



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

09/10/2026

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

RE: Brookdale Courtyard Puyallup # 2366

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 81435 (Completion Date 09/10/2026) and 76427 (Completion Date 06/16/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/10/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

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

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(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.

The Department staff who did the On Site verification:

Carol Gijima, Community Complaint Investigator (NCI)

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit D
Residential Care Services



Residential Care Services Investigation Summary Report

Provider/Facility: Brookdale Courtyard
Puyallup

License/Cert.#: 2366

Compliance Determination #: 76427

Investigator: Carol Gijima

Investigation Date(s): 04/24/2026 through 06/16/2026

Complainant Contact Date(s): 06/16/2026

Provider Type: Assisted Living Facility

Intake ID: 220721

Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1. Resident rights
-

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size: 2
Observations:	General environment Residents in their rooms, in common areas and dining room Staff-to-resident interactions Resident behaviors
Interviews:	Residents including named resident Residents Resident representatives Collateral Contacts Staff
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 Incident log / reports Grievance logs Disclosure services Financial ledger Weight logs

Investigation Summary:

1. Per record review and interviews with named resident, residents in the facility, residents' representatives, collateral contacts and staff, the Assisted Living Facility denied residents the ability to eat in the dining room with staff assistance. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies

cited on 06/16/2026.

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 Courtyard
Puyallup

License/Cert.#: 2366

Compliance Determination #: 76427

Investigator: Carol Gijima

Investigation Date(s): 04/24/2026 through 06/16/2026

Complainant Contact Date(s): 06/16/2026

Provider Type: Assisted Living Facility

Intake ID: 223183

Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1. Allegations of financial exploitation
2. Allegation of neglect
3. Quality of care

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size: 2
Observations:	General environment Residents in their rooms, in common areas and dining room Staff-to-resident interactions Resident behaviors
Interviews:	Residents including named resident Residents Resident representatives Collateral Contacts Staff
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 Incident log / reports Grievance logs Disclosure services Financial ledger Weight logs

Investigation Summary:

1. Per record review of resident's records including financial ledger, interviews with resident's representative and staff, the facility credited the resident for services not provided and days resident was not in the facility. There was not sufficient

information to support failed practice.

2. Per record review of resident's records, interviews with resident's representative, collateral contacts, and staff, care and services were not provided as agreed upon. There was not sufficient information to support resident neglect. The investigation did not determine failed provider practice.

3. Per record review and interviews with residents in the facility, residents' representatives, collateral contacts and staff, the Assisted Living Facility failed to investigate circumstances surrounding resident's multiple falls, denied residents the ability to eat in the dining room with staff assistance and failed to take appropriate action when resident experienced a significant weight loss. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies cited on 06/16/2026.

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
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2366	Compliance Determination # 76427
Plan of Correction	Brookdale Courtyard Puyallup	Completion Date
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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 04/24/2026 and 05/27/2026 of:

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

This document references the following complaint number(s): 220721, 223183

The following sample was selected for review during the unannounced on-site visit: 3 of 0 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Complaint Investigator (NCI)

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

Statement of Deficiencies	License #: 2366	Compliance Determination #76427
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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.

Laurie Anderson

Residential Care Services

06-18-2026

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.

Mike Schwartz

Administrator (or Representative)

6/24/26

Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights.

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) denied 2 of 2 sample residents (Resident 1 and Resident 2) the ability to eat in the dining room with staff assistance. This failure resulted in decreased quality of life and isolation for Resident 1 and Resident 2.

Findings included...

RESIDENT 1

Review of Resident 1's undated records showed the ALF admitted Resident 1 on [REDACTED] 2024.

Review of Resident 1's negotiated service agreement, dated 03/19/2025, showed that Resident 1 needed total direct physical assistance to eat

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.

Laurie Anderson

Residential Care Services

06-18-2026

Date

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Administrator (or Representative)

Date

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Based on record review and interviews, the Assisted Living Facility (ALF) denied 2 of 2 sample residents (Resident 1 and Resident 2) the ability to eat in the dining room with staff assistance. This failure resulted in decreased quality of life and isolation for Resident 1 and Resident 2.

