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

EMERITUS CORPORATION
Brookdale Courtyard Puyallup
4610 6TH STREET PLACE SE
PUYALLUP, WA 98374

RE: Brookdale Courtyard Puyallup License # 2366

Dear Administrator:

This letter addresses Compliance Determination(s) 61161 (Completion Date 06/16/2025) and 52276 (Completion Date 03/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/16/2025 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-2450-1-a, WAC 388-78A-2150-1, WAC 388-78A-2150-3, WAC 388-78A-2420-3, WAC 388-78A-2420-4, WAC 388-78A-2640-2, WAC 388-78A-2640-2-a, WAC 388-78A-2640-2-b, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2640-3, WAC 388-78A-2305-1, WAC 246-215-03525-1-a, WAC 246-215-03525-1-b, WAC 246-215-03525-1, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-d, WAC 388-78A-3090-1-c

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just, Field Services Administrator
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Courtyard Puyallup
License/Cert.#: 2366
Compliance Determination #: 52276
Investigator: Carol Gijima
Provider Type: Assisted Living Facility
Intake ID: 154838
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 12/27/2024 through 03/24/2025
Complainant Contact Date(s): 03/26/2025

Allegation(s):

1. Alleged safety issues and code violations
2. No AEDs
3. Short staffed

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: Closed records sample size: 9
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Collateral Contacts Staff Resident representatives
Record Reviews:	Resident Characteristic Roster Maintenance/ housekeeping logs Staffing schedules

Investigation Summary:

1. Per observations, record review, interviews with residents, collateral contacts and staff, the facility failed to ensure that work orders were completed. Facility failed practice identified. See Statement of deficiency dated 03/24/2025.
2. Per record review and interviews with staff, facility followed procedure. No failed facility practice identified.
3. Per record review, interviews with residents, resident representatives, collateral contacts and staff, the facility failed to ensure enough staff to provide services for residents. Failed provider practice identified. See Statement of deficiency dated 03/24/2025.

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 Courtyard Puyallup
License/Cert.#: 2366
Compliance Determination #: 52276
Investigator: Carol Gijima
Provider Type: Assisted Living Facility
Intake ID: 165787
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 12/27/2024 through 03/24/2025
Complainant Contact Date(s): 03/26/2025

Allegation(s):

1. Resident being charged for standby assistance for showers and dressing and the staff doesn't show up
2. Short staffed
3. Call lights take a long time being answered
4. Bed buds in building not being take care of

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: Closed records sample size: 9
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Collateral Contacts Staff Resident representatives
Record Reviews:	Resident Characteristic Roster List of discharged Residents Resident assessments and negotiated service agreements including the records of the named resident Staff progress notes Staffing schedules Incident log / reports Pest control invoices

Investigation Summary:

1. Per observations, record review, interviews with residents, collateral contacts and staff, the facility failed to provide assistance as agreed upon. Facility is currently not incompliance. See Statement of deficiency dated 02/20/2025 and 10/18/2024. No additional citations written.

2. Per observations, record review, interviews with residents, collateral contacts and staff, the facility failed to ensure they had adequate staff to meet resident needs. Facility practice identified. See Statement of deficiency dated 03/24/2025.
3. Per observations, record review, interviews with residents, collateral contacts and staff, the facility failed to ensure they had adequate staff to meet resident needs. Facility practice identified. See Statement of deficiency dated 03/24/2025.
4. Per record review, interviews with resident representatives and staff, facility followed procedure. No failed facility practice identified.

