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 # 2619

Dear Administrator:

This document references Compliance Determination 57935 (04/23/2025), which included complaint number(s) 174984.

The Department completed a complaint investigation of your Assisted Living Facility on 04/23/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Michael Goulet, Complaint Investigator

Consultation:

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:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

One facility staff caregiver did not ensure that the exit door alarm had been reset correctly, allowing one resident to exit the facilty. The resident was returned without harm or issue from the facility parking lot, and all facility staff were re-educated regarding the correct method for re-setting exit door alarms, with no further similar

issues occuring after these measures were put in place.

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately; and
• Complete correction as soon as possible.

You Are Not:
• Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
• Inspect the facility to determine if you have corrected all deficiencies.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:
• Please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Allied Health 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
Intake ID: 174984
Compliance Determination #: 57935
Region/Unit #: RCS Region 3 / Unit D
Investigator: Michael Goulet
Investigation Date(s): 04/14/2025 through 04/23/2025
Complainant Contact Date(s): 04/15/2025

Allegation(s):

1) Facility resident exited the facility without staff knowledge, and then entered a car in the facility parking lot, drove the car around the parking lot and then re-parked the car in the parking lot
2) The named resident had not been placed on alert (increased monitoring) for exit seeking behavior, even though this behavior was noted in the resident's assessment
3) Facility did not report the resident driving a car in the parking lot to the state
4) Facility caregiver (not named) reported the incident to the person named as the complainant, even though the complainant was not employed by the facility and was not privy to information regarding facility residents
5) Caregiver's (not named) statement was re-written by the facility director
6) Many employees (none named) have expired credentials (no details provided)
7) Facility does not have liability insurance
8) Many residents (none named) on hospice 'died prematurely' (no details provided)

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Liability insurance declaration Login record for facility computer system (r/t resident data accessed by former staff) Initial facility assessment (for named resident)

Investigation Summary:

1) Per interview with facility director, two staff were on duty on the night of the incident. One staff member did state that they had found the named resident outside of the facility in the parking lot standing next to a car, but that the resident

was not in the car, was not driving the car, and did not have the keys for the car to be able to operate the car. Per this staff, the resident likely was able to leave the facility without alerting staff sue to the other staff member not re-setting the exit door alarm after the resident had activated the alarm previously. Per staff, the resident was returned to the facility without incident or harm. No interview with the second staff member was possible, as this staff member (who was stated by staff as not re-setting the door alarm) refused to contact this investigator after a message was left requesting them to do so. The issue involving the door alarm not being re-set, and thus allowing the resident to leave the facility without alerting staff, was cited as per WAC 388-78A-2600 (2i) Policies and Procedures, but as a consultation, as the issue had been resolved prior to the initiation of the investigation, with no subsequent issues of this type noted following the facility's addressing of the issue.
2) Per record review of the named resident's progress notes, the resident had been placed on alert (increased monitoring) for behaviors and agitation following their admission to the facility. The issue that allowed the resident to leave the facility without staff knowledge (staff not correctly re-setting the door alarm) was not related to the resident being on alert/ increased monitoring. The resident had been placed on alert for their behavior, but it is unlikely that this would have altered the outcome regarding the staff not re-setting the door alarm. There is no specific regulation stating that a resident must be placed on alert for exit-seeking behavior in a memory care setting, as the vast majority of memory care residents could be said to be exit-seeking to some degree. This would not constitute failed facility practice. It should be noted that the person named as the complainant (who subsequently denied ever having made this complaint or the allegations associated with the complaint) only knew about the details of the incident (by their own admission) from accessing the named resident's protected health information (PHI) by illegally logging onto the facility computer system months after their employment at the facility had been terminated. This information was forwarded to the state Department of Health and to local law enforcement personnel, both by facility staff and by the department.
3) Per record review of reporting requirements for assisted living facilities, the issues surrounding the resident leaving the facility and being returned by facility staff without harm, would not require notification to the department.
4) It was not possible to determine what was reported to the former employee (named incorrectly as the complainant). The former employee only stated that one of the two staff members working on the evening in question (3/13/25) had contacted them but would not state which staff had done so. Of the two staff known to have been on duty on the night of 3/13/25, only one (caregiver A) agreed to speak with this investigator. The other staff caregiver on duty declined to be interviewed after interview was requested by this investigator. Caregiver A stated they had not contacted any former staff, and denied divulging any information about the named resident to any former staff member. Record review of facility login records for the facility's computer system did show that the former staff member named as the complainant did access the facility system seven separate times on 3/15/25, for a total of 119 minutes, even though they had been terminated as an employee on 1/25/25. Per interview, the former staff member named as the complainant admitted to accessing the facility resident data, and stated that they felt this access was not a criminal action or a violation of HIPAA (Health Insurance Portability and Accountability Act) statutes, even though they were no longer employed by the facility and had no viable reason to access the resident's information.
5) No information available served to support that the facility staff caregiver was asked to re-write their statement, especially as the caregiver in question refused to speak to this investigator. Unable to substantiate this allegation.
6) This same allegation was made in a recent investigation and looked into, with no indication of staff without valid credentials.

7) Per record review, the facility does possess valid and current liability insurance related to general liability, auto (for facility vehicles), workman's comprehensive liability and professional liability insurance as required. This allegation would appear to be a fabrication.
8) No information available served to support or substantiate this allegation. Per facility director, several residents have been on hospice care for extended periods of time, one for five to six months, and two for more than one year. One hospice resident was directly observed to have extensive care provision, including a 1:1 sitter in the resident's room 24 hours a day, and there was no indication of other than appropriate care being provided for this resident.. As residents on hospice are considered to be imminent (near death), to state that the facility is causing their deaths prematurely would not appear to be a valid allegation.
Cited as per #1 above.

Conclusion / Action:

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