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

Bremerton SCC LLC
The Arbor at Bremerton
3510 9th Street
Bremerton, WA 98312

RE: The Arbor at Bremerton License # 2619

Dear Administrator:

This letter addresses Compliance Determination(s) 38496 (Completion Date 03/22/2024) and 35347 (Completion Date 01/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/22/2024 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-2600-2-j-i, WAC 388-78A-2600-2-j-ii, WAC 388-78A-2600-2-j-iii

The Department staff who did the on-site verification:
Michael Goulet, Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Jody Just Region 3 Field Serices Administrator signing for Manfay Chan

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: The Arbor at Bremerton
Provider Type: Assisted Living Facility
License/Cert.#: 2619
Compliance Determination #: 35347
Intake ID: 114660
Investigator: Michael Goulet
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 01/17/2024 through 01/22/2024
Complainant Contact Date(s):

Allegation(s):
1) Resident to resident altercation with significant injury (bruising to face and back of head)

Investigation Methods:

Sample:	Total residents: Resident sample size: 6 Closed records sample size:
Observations:	General environment Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Resident Care Plan Facility Incident Reports (5)

Investigation Summary:
1) Per facility report to the department made on 1-13-24, the male resident (AP) did hit a female resident (AV, struck in the face and on the back of the head) leading to hospitalization for the female resident. The facility report stated that this behavior on the part of the AP "occurs daily", and that the AP wanders into peers' rooms or sleeps in peers' beds and then becomes violent when confronted. Per record review of facility incident reports (many of which were made by the facility but not forwarded to investigative field staff) showed that there had been five resident to resident altercations in which the named resident (AP) had struck peers between 12-17-23 and [redacted]-24, with three of these altercations leading to injury. Per facility staff interviews and record review of facility documents, the only intervention noted was to increase monitoring frequency for the named resident (AP) to once per hour. Staff noted that the named resident did have an as needed (PRN) medication for agitation (Ativan/ Lorazepam) but that the resident would often refuse this medication and that, due to the rapid escalation of the resident's behavior when interacting with peers, the medication was not effective at preventing altercations. The facility did request psychiatric hospitalization of the resident for evaluation and medication reconciliation, but only following the fifth altercation which occurred on [redacted]-24.
Cited per WAC 388-78A-2600 (2j) Policies and procedures

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2619	Compliance Determination # 35347
Plan of Correction	The Arbor at Bremerton	Completion Date
Page 1 of 3	Licensee: Bremerton SCC LLC	01/22/2024

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 01/17/2024 and 01/17/2024 of:

The Arbor at Bremerton
3510 9th Street
Bremerton, WA 98312

This document references the following complaint number(s): 114660

The following sample was selected for review during the unannounced on-site visit: 6 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

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

02/01/2024
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-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

This requirement was not met as evidenced by:

Based on interviews and records review, the assisted living facility (ALF) failed to adequately address the behavior of 1 of 1 resident after it was noted that the resident had been involved in multiple resident-to-resident altercations leading to injury for peers at the facility. This failure placed all residents at risk of harm and did lead to injuries for 3 of 5 residents (Residents 2, 3 and 4).

Findings included...

During an interview on 01/08/2024 at 10:55am, Staff Caregiver (Staff A) stated that Resident 1 (R1) had been "really aggressive with folks" and that the medication prescribed for R1 was often not effective regarding minimizing this behavior.

During an interview on 01/17/2024 at 10:15am, Resident 2 (R2) stated that they were not aware of any actions the facility had taken to address the behavior of R1 prior to R2 being injured on [redacted]/2024 and stated that "I heard he did that with a lot of other people too."

During an interview on 01/17/2024 at 10:25am, Facility Caregiver (Staff C) stated that R1 had "hit about five people" including Resident 5 (R5). Staff C stated that R1 only had 'as needed' (PRN) medication to address their behaviors, and that R1 would often refuse this medication when agitated. Staff C also stated that it was known that R1 had exhibited similar behavior at their prior facility, and that it was thought that R1 had previously beat another resident at their former facility leading to that resident's death.

Record review on 01/16/2024 at 2:30pm of the facility report made by Facility Assistant Executive Director (AED, Staff B) noted the resident-to-resident altercation occurring on

[redacted]/2024 (involving R1 injuring R2) and stated that R1's "behavior occurs daily."

Record review on 01/16/2024 at 2:30pm of prior facility reports showed that the facility had reported resident to resident altercations instigated by R1 on 12/17/2023, 12/31/2023, 01/04/2024 and 01/08/2024, in addition to the report made on 01/13/2024. Three of these altercations (reported on 12/17/2023, 01/08/2024 and 01/13/2024) were noted to involve injury to facility residents (Residents 2, 3 and 4 [R2, 3, & 4]).

Record review on 01/22/2024 at 7:45am of R1's Negotiated Service Agreement (care plan) showed that the only behavior noted for R1 was exit seeking behavior with no indication of any prior aggressive behavior, resident to resident altercations or interventions to address aggressive behavior.

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, The Arbor at Bremerton is or will be in compliance with this law and / or regulation on (Date) 2/15/24.

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

Melissa Green — Administrator (or Representative)

2/1/2024 — Date

CAREPARTNERS
SENIOR LIVING

Plan of Correction

Citation: WAC 388-78A-2600

Immediate Action Taken

Based on the statement of deficiency, the resident who initiated this incident in question was sent to the ER on [redacted]/2024 Resident was not readmitted to the facility due to unmanaged behaviors.

Actions Taken:

1. Based on the Statement of Deficiencies, all of the residents with a diagnosis of [redacted] were identified as being at risk. All service plans will be reviewed to ensure that appropriate interventions are in place and resident-specific. Review of Service plans will be completed by February 15th, 2024
2. Staff education with all caregivers will include de-escalation techniques and redirecting residents with cognitive deficits. Staff education will be completed February 15th, 2024. Inservices and training will be provided to state surveyors.

Monitoring Compliance:

1. All resident incident reports will be monitored for 4 weeks to ensure appropriate interventions are implemented for residents with verbal and / or physical aggression.
2. After 4 weeks of monitoring, incident reports involving verbal or physical altercations will be randomly reviewed quarterly by either the quality control nurse or administrator designee and evaluated by the regional clinical team.

Date of compliance will be 2/15/2024

Melissa Shaw