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 Courtyard Puyallup
License/Cert.#: 2366
Compliance Determination #: 52276
Investigator: Carol Gijima
Provider Type: Assisted Living Facility
Intake ID: 167377
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 12/27/2024 through 03/24/2025
Complainant Contact Date(s): 03/26/2025

Allegation(s):

1. Resident apartment and facility not clean
2. Food is cold
3. Facility has bed bugs

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: Closed records sample size: 9
Observations:	General environment Meal service-lunch Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Collateral Contacts Staff Resident representatives
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records- food handlers cards Menu Staff progress notes Pest control invoices

Investigation Summary:

1. Per observations, record review, interviews with residents, collateral contacts and staff, the facility failed to ensure that resident's room were cleaned weekly as agreed upon. Facility failed practice identified. See Statement of deficiency dated 03/24/2025.
2. Per observations, record review, interviews with residents, collateral contacts and staff, the facility failed to ensure that residents received food at appropriate

temperatures. Facility failed practice identified. See Statement of deficiency dated 03/24/2025.
3. Per record review, interviews with resident representatives and staff, facility followed procedure. No failed facility practice identified.

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 Courtyard Puyallup
License/Cert.#: 2366
Compliance Determination #: 52276
Investigator: Carol Gijima
Provider Type: Assisted Living Facility
Intake ID: 163096
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 12/27/2024 through 03/24/2025
Complainant Contact Date(s): 03/26/2025

Allegation(s):

1. Facility failed to follow bed hold reporting requirements.
2. Facility failed to provide residents' service agreements for signature

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: Closed records sample size: 9
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Collateral Contacts Staff Resident representatives
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the records of the named resident Incident log / reports Progress notes

Investigation Summary:

1. Per record review and interviews with collateral contacts and staff, the facility failed to notify the department case manager when a resident was discharged to the hospital and when they passed away. Facility failed practice identified. See Statement of deficiency dated 03/24/2025.
2. Per record review and interviews with residents, resident representatives, collateral contacts and staff, the facility failed to ensure that negotiated service plans were signed by the department case manager. Facility failed practice identified. See Statement of deficiency dated 03/24/2025.

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

PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2366	Compliance Determination # 52276
Plan of Correction	Brookdale Courtyard Puyallup	Completion Date
Page 1 of 14	Licensee: EMERITUS CORPORATION	03/24/2025

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 12/27/2024 and 03/11/2025 of:

Brookdale Courtyard Puyallup
4610 6TH STREET PLACE SE
PUYALLUP, WA 98374

This document references the following complaint number(s): 154838, 165787, 167377, 163096

The following sample was selected for review during the unannounced on-site visit: 0 of 78 current residents and 9 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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: 04/03/2025

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-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to ensure they had adequate staff to complete maintenance requests timely or provide care and services for residents as agreed upon in negotiated service agreements (NSA) for 6 of 9 sample residents (Residents 1, 2, 3, 4, 5, & 7 [R1, 2, 3, 4, 5, & 7]). This failure resulted in Residents 1, 2, 3 & 4 not getting their showers, and Residents 5 &7's rooms not being cleaned.

Findings included...

Observations on 03/11/2024 showed the following:
At 10:33am, Room [redacted] (R7) appeared unclean, not vacuumed with dirt particles on the floor.
At 10:45am, Room [redacted]'s (R5) counters and furniture had accumulated dust.

Record review of resident NSAs showed that residents were supposed to receive showers as follows:
Resident 1
A NSA dated 11/12/2024 showed that R1 was to have seven showers per week.
Resident 2
An unsigned NSA dated 08/23/2024 showed that R2 was to have two showers per week,

Thursday and Saturday.
Resident 3
An unsigned NSA dated 06/27/2024 showed that R3 was to have two showers per week, Sunday and Thursday.
Resident 4
A NSA dated 08/30/2024 showed that R4 was to have two showers per week, Tuesday and Friday.

There were no shower records on file to review.
There was no housekeeping records provided to review weekly room cleaning.

