



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

BLC FEDERAL WAY LH LLC
Brookdale Foundation House
32290 FIRST AVE SOUTH
FEDERAL WAY, WA 98003

RE: Brookdale Foundation House License # 1917

Dear Administrator:

This letter addresses Compliance Determination(s) 68278 (Completion Date 11/07/2025) and 64483 (Completion Date 09/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/07/2025 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-2462-2-a, WAC 388-78A-2462-3-d, WAC 388-78A-2464-1, WAC 388-78A-2464-2, WAC 388-78A-2481, WAC 388-78A-2481-1, WAC 388-78A-2481-1-a, WAC 388-78A-2481-1-b, WAC 388-78A-2481-2, WAC 388-78A-2474-2-a, WAC 388-78A-2474-2-b, WAC 388-78A-2700-1-e-i, WAC 388-78A-2700-1-e-ii, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-2290-3-e, WAC 388-78A-2290-3-d, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3, WAC 388-78A-2290-4-a, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d, WAC 388-78A-2290-4, WAC 388-78A-2150-3, WAC 388-78A-2150-2, WAC 388-78A-2150-1, WAC 388-78A-2150, WAC 388-78A-2100-2-b-i, WAC 388-78A-2320-1-b, WAC 388-78A-2320-2-b, WAC 388-78A-2320-3-b, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-4

The Department staff who did the on-site verification:

Steven Garrett, LTC Licensors
Claudia Allis, ALF Licensors

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

Brookdale Foundation House # 1917

11/07/2025

Page 2 of 2

James Sherman, Field Manager

Region 2, Unit D

Residential Care Services



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 1 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

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 the unannounced on-site full inspection on 08/25/2025 and 08/28/2025 of:

Brookdale Foundation House
32290 1st Ave S
Federal Way, WA 98003

The following sample was selected for review during the unannounced on-site visit: 11 of 100 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Claudia Allis, ALF Licenser
Steven Garrett, LTC Licenser
Jane Hermano, NCI
Kathy Young, Licenser
James Sherman, Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 2 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

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.

James Sherman

Residential Care Services

09-18-2025

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.

Citra Davidson
Administrator (or Representative)

9/19/25
Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:

(d) Contractors other than the administrator and caregivers who may have unsupervised access to residents.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to conduct a Washington State Name and Date of Birth Background check for 4 of 6 staff (Staff B, Staff C, Staff D, and Staff E) and for 2 of 2 private caregivers (Resident 8's private caregiver and Resident 9's private caregiver). This failure placed all residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included....

STAFF B

Review of Staff B, Health and Wellness Coordinator, facility employee records showed the facility hired Staff B on 05/27/2025. The records showed no documentation that Staff B completed a DSHS name and date of birth background check.

Review of the facility's employee roster showed Staff B provided supervision of direct care to facility residents for 95 days without a Washington State Name and Date of Birth

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
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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-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

- (a) A Washington state name and date of birth background check; and
- (3) The assisted living facility must ensure that the following individuals have a Washington state name and date of birth background check:
- (d) Contractors other than the administrator and caregivers who may have unsupervised access to residents.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to conduct a Washington State Name and Date of Birth Background check for 4 of 6 staff (Staff B, Staff C, Staff D, and Staff E) and for 2 of 2 private caregivers (Resident 8's private caregiver and Resident 9's private caregiver). This failure placed all residents at risk of potential abuse or neglect by a caregiver with an unknown background.

Findings included....

STAFF B

Review of Staff B, Health and Wellness Coordinator, facility employee records showed the facility hired Staff B on 05/27/2025. The records showed no documentation that Staff B completed a DSHS name and date of birth background check.

Review of the facility's employee roster showed Staff B provided supervision of direct care to facility residents for 95 days without a Washington State Name and Date of Birth

Background check.

STAFF C

Review of Staff C, Medication Technician, facility employee records showed the facility hired Staff C on 05/19/2025. The records showed no documentation that Staff C completed a Washington State Name and Date of Birth Background check.

Review of the facility's employee roster showed Staff C provided direct care to facility residents for 87 days without a Washington State Name and Date of Birth Background check.

STAFF D

Review of Staff D, Care Partner, facility employee records showed the facility hired Staff D on 07/30/2024. The records showed no documentation that Staff D completed a Washington State Name and Date of Birth Background check.

