "I'm not sure, why care givers don't report to state". They stated, "me or Staff C report with in twenty-four hours".

In an interview on 09/09/2024 at 12:29 PM Staff A stated, 'our training to staff is to notify the nurse, they don't need to call state".

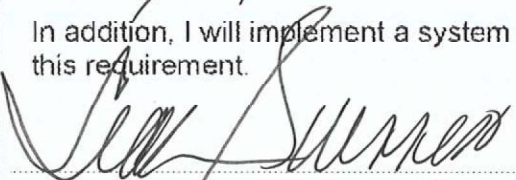
In an interview on 09/12/2024 at 1:33 PM staff C Health and wellness coordinator says, "it's our preference that staff report to me or staff B", we do the reporting to state".

Statement of Deficiencies	License #: 2308	Compliance Determination # 46833
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Page 4 of 4	Licensee: EMERITUS CORPORATION	09/12/2024

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 Vancouver Stonebridge is or will be in compliance with this law and / or regulation on (Date) 10/20/24.

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


Administrator (or Representative)

9/20/24
Date

This document was prepared by Residential Care Services for the Locator website.

Monday, October 14, 2024

Brookdale Vancouver Stonebridge
7900 NE Vancouver Mall Drive
Vancouver, WA 98662
License No: 2308

Mr. Richard Westom, NCI, ALF Complaint Investigator
Mr. Michael Burdick, AFH Nurse Field Manager
RE: Compliance Determination No: 46833

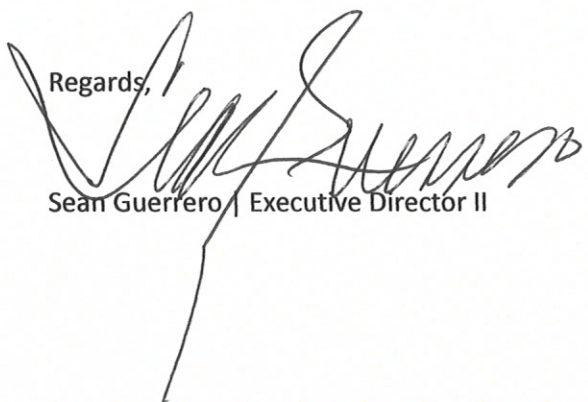
Gentlemen,

After review of compliance determination 46833, the following measures were reiterated to staff and programs reinforced for compliance.

- A) It was reviewed with all staff members that we are all mandatory reporters. Brookdale Senior Living prefers that all allegations of resident abuse and/or neglect be reported to upper management immediately and that a statement of the incident be provided by the individual making the report to that manager with whom the allegation is reported.
- B) The manager with whom the allegation was presented must report to the state promptly the alleged resident abuse and/or neglect. If for any reason the manager is unable to make the state report in a prompt manner, it will be provided to another manager for completion.
- C) Staff members were also informed that because they are mandatory reporters, they are welcome to make the report themselves should they so choose without fear of retaliation.
- D) Staff members were directed to where they can find the toll-free phone number to report resident allegations of abuse and/or neglect. They are located at both entrances to the community, time clock, as well as both employee breakrooms.
- E) Staff members have been provided a sticker to place on the back side of their name badge that also includes the toll-free phone number to report allegations of resident abuse and/or neglect.

If you have any further questions with regards to this statement, please feel free to reach out to me at 360.882.8800 or sguerrero5@brookdale.com. Thank you.

Regards,



Sean Guerrero | Executive Director II



7900 NE Vancouver Mall Dr.
Vancouver, WA 98662
Phone (360) 882-8800
brookdale.com

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