Review of the maintenance logs on 03/11/2025 showed that multiple maintenance requests including those logged in as critical had not been completed for weeks.
6148 - possible bathroom or sink leak was open since 12/17/2024
6144 - entry light needing replacing was open since 12/22/2024
6120 - rehanging closet doors, toilet seat needing to be retightened was open since 12/03/2024
6067 - Install grab bar was still open since11/06/2024
6130 - Bathroom cabinet door loose was open since 12/12/2024
6132 - sink plugged up was open since12/13/2024
6107 - carpet came up off floor was open simnce11/22/2024

During an interview on 12/26/2024 at 11:50am, Collateral Contact 1 (CC1), Regional Maintenance, stated that they have heard residents yelling for help and when CC1 spoke to the resident, they stated that that they had pressed their call light for a long time and nobody had responded. CC1 stated that there were many residents requesting assistance that they could not provide, and resident rooms were dirty. CC1 stated that the facility was short staffed.

During an interview on 12/27/2027 at 10:50am Collateral Contact 2 (CC2), Anonymous Resident, stated that they were independent with care and needed housekeeping. When asked how often their apartment needed to be cleaned, CC2 stated that housekeeping was supposed to clean every week, and they had not done so in a few weeks. CC2 stated that the caregivers picked up the garbage only.

During an interview on 12/27/2024at 11:27am Staff C, Maintenance, was asked how quickly they responded to resident requests for maintenance. Staff C stated that they prioritized requests depending on how critical they were. When asked about why residents' requests were waiting months to be completed, Staff C stated that they were the only employee helping with housekeeping and maintenance. Staff C stated that they were trying their best.

During an interview on 12/27/2024 at 11:45am, Staff B, Health and Wellness Director, was asked if they had received complaints about being short staffed. Staff B stated that they had received complaints from staff. In a separate interview on 03/11/2025 at 12:

45pm, Staff B stated that staffing was adequate "according to benchmarks."

During an interview on 12/27/2024 at 2:42pm, Collateral Contact 3 (CC3), Anonymous Staff, stated that the facility did not have enough staff. CC3 stated that they had one caregiver per floor, and it was not enough to provide showers or care for all residents. CC3 stated that at night there was only one caregiver for the entire building and a medication technician. CC3 stated that some residents did not receive their showers as scheduled.

During an interview on 12/27/2024 at 3:16pm, Collateral Contact 4 (CC4), Anonymous Staff, stated that they were short staffed. CC4 stated that they worked with two caregivers most of the time to manage three floors. CC4 stated they were not able to complete showers and would move them to the next day. When asked if those showers were completed the next day, CC4 stated, "no, not really…sometimes we could get to them."

During an interview on 01/07/2025 at 3:18pm, Collateral Contact 5 (CC5), Resident's Representative, stated that staff did not show up to give R1 a shower or stand by assistance as agreed upon in the service agreement. CC5 stated that there was a time when R1 sat on the toilet for over an hour before staff assisted them off. CC5 stated resident needed assistance early in the morning and staff did not assist most of the time. CC5 stated there was not enough staff to provide care. In a separate interview on 03/10/2025 at 11:38am, CC5 stated that when residents complained to staff about call lights not being answered timely, Staff A, Administrator, told them to use the bathroom emergency call light to get a quicker response from staff.

During an interview on 02/13/2025 at 11:19am, Staff D, Health and Wellness Coordinator stated that they had three caregivers in the morning, two - three in the evening, one caregiver and a med tech at night. When asked if staffing was enough to provide care for all residents, Staff D stated that they believed it was enough. Staff D was unable to provide an answer when asked who would be on the floor to respond to resident care needs or an emergency at night if the two staff were in a room with a resident who required two - person assist.

During an interview on 03/11/2025 at 8:24am, Collateral Contact 6 (CC6),Resident's Representative stated that R1 was not getting showers as they were supposed to. CC6 stated that sometimes staff would make resident get up at 4:00am to get a shower because they didn't have enough help. CC6 stated that staff told R1 that they were short staffed and would not be able to give R1 showers when she needed them if R1 didn't agree to the 4:00am time. CC6 stated that R1's room was not always cleaned every week and that the room was unclean. CC6 stated that R1 had complained on multiple occasions about apartment not being cleaned but was told that their housekeeper had quit. CC6 stated that the facility did not have a housekeeper.