Findings included...

RESIDENT 1

Review of Resident 1's undated records showed the ALF admitted Resident 1 on [REDACTED] 2024.

Review of Resident 1's negotiated service agreement, dated 03/19/2025, showed that Resident 1 needed total direct physical assistance to eat.

Review of Resident 1's progress notes dated 04/13/2026 at 9:51 AM showed that Resident 1 reported "having mental health stress" after they were informed that they cannot eat meals in the dining room.

During an interview on 04/23/2026 at 5:00 PM, Resident 1 stated that they needed physical help with eating. Resident 1 stated that staff were aware they needed physical feeding assistance from staff. Resident 1 stated that they always received the needed help since they transferred from another sister community. Resident 1 stated "staff spoon fed me in the dining room since admission to this facility two years ago." Resident 1 stated that recently Staff A, Administrator, informed Resident 1 they were no longer allowed to be fed in the dining room and had to be fed in their room. Resident 1 stated that Staff A told them that being fed in the dining room "was demeaning to other residents".

During an interview on 04/24/2026 at 11:20 AM, Resident 1 stated that Staff A informed them they were restricted to eating meals in their room alone. Resident 1 stated that the restriction prevented them from socializing and eating with my friends. Resident 1 stated that they informed Staff A this caused them to have psychological issues.

During an interview on 04/24/2026 at 11:30 AM, Collateral Contact 1 (CC1), Long term care Ombudsman, stated that Staff A informed them that the ALF policy did not allow staff to feed residents in the dining room. CC1 stated that Resident 1 was being fed in the dining room for over two years. CC1 stated that Staff A informed them there were complaints brought up about staff feeding Resident 1 in the dining room. CC1 stated that food was brought on paper plates and sometimes it was not hot. CC1 stated "this is a dignity and rights issue... [Resident 1] wants to be down there with others and [their] friends".

RESIDENT 2

Review of Resident 2's undated records showed the ALF admitted Resident 2 on [REDACTED]/2026.

Record review of Resident 2's pre-move in assessment, dated 02/26/2026, showed that Resident 2 needed staff physical assistance help with eating.

Review of Resident 2's negotiated service agreement, dated 03/19/2026, showed that Resident 2 needed direct physical assistance to eat.

Review of the facility's progress notes showed that Resident 2 received staff assistance with feeding at mealtimes.

During an interview on 05/19/2026 at 4:07 PM, Collateral Contact 2 (CC2), Resident 2's representative, stated that Staff A informed them prior to Resident 2's admission that staff would feed Resident 2 in the dining room because they were already doing it for someone else (Resident 1). CC2 stated that Staff A told them that Resident 2 could not be fed in the dining room because of the dignity of other residents. CC2 stated that Staff A offered to have staff feed Resident 2 in the dining room after everyone else left. CC2 stated that when Resident 2 was restricted to being fed in their room, Resident 2 lost over 14 pounds in six weeks. CC2 stated that they refused to allow Resident 2 to be secluded. CC2 stated that they were forced to come into the building to feed Resident 2 in the dining room to ensure that Resident 2 socialized with others.

RESIDENT 3

During an interview on 05/27/2026 at 10:35 AM, Resident 3 stated that they were very upset and very angry when they were notified that Resident 1 was not allowed to eat meals in the dining room. Resident 3 stated that staff fed Resident 1 in the dining room ever since Resident 1 moved into the facility. Resident 3 stated that meals were the times they socialized with Resident 1 and everybody else. Resident 3 stated that Resident 1's absence was felt by many residents.

RESIDENT 4

During an interview on 05/27/2026 at 10:50 AM, Resident 4 stated that they were bothered that Resident 1 was confined to their room for meals. Resident 4 stated that they never see Resident 1 at mealtimes anymore. Resident 4 stated that mealtimes were when they socialized and they were sad not to see Resident 1 at their table for meals. Resident 4 stated that they tried to visit Resident 1 in their room and they were not the same.