Review of the facility's employee roster showed Staff D provided direct care to facility residents for 417 days without a Washington State Name and Date of Birth Background check. background check.

STAFF E

Review of Staff E, Care Partner, facility employee records showed the facility hired Staff E on 05/15/2025. The records showed no documentation that Staff E completed a Washington State Name and Date of Birth Background check.

Review of the facility's employee roster showed Staff E provided direct care to facility residents for 91 days without a Washington State Name and Date of Birth Background check.

RESIDENT 8

Review of Resident 8's records showed the facility admitted Resident 8 on [REDACTED]/2022. Review of Resident 8's Personal Service Plan (PSP), (equivalent to the Negotiated Service Agreement), dated 07/30/2025, showed Resident 8 was assisted with showering by a private caregiver.

Review of the facility's records showed no documentation of Resident 8's private caregiver completing a Washington state name and date of birth background check.

RESIDENT 9

Review of Resident 9's records showed the facility admitted Resident 9 on [REDACTED]/2023. Review of Resident 9's PSP, dated 04/27/2025, showed Resident 9 had a private caregiver 7 days a week during the day and evening.

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 4 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

Observation on 08/27/2025 at 10:40 AM, showed Resident 9 in their apartment with their private caregiver.

Review of the facility's records showed no documentation of Resident 9's private caregiver completing a Washington state name and date of birth background check.

During an interview on 08/28/2025 at 2:15 PM, Staff N, Assistant Executive Director, stated that when the facility hired Staff B, Staff C, Staff D, and Staff E, the facility failed to submit a Washington State Name and Date of Birth Background check. Staff A stated that they were unaware that a Washington State Name and Date of Birth Background check was required for Staff B, Staff C, Staff D, and Staff E. Staff A stated that they were unaware that a Washington State Name and Date of Birth Background check was required for private caregivers, private companions, and contractors.

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 Foundation House is or will be in compliance with this law and / or regulation on (Date) 10/23/25.

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


Administrator (or Representative)

9/19/25
Date

WAC 388-78A-2464 Background checks Process Background authorization form. Before the assisted living facility employs, directly or by contract, an administrator, staff person or caregiver, or accepts any volunteer, or student, the home must:

- (1) Require the person to complete a DSHS background authorization form; and
- (2) Submit to the department's background check central unit, including any additional documentation and information requested by the department.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete and submit a DSHS background authorization form check prior to employment for 1 of 4 staff (Staff D). This failure placed all residents at risk of potential abuse or neglect by staff with an unknown background.

Observation on 08/27/2025 at 10:40 AM, showed Resident 9 in their apartment with their private caregiver.

Review of the facility's records showed no documentation of Resident 9's private caregiver completing a Washington state name and date of birth background check.

During an interview on 08/28/2025 at 2:15 PM, Staff N, Assistant Executive Director, stated that when the facility hired Staff B, Staff C, Staff D, and Staff E, the facility failed to submit a Washington State Name and Date of Birth Background check. Staff A stated that they were unaware that a Washington State Name and Date of Birth Background check was required for Staff B, Staff C, Staff D, and Staff E. Staff A stated that they were unaware that a Washington State Name and Date of Birth Background check was required for private caregivers, private companions, and contractors.

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

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- (1) Require the person to complete a DSHS background authorization form; and
- (2) Submit to the department's background check central unit, including any additional documentation and information requested by the department.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to complete and submit a DSHS background authorization form check prior to employment for 1 of 4 staff (Staff D). This failure placed all residents at risk of potential abuse or neglect by staff with an unknown background.

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 5 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

Findings included....

STAFF D

Review of Staff D, Care Partner, facility employee records showed the facility hired Staff D on 07/30/2024. The records showed documentation that Staff D submitted a DSHS background authorization form on 09/27/2024. The records showed no documentation that Staff D completed a DSHS name and date of birth background check.

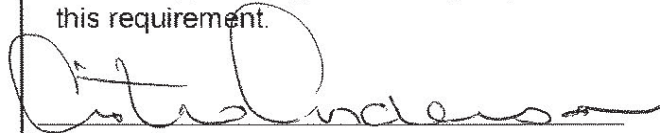
Review of the facility's employee roster showed Staff D provided direct care to facility residents for 60 days without a submitted DSHS background authorization form.