During an interview on 03/11/2025 at 10:33am, Collateral Contact 7 (CC7), Anonymous

Resident, stated that they had no care concerns except the housekeeping. CC7 stated that their apartment had not been cleaned in three weeks. CC7 stated caregivers removed garbage.

During an interview on 03/11/2025 at 10:45am, Collateral Contact 8 (CC8), Anonymous Resident, stated that last month their apartment had not been cleaned for three - four weeks. CC8 stated that other residents had the same complaint. CC8 stated that Staff A told them that they were working on it. CC8 stated that many residents complain but "let it ride" because nothing was done about it.

During an interview on 3/11/2025 at 10:50am Collateral Contact 9 (CC9),Anonymous Resident, stated that there was not enough staff. CC9 stated they have not been affected a lot because they were independent with most activities. CC9 stated that it took a long time for call lights to be answered and when staff responded they would inform them that they were short staffed.

During an interview on 03/11/2025 at 11:25am, Collateral Contact 10 (CC10), Anonymous Staff, stated staff were resigning due to staffing shortages. CC10 stated that one caregiver per floor was too much for one person, that some resident took 45 minutes to care for. CC10 stated that the management told them they could call for other caregivers to assist. CC10 stated that other caregivers have their own floors to care for. CC10 stated they called for assistance with two - person assist residents, and "just struggle and do the best I can" with the rest.

During an interview on 03/11/2025 at 11:40am, Collateral Contact 11 (CC11), Anonymous Resident, stated that the facility did not have a housekeeper for a long time, and not enough caregivers to provide care. CC11 stated that there was only one caregiver per floor and some residents needed a lot of care. CC11 stated that their room had not been cleaned for a few weeks. CC11 stated that they were told that the facility was working to hire a housekeeper and Staff C would take care of housekeeping.

During an interview on 03/11/2025 at 11:55am, Collateral Contact 12 (CC12), Anonymous Resident, stated that they have not had their room cleaned every week. CC12 stated that weekly housekeeping was part of the services they paid for, and it was not being done. CC12 stated that the facility did not have a housekeeper for a few weeks and just hired a new housekeeper about a week ago.

During an interview on 03/20/2025 at 10:56am, Collateral Contact 13 (CC13), Resident Representative, stated that CC8 did not get their showers consistently because staff told them they were short staffed. CC13 stated that CC8 would call staff to remind them of their shower. If not, CC8 would not get the shower. CC13 stated that CC8 did not get their apartment cleaned every week per agreement; stated that staff would come in and take the garbage away and stated they would be back later to clean but never come back. CC13 stated that CC8 "complained a lot about housekeeping" but the facility didn't do anything.

During and interview on 12/27/2025 at 12:30pm, Staff A was asked if they were short staffed. Staff A stated that they had let some staff go for industry practice violations. Staff A stated that they had no complaints of residents not receiving care. Staff A stated that when they had a shift that needed coverage on 12/24/2024 they (Staff A) went to help. In a separate interview on 03/24/2025 at 3:21pm, Staff A stated that their housekeeper resigned abruptly but that they had other staff assist with housekeeping tasks. Staff A was asked if the staff from other departments were cross trained to do housekeeping tasks. Staff A stated that they were, and that housekeeping was not a difficult task. When asked if rooms went a long time without being cleaned, Staff A stated that different departments helped. Staff A stated that Staff C completed most of the housekeeping tasks. Staff A was asked if Staff C's housekeeping responsibilities could have contributed to maintenance requests not to be completed timely. Staff A stated that they assisted with maintenance requests, and that Staff C was given extra hours to complete their tasks. Staff A was asked what the facility timeline was for completing work orders. Staff A stated that it would ideally be within 24hrs. When asked why some work orders had not been completed for weeks, Staff A stated that they had been and that they were either not logged as completed or the report wasn't running accurately. Staff A was asked if they had been short staffed the last few months in caregivers. Staff A stated that they were not. Staff A was asked who was responsible for other residents on night shift if the two scheduled staff were tied up in a room. Staff A stated that they would need to complete the task and then respond to other residents. When asked if staffing issues contributed to residents not receiving showers, Staff A stated that it was hard to say as facility staffing was depended on resident needs and census.

