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) 37206 (Completion Date 02/27/2024) and 34053 (Completion Date 01/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/27/2024 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-2170-1

The Department staff who did the on-site verification:
Yvonne Chitekwe

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 #: 34053
Investigator: Yvonne Chitekwe
Provider Type: Assisted Living Facility
Intake ID: 109890
Region/Unit #: RCS Region 3 / Unit I
Investigation Date(s): 12/19/2023 through 01/18/2024
Complainant Contact Date(s): 12/18/2023

Allegation(s):

1.Quality of Care /Treatment; resident was given hot beverage, not monitoring resident spilled the hot liquid burning themselves.
2. Resident/Patient/ Client Assessment; hot beverage was given to resident without monitoring resident spilled and burned themselves.

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Nursing staff Residents Family members Kitchen staff
Record Reviews:	Facility policies Incident investigation Maintenance logs State reporting log

Investigation Summary:

1.Quality of Care /Treatment; The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations, and records review, failed facility practice when resident was given a hot beverage that spilled causing a skin burn was substantiated during the investigation.

2. Resident/Patient/ Client Assessment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews,

observations, and records review, failed facility practice in monitoring resident who was given a hot beverage that spilled causing a skin burn was substantiated during the investigation.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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 12/19/2023 and 12/19/2023 of:

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

This document references the following complaint number(s): 109890

The following sample was selected for review during the unannounced on-site visit: 4 of 74 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Yvonne Chitekwe

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 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-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide for the safety and well-being for 1 of 4 sampled residents (Resident 1/R1) reviewed for injury related to hot beverage service. The failure to implement preventative measures as recorded in the resident's negotiated services plan, resulted in a burn to R1.

Findings included…

Record review of a facility policy, titled "SAFETY OF HOT LIQUIDS", dated 09/2020 showed "Appropriate interventions could be implemented to minimize the risk from burns. Such interventions may include but not limited to: Maintaining a hot liquid serving temperature of not more than 155 degrees Fahrenheit."

Record review of R1's Personal Service Assessment and R1's Personal Service plan both dated, 10/25/2023, documented that caregivers will provide direct staff attention to R1 while eating and will provide direct physical assistance to R1 while eating.

Record review of R1's Alert Charting Note dated 12/09/2023 documented R1 was given hot chocolate for dinner, the hot chocolate spilled on R1's right inner thigh causing a large red mark. On 12/10/2023 R1's Alert Charting note documented a large red mark on R1's inner thigh had turned into a blister that had been broken open.

Record review of R1's Resident Log notes dated December 9; Staff C Caregiver documented R1 was given hot chocolate. The notes stated Staff C left R1 unattended to go serve other residents. When they returned to check on R1 they noted R1 had spilled their hot chocolate on their lap.

In an interview on 12/19/2023 at 11:32AM, Staff B, Dining Service Manager, reported a hot water dispenser temperature of 164 degrees Fahrenheit as not safe to leave the kitchen and that the liquid needed to be cooled to between 140- and 135-degrees Fahrenheit to leave the kitchen for residents' consumption. Staff B stated that caregivers were not trained to cool hot liquids prior to R1 getting their skin burned from spilled hot chocolate. Staff B admitted that Staff C did not cool the hot water resulting in a harm of R1 after they sustaining a skin burn from a hot chocolate.

In an interview on 12/19/2023 at 2:45PM, Staff D, Caregiver, reported they worked the evening shift with Staff C who was assigned to dining room duties. They reported Staff C gave R1 hot chocolate and walked away to serve other residents. When they returned to R1

they noted R1 had spilled the hot chocolate on their lap. R1 was taken back to their apartment. The skin assessment showed redness to right inner thigh.

In an interview on 01/16/2023 at 1:23 PM, Staff A, Executive Director, stated that Staff C took the hot water directly from the hot water dispenser and did not check the temperature. Staff A stated that Staff C should have checked the temperature of the hot water and placed a lid on the cup prior to giving the hot beverage to R1 for consumption.

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)_____ .

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

_____ _____

Administrator (or Representative) Date