During an interview on 08/28/2025 at 2:35 PM, Staff N, Assistant Executive Director, stated that when the facility hired Staff D the facility failed to complete and submit a DSHS background authorization form for Staff D.

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)

9-19-25
Date

WAC 388-78A-2481 Tuberculosis Testing method Required. The assisted living facility must ensure that all tuberculosis testing is done through either:

- (1) Intradermal (Mantoux) administration with test results read:
 - (a) Within forty-eight to seventy-two hours of the test; and
 - (b) By a trained professional; or
- (2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

This requirement was not met as evidenced by:

Findings included....

STAFF D

Review of Staff D, Care Partner, facility employee records showed the facility hired Staff D on 07/30/2024. The records showed documentation that Staff D submitted a DSHS background authorization form on 09/27/2024. The records showed no documentation that Staff D completed a DSHS name and date of birth background check.

Review of the facility's employee roster showed Staff D provided direct care to facility residents for 60 days without a submitted DSHS background authorization form.

During an interview on 08/28/2025 at 2:35 PM, Staff N, Assistant Executive Director, stated that when the facility hired Staff D the facility failed to complete and submit a DSHS background authorization form for Staff D.

Plan/Attestation Statement

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Administrator (or Representative)

Date

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(a) Within forty-eight to seventy-two hours of the test; and

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This requirement was not met as evidenced by:

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 6 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

Based on interview and record review the facility failed to ensure 1 of 6 staff (Staff C) were screened for tuberculosis (TB) with an Intradermal (Mantoux) test or a blood test for tuberculosis within three days of employment. This failure placed all the residents at risk of contracting a serious and contagious respiratory disease.

Findings included...

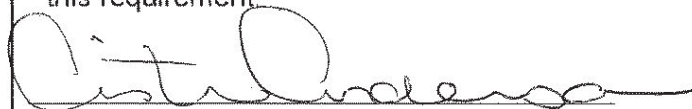
Review of Staff C's personnel records showed from 5/19/2025 through 08/24/2025, Staff C worked at the facility. Staff C provided care and services for residents. There was no documentation in Staff C's records that showed the facility screened Staff C for TB within three days of employment with an Intradermal test or a blood test. Staff C's records showed that Staff C had a chest x-ray completed on 12/26/2024.

During an interview on 08/24/2025 at 2:10 PM, Staff N, Executive Director, confirmed that when Staff C was hired, they were not screened for tuberculosis. Staff A stated that they were not aware that screening and testing for tuberculosis required intradermal or blood test for all facility staff within three days of employment.

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 Foundation House is or will be in compliance with this law and / or regulation on (Date) 09-23-25.

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



Administrator (or Representative)

09-19-25

Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

- (a) Orientation and safety;
- (b) Basic;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 6 staff (Staff C) were screened for tuberculosis (TB) with an Intradermal (Mantoux) test or a blood test for tuberculosis within three days of employment. This failure placed all the residents at risk of contracting a serious and contagious respiratory disease.

Findings included...

Review of Staff C's personnel records showed from 5/19/2025 through 08/24/2025, Staff C worked at the facility. Staff C provided care and services for residents. There was no documentation in Staff C's records that showed the facility screened Staff C for TB within three days of employment with an Intradermal test or a blood test. Staff C's records showed that Staff C had a chest x-ray completed on 12/26/2024.

During an interview on 08/24/2025 at 2:10 PM, Staff N, Executive Director, confirmed that when Staff C was hired, they were not screened for tuberculosis. Staff A stated that they were not aware that screening and testing for tuberculosis required intradermal or blood test for all facility staff within three days of employment.

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 Foundation House 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-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 6 staff (Staff E) completed all required training to perform their job duties and responsibilities. This failure placed residents at risk of unmet care needs from staff with incomplete training.

Findings included...

Review of facility's undated personnel records showed the facility hired Staff E, Care Partner, on 05/19/2025.

Orientation

There was no documentation in Staff E's records that showed Staff E completed facility orientation and safety training. There was no documentation in Staff E's records that showed Staff E completed the 5-hour Department of Social and Health Services orientation and safety training.