During an interview on 04/24/2026 at 10:30 AM, Staff B, Health and Wellness Director, stated that both Resident 1 and Resident 2 were admitted to the facility needing staff assistance with feeding. Staff B stated that Resident 1 was happy around people and liked to socialize. Staff B stated that until recently, both Resident 1 and Resident 2 received physical assistance from staff with eating in the dining room. Staff B stated that they were informed by their corporate management that Resident 1 could no longer be fed in the dining room because of dignity and resident privacy. Staff B stated that they were informed by their corporate office that it was against state regulation and that the facility would be cited if residents were fed in the dining room.

During an interview on 04/24/2026 at 11:50 AM, Staff A, Administrator, stated that Resident 1 was always spoon fed by staff. Staff A stated that they informed Resident 1 last summer that "our internal audits with supervisors did not meet the internal standards of care...feeding residents in the dining room." Staff A stated that they had a long delay to get this going. Staff A stated that they informed Resident 1 last month of the change for staff assistance with feeding. Staff A stated that other residents complained of Resident 1 being fed in the dining room, that it had a nursing home feel. Staff A stated that Resident 1 was upset that they could no longer be fed in the dining room. Staff A stated there was no facility policy regarding feeding residents.

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During an interview on 05/27/2026 at 11:15 AM, Staff C, Health and Wellness Coordinator, stated that the plan was to allow staff to feed Resident 2 in the dining room since the staff were already feeding Resident 1 there. Staff C stated that staff from the corporate office came into the building one day and then the facility was informed the residents could not be fed in the dining room anymore.

On 05/27/2026, between 12:55 PM and 3:01 PM, seven anonymous staff (CC3, CC4, CC5, CC6, CC7, CC8, and CC9) were interviewed. Several of the anonymous staff stated that they were unaware of any complaints from other residents regarding Resident 1 and Resident 2 being fed in the dining room. Several staff stated that Resident 1 and Resident 2 were normally fed by staff in the dining room. The staff stated that they were unaware of why this changed.

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) 7/17/26.

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



Administrator (or Representative)



Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

- (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation, or accident or incident jeopardizing or affecting a resident health or life;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to investigate, determine the circumstances, or implement interventions surrounding 1 of

During an interview on 05/27/2026 at 11:15 AM, Staff C, Health and Wellness Coordinator, stated that the plan was to allow staff to feed Resident 2 in the dining room since the staff were already feeding Resident 1 there. Staff C stated that staff from the corporate office came into the building one day and then the facility was informed the residents could not be fed in the dining room anymore.

On 05/27/2026, between 12:55 PM and 3:01 PM, seven anonymous staff (CC3, CC4, CC5, CC6, CC7, CC8, and CC9) were interviewed. Several of the anonymous staff stated that they were unaware of any complaints from other residents regarding Resident 1 and Resident 2 being fed in the dining room. Several staff stated that Resident 1 and Resident 2 were normally fed by staff in the dining room. The staff stated that they were unaware of why this changed.

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- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to investigate, determine the circumstances, or implement interventions surrounding 1 of

2 sample residents (Resident 2) falls. This failure placed Resident 2 at risk of a decrease in quality of life and the potential for serious injury.

Findings included...

Review of the facility's incident reports for Resident 2 showed the following:

On 04/21/2026 at 4:15 AM, Resident 2 was found on the floor. The report showed[LA1.1] that Resident 2 slid out of bed. There was no documentation that showed any interventions were put in place to prevent recurrence.

On 04/24/2026 at 1:25 AM, Resident 2 was found on the floor. The report showed that Resident 2 slid out of the bed and sustained a skin tear to left shin. There was no documentation that showed an investigation was completed and no documentation that showed any interventions were put in place to prevent recurrence.

On 04/29/2026 at 4:00 AM, Resident 2 was found on the floor. The report showed Resident 2 lost a tooth and had bruising on their face. The report showed that this fall was due to Resident 2's attempt to try and find their phone that was likely ringing. There was no documentation that showed an investigation was completed and no documentation that showed any interventions were put in place to prevent recurrence.