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 Courtyard Puyallup 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

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that negotiated Service Agreements (NSAs) were signed by their department case manager for 4 of 4 sample residents (Resident 2,5,6 & 7 [R2, 5, 6, & 7]). This failure placed these four residents at risk for not receiving agreed upon services.

Findings included...

Record review of resident records showed the following:

R2's NSA dated 08/23/2024 was not signed by the resident, their representative or case manager. A noted written on the NSA by Staff B, Health and Wellness Director, stated that the signed original copy was sent to medical records.

R5's NSA dated 08/01/2023 and 02/04/2025 were not signed by the resident's case manager.

R6's NSA dated 09/28/2024 was signed by resident on 03/11/2025. There was no signature from the case manager.

R7's NSA dated 11/22/2023, 05/26/2024 and 11/22/2024 were not signed by case manager. The 11/22/2024 service plan was signed by resident on 03/11/2025.

During an interview on 03/11/2025 at 7:49am, Collateral; Contact 14 (CC14), Case Manager, stated that the facility did not provide any service agreements for them to sign for R2, 5, 6 & 7 and there was no communication from the facility regarding these residents. CC14 stated that when they asked Staff B to review service agreements, Staff B told them that they were busy.

During an interview on 03/21/2025 at 3:27pm, Staff B was asked who was supposed to sign the residents' service agreements. Staff B stated that they were responsible, the resident, their representative and case manager if the resident received state funding. When asked why R2, 5, 6 & 7's service agreements were not signed by their case manager, Staff B stated, "they didn't come to sign." When asked what the process was for ensuring that the case manager was informed that service agreements were ready to be signed, Staff B stated they didn't know what the process before them was.

This is a repeated deficiency previously cited on 10/18/2024.

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 Courtyard Puyallup 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

WAC 388-78A-2420 Record retention.

(3) The assisted living facility must maintain all documentation filed in a closed resident record, on the assisted living facility premises for six months after the date the resident leaves the assisted living facility and on the assisted living facility premises or another location for five years after the date the resident leaves the assisted living facility.

(4) All active, inactive, and closed resident records must be available for review by department staff and other authorized persons.

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to maintain a resident's signed negotiated service agreement on file for 1 of 1 sampled resident (Resident 2 [R2]). This failure placed Resident 2 at risk for not receiving agreed upon services.

Findings included...

Record review of resident records showed that Resident 2 (R2) was admitted to the ALF on [redacted]/2020 with diagnoses to include [redacted]. There was no 2024 signed care plan on file to review.

During an interview on 03/11/2025 at 1:10pm, Staff H, Business Office Manager was asked for records showing that R2's case manager had been notified of the [redacted] 2024 hospital transfer, return to the facility and subsequent death. Staff H stated that they did not have the records as the previous business manager was no longer employed. Staff H stated that communication with the case manager was done via email. Staff H stated they were not able to produce the emails from the previous manager. Staff H stated they would ask management to access records and will send to the department. No documents were provided.

In an email dated 03/14/2025 at 11am, Staff A, Administrator stated that R2's care plan was somewhere in the closed file, and they could not locate the original signed care plan.

During an interview on 03/21/2025 at 3:27pm, Staff B, Health and Wellness Director stated that resident records were broken down and stored onsite. When asked about R2's 2024 signed service plan, Staff B stated that it was their understanding that the Administrator had searched and couldn't find it.