Basic

Review of Staff E's undated personnel records showed there was no documentation in Staff E's records that showed Staff E completed the required 70-hour basic training. Review of Staff E's record showed documentation that Staff E completed the 54 -hour Core Basic on 07/17/2024. There was no documentation in Staff E's records that showed Staff E was enrolled in a Home and Community Aide training program. A review of facility staff schedules showed that Staff E was providing care to residents without direct supervision.

During an interview with Staff A, Executive Director, on 08/28/2025 at 2:30 PM, Staff N, Assistant Executive Director, stated that Staff E was not currently scheduled to complete the 70-hour training requirement. Staff A stated that they were not aware that Staff E had not completed facility orientation and safety training and the 5-hour Department of Social and Health Services orientation and safety training.

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 8 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

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 Foundation House is or will be in compliance with this law and / or regulation on (Date) <u>10/23/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>10/23/25</u> Date

WAC 388-78A-2700 Emergency and disaster preparedness.

- (1) The assisted living facility must:
- (e) Make sure first-aid supplies are:
- (i) Readily available and not locked;
- (ii) Clearly marked;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure first aid kits were unlocked, clearly marked, and readily available within 1 of 1 assisted living unit (AL). This failure placed all 75 assisted living residents at risk of delayed emergency response.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a consultation for this regulation on 04/24/2024.

Review of the facility's Resident Characteristic Roster showed the facility provided care and services to 75 assisted living residents.

Observation of the facility on 08/25/2025 at 10:00 AM through 08/27/2025 at 10:30 AM, showed no unlocked, clearly marked, and readily available first aid kits within the assisted living unit.

During an interview on 08/27/2025 at 9:19 AM, Staff I, Maintenance Director, stated that there were no unlocked first aid kits within the facility.

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 Foundation House 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-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure first aid kits were unlocked, clearly marked, and readily available within 1 of 1 assisted living unit (AL). This failure placed all 75 assisted living residents at risk of delayed emergency response.

Findings included...

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) showed the Assisted Living Facility (ALF) received a consultation for this regulation on 04/24/2024.

Review of the facility's Resident Characteristic Roster showed the facility provided care and services to 75 assisted living residents.

Observation of the facility on 08/25/2025 at 10:00 AM through 08/27/2025 at 10:30 AM, showed no unlocked, clearly marked, and readily available first aid kits within the assisted living unit.

During an interview on 08/27/2025 at 9:19 AM, Staff I, Maintenance Director, stated that there were no unlocked first aid kits within the facility.

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 9 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

During an interview on 08/27/2025 at 10:30 AM, Staff H, Corporate Nurse, stated that they were unaware they were not meeting the regulation.

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 Foundation House is or will be in compliance with this law and / or regulation on (Date) <u>10/23/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>9-19-25</u> 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;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the mechanical air exchange vents were functional for 4 of 5 resident laundry rooms (Laundry Room A, 3rd floor, Laundry Room B, 3rd floor; Laundry Room A, 2nd floor; Laundry Room B, 2nd floor; and Laundry Room, 1st floor), for 2 of 9 janitor's closets with mop sinks (2nd floor by Unit 285 and 1st floor by Activities Storage) and for 4 of 11 common bathrooms (Women's Room, 2nd floor by garbage room; Men's Room, 2nd floor by garbage room; Spa/Bathroom in Memory Care; and Common Bathroom closest to the Spa in Memory Care) and failed to ensure that 3 of 3 exterior benches were maintained with a safe and smooth finish. This failure placed all 100 residents at risk of poor air quality, respiratory distress, injury, and a diminished quality of life.

Findings included...

NOTE: Washington Administrative Code 388-78A-3030, Toilet Rooms and Bathrooms, showed (2) the assisted living facility must provide each toilet room and bathroom with: (e) mechanical ventilation to the outside; and WAC 388-78A-3040, Laundry, showed (5) the assisted living facility must ventilate laundry rooms and areas to the outside of the

During an interview on 08/27/2025 at 10:30 AM, Staff H, Corporate Nurse, stated that they were unaware they were not meeting the regulation.

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 Foundation House 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;
- (b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the mechanical air exchange vents were functional for 4 of 5 resident laundry rooms (Laundry Room A, 3rd floor, Laundry Room B, 3