On 04/30/2026 at 4:30 AM, Resident 2 was found on the floor with a skin tear to right elbow. The report showed Resident 2 was placed back into bed. There was no documentation that showed an investigation was completed and no documentation that showed any interventions were put in place to prevent recurrence.

Review of the facility's progress notes for Resident 2 showed the following:

On 03/29/2026 at 3:30 PM, Resident 2 had a fall while trying to self-transfer. There was no documentation of a completed incident report, no documentation that showed an investigation was completed, and no documentation that showed any interventions were put in place to prevent recurrence.

During an interview on 05/19/2026 at 4:07 PM, Collateral Contact 2 (CC2), Resident 2's representative, stated that Resident 2 sustained multiple falls at night. CC2 stated that they were unaware of any interventions put in place by the staff. CC2 stated that facility staff failed to call 911 when Resident 2 fell, hit their head, and knocked their front tooth out. CC2 stated that staff reported that Resident 2 was "fine".

During an interview on 05/27/2026 at 11:30 AM, Staff B, Health and Wellness Director, stated that upon admission to facility, Resident 2 was assessed as a fall risk and was placed on frequent checks. Staff B stated that on 04/21/2026, Resident 2 fell because someone was talking to them on the camera. Staff B stated that when asked about the fall on 04/29/2026, Resident 2 was unsure if they rolled out of bed. Staff B stated that related to the fall on 04/30/2026, Resident 2 was speaking to someone on video. Staff B stated that the interventions put in place included an increase in more frequent checks. Staff B stated that they were unsure of the frequency of the checks. Staff B stated that it was Staff A's responsibility to investigate Resident 2's falls.

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During an interview on 05/27/2026 at 11:40 AM, Staff A, Administrator, stated that Resident 2 had four falls in less than five days. Staff A stated that Resident 2's family called in the middle of the night, and Staff A believed Resident 2 tried to answer the phone and fell. Staff A stated that other falls occurred when Resident 2 attempts to get up or do something for themselves. Staff A stated that their investigation ruled out abuse and neglect. Staff A did not state how they ruled out abuse or neglect. Staff A did not provide interventions put in place to prevent recurrence.

On 05/27/2026, between 1:13 PM and 1:58 PM, five anonymous staff (CC4, CC5, CC6, CC7, and CC8) were interviewed. All five staff stated that they were aware of Resident 2's falls. All five staff stated that they were unaware of any interventions put into place to prevent any recurrences.

Plan/Attestation Statement

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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.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition,

(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 record review and interviews, the Assisted Living Facility (ALF) failed to notify the primary care provider and document in the record when 2 of 5 sample residents (Resident 2 and Resident 5) experienced significant weight loss. This failure placed

During an interview on 05/27/2026 at 11:40 AM, Staff A, Administrator, stated that Resident 2 had four falls in less than five days. Staff A stated that Resident 2's family called in the middle of the night, and Staff A believed Resident 2 tried to answer the phone and fell. Staff A stated that other falls occurred when Resident 2 attempts to get up or do something for themselves. Staff A stated that their investigation ruled out abuse and neglect. Staff A did not state how they ruled out abuse or neglect. Staff A did not provide interventions put in place to prevent recurrence.

On 05/27/2026, between 1:13 PM and 1:56 PM, five anonymous staff (CC4, CC5, CC6, CC7, and CC8) were interviewed. All five staff stated that they were aware of Resident 2's falls. All five staff stated that they were unaware of any interventions put into place to prevent any recurrences.

Plan/Attestation Statement

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Administrator (or Representative)

Date

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(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

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(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 record review and interviews, the Assisted Living Facility (ALF) failed to notify the primary care provider and document in the record when 2 of 5 sample residents (Resident 2 and Resident 5) experienced significant weight loss. This failure placed

Resident 2 and Resident 5 at risk of delayed medical services and a decline in their quality of life.

Findings included...