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 Courtyard Puyallup 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

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(2) The assisted living facility must notify any agency responsible for paying for the resident's care and services as soon as possible whenever:

(a) The resident is relocated to a hospital or other health care facility; or

(b) The resident dies.

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to timely notify the case manager when a resident was sent to the hospital and when they passed away for 1 of 1 sampled resident (Resident 2 [R2]). This failure placed residents at risk for delayed services and a potential overpayment from the department.

Findings included...

Review of R2's records showed that resident was admitted to the ALF on [redacted]/2020 with diagnoses to include [redacted]. Review of progress notes showed that on [redacted]/2024, R2 was sent to the hospital to be evaluated for blood-tinged urine, and that on [redacted]/2025 R2 passed away after returning to ALF. There was no documentation in resident's record that the case manager was notified of hospital transfer or death.

During an interview on 03/11/2025 at 7:49am, Collateral Contact 14 (CC14), Case Manager stated that the ALF did not inform them that the resident had been transferred to the hospital on [redacted]/2024 so that they could place a bed hold. CC14 stated that the hospital had a discharge date of either [redacted]/2025 or [redacted]/2025, and by 01/09/2025, they "still hadn't heard anything from the facility." CC14 stated they went to the facility and spoke to Staff B, Health and Wellness Director who stated that resident was back at facility but was not sure when the resident returned. CC14 stated they sent a follow up email requesting discharge and return dates and did not get a response until 01/15/2025. CC14 stated that the facility did not notify them of the resident passing away. CC14 stated that the resident's family were the ones who called to notify them of resident's passing. CC14 stated that Staff B stated the reason the facility didn't communicate the discharge, return to facility and death was because their "biller had quit in the middle of the month."

During an interview on 03/11/2025 at 12:45pm, Staff B, Health and Wellness director was asked who was notified when a resident discharged to the hospital or passed away. Staff B stated that they notified the resident representatives and physicians, and the business office manager was responsible for state sponsored residents.

During an interview on 03/11/2025 at 1:10pm, Staff H, Business Office manager stated that they were responsible for notifying the department when the resident passed away. Staff H stated that notification was done via email. When asked for documentation, Staff H stated that it was the previous business office manager that would have handled R2's case and that they would not be able to access their emails. When asked how their process ensured availability of resident records and information, Staff H stated they would ask management for documentation and send to department. No documents were received as of the writing of this statement of deficiency.

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 Courtyard Puyallup 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

WAC 246-215-03525 Temperature and time control Time/temperature control for safety food, hot and cold holding (FDA Food Code 3-501.16).

(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530 , and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:

(a) At 135 F (57 C) or above, except that roasts cooked to a temperature and for a time specified under WAC 246-215-03400 (2) or reheated as specified under WAC 246-215-03440 may be held at a temperature of 130 F (54 C) or above; or

(b) At 41 F (5 C) or less.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interviews, the Assisted Living Facility (ALF) failed to maintain food and liquids at the required temperatures for all 78 residents in the facility. This failure resulted in residents being served food at unsafe temperatures and placed all 78 residents at risk for food borne illness.

Findings included...

During a lunch service on 03/11/2025 at 11:58am, Staff E, Cook was observed serving meals in the kitchen. Staff E was asked to check the holding temperature for the meat. Temperature was 126 degrees.

During an interview on 03/11/2025 at 12:00pm, Staff E was asked what the holding temperatures for hot foods were. Staff E stated, "between 140-165 degrees." When

asked if they recorded and kept a temperature log, Staff E stated they did and that it was in the back.

During an interview on 03/11/2025 at 12:15pm Staff F was asked what temperatures hot foods and cold liquids should be served at. Staff F stated above 70 degrees for hot foods and less than 50 degrees for cold. When asked how they would know if the liquids they pour for residents were hot or cold enough, Staff F stated that they knew "because they just came out of the containers." Staff F was asked if residents complained about food not being hot or cold enough. Staff F stated, "sometimes." When asked what they did if a resident complained about food, Staff F stated that they got a new plate or new drink for the resident.

During an interview on 03/11/2025 at 12:30pm, Staff G, Chef stated that hot foods should be held at 140 degrees and food should go out to residents at the same temperature. When asked about plates that were left on the counter for a long time before being served to residents, Staff G stated that food usually was delivered to residents right away but "today they were late.". Staff G stated cold foods were to be serviced below 41 degrees and hot liquids between 140 - 165 degrees. When asked if residents had complained about food not being hot or cold enough, Staff G stated that they were not aware of any food complaints.

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 Courtyard Puyallup 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

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that the living environment for residents was well maintained, in good repair and attended to timely. This failure placed residents at risk for accidents and decreased quality of life resulting from delayed completion of orders.

Findings included...

Record review of uncompleted resident room work orders on 12/27/2024 for review period of October 1 - December 2024 showed the following:
The following orders were logged in as critical priority but had not been completed:
Order #
6002 - broken toilet seat
6152 - no hot water
6100 - toilet not flushing
6111 - lukewarm water
6135 - toilet clogged
6136 - bathroom sink clogged

The following orders were given a high priority:
6120 - Rehanging closet doors and tightening toilet seat
6130 - bathroom cabinet loose
6132 - Sink clogged
6140 - possible bathroom leak
6144 - room entry light was out

Record review on 03/11/2025 of open and uncompleted work orders from October 1, 2024, showed the following orders not completed:
6148 - possible bathroom or sink leak was open since 12/17/2024
6144 - entry light needing replacing was open since 12/22/2024
6120 - rehanging closet doors, toilet seat needing to be retightened was open since 12/03/2024
6067 - Install grab bar was still open since 11/06/2024
6130 - Bathroom cabinet door loose was open since 12/12/2024
6132 - sink plugged up was open since 12/13/2024
6107 - carpet came up off floor was open since 11/22/2024

During an interview on 12/26/2024 at 11:50am, Collateral Contact 1 (CC1), Regional Maintenance, stated that work orders were not being completed timely leaving residents at risk for accidents. CC1 stated that there were multiple orders that had not been completed since October 2024 including clogged sinks, toilets, baseboard heater off the wall, grab bars not being installed and toilet seats not stable.

During an interview on 12/27/2024 at 11:27am Staff C, Maintenance, stated that orders were completed according to priority. When asked why work orders that were marked as critical or high priority were not completed for weeks, Staff C stated that they were

only one person. When asked if resident's safety was at risk especially when grab bars were not installed, clogged up toilets not fixed and room lights being out, Staff C stated that they were trying to get orders done.

During an interview on 12/27/2024 at 12:30pm, Staff A, Administrator stated that their previous maintenance personnel left abruptly, and that Staff C was new. When asked if work orders were not completed timely, Staff A stated that they had kept up with life safety and critical maintenance issues. In a separate interview on 03/24/2025 at 3:21pm, Staff A was asked who was managing work orders if Staff C was completing housekeeping tasks. Staff A stated that they brought in some help, that they (Staff A) jumped in and helped, and that Staff C was given extra hours to complete maintenance tasks. When asked about order 6132 with the sink that was plugged up, Staff A stated it was opened on 12/13/2024 and completed on 01/7/2025. When asked why it took three weeks to fix a clogged sink, Staff A stated they would have to ask some questions. When asked when order 6002 for a broken toilet seat was placed and completed, Staff A stated that it was placed in September but there was no completed date. Staff A stated that the work order was reassigned on 10/25/2024 as "there was a disagreement that it (toilet seat) was broken" and was completed the same day. When asked why the work orders were showing as uncompleted, Staff A stated that they were not being marked as completed or the report was not running accurately.

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 Courtyard Puyallup 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