Review of the ALF's "Nutrition at Risk Program: Weight loss guideline," dated March 2019, showed that significant weight loss was defined as at least 5% loss in 30 days, 7.5% in 90 days and 10% in 180 days. The guideline showed that staff were to notify the resident's primary care provider, institute weekly weight checks, record percentage of food eaten at each meal, and file the documentation in the residents' record.

Resident 2

Review of Resident 2's undated records showed the ALF admitted Resident 2 on [REDACTED] 2026. Review of Resident 2's weight log showed that Resident 2 weighed 108 pounds at admission. The weight log showed that Resident 2 weighed 94.6 pounds on 04/03/2026. Resident 2 lost 13.4 pounds, a 12.6% weight loss within five weeks.

Review of Resident 2's progress note, dated 04/17/2026, showed that Resident 2 was placed on a meal consumption tracking plan. The progress note showed that staff were to encourage Resident 2 to drink more. There was no documentation that showed Resident 2's primary care provider was notified of the weight loss. There was no documentation in the records that showed the percentage of Resident 2's food intake.

RESIDENT 5

Review of Resident 5's records showed the ALF admitted Resident 5 on [REDACTED]/2025. Review of Resident 5's weight log showed that Resident 5 weighed 114 pounds at admission. The weight log showed that Resident 5 weighed 94.3 pounds on 03/09/2026. Resident 5 lost 19.7 pounds, a 17.28% weight loss within 180 days. There was no documentation of Resident 5's weight loss in the progress notes. There was no documentation that Resident 5's representative or primary care provider were notified of the weight loss. There was no documentation in the records that showed the percentage of Resident 5's food intake.

During an interview on 05/19/2026 at 4:07 PM, Collateral Contact 2 (CC2), Resident 2's representative stated that Resident 2 was supposed to be fed in the dining room by staff. CC2 stated that Staff A directed staff to feed Resident 2 in their room. CC2 stated that staff were not feeding Resident 2 in their room and "they dropped 14 pounds in six weeks." CC2 stated that Resident 2's family decided to go into the facility during meals and feed Resident 2. CC2 stated that Resident 2 was not getting enough nutrition, had multiple falls which led to hospitalization, and subsequent death within days of being released from the hospital.

During an interview on 05/27/2026 at 11:30 AM, Staff B, Health and Wellness Director stated that Resident 5 was not eating and lost a lot of weight. Staff B stated that they were unsure of when Resident 5 started losing weight. When asked if the primary care

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provider was notified. Staff B stated that they believe they asked Resident 5's family to bring Ensure (a nutritional supplemental drink) into the facility. Staff B stated that they initiated a meal attendance and consumption plan. There was no documentation in Resident 5's record that showed Resident 5's primary care provider was notified of the significant weight loss.

During an interview on 06/10/2026 at 11:13 AM, Staff B stated that staff were to notify the residents' primary care providers, representatives, and initiate weekly weights when there was significant weight loss, per the nutrition guidelines. Staff B stated that Resident 2's primary care provider was notified of the weight loss. Staff B stated that the fax that was sent to the primary care provider was not retained in the records. Staff B stated that the facility initiated daily meal trackers. Staff B stated that the nutrition guideline "was definitely not followed."

Plan/Attestation Statement

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



Administrator (or Representative)



Date

provider was notified, Staff B stated that they believe they asked Resident 5's family to bring Ensure (a nutritional supplemental drink) into the facility. Staff B stated that they initiated a meal attendance and consumption plan. There was no documentation in Resident 5's record that showed Resident 5's primary care provider was notified of the significant weight loss.

During an interview on 06/10/2026 at 11:13 AM, Staff B stated that staff were to notify the residents' primary care providers, representatives, and initiate weekly weights when there was significant weight loss, per the nutrition guidelines. Staff B stated that Resident 2's primary care provider was notified of the weight loss. Staff B stated that the fax that was sent to the primary care provider was not retained in the records. Staff B stated that the facility initiated daily meal trackers. Staff B stated that the nutrition guideline "was definitely not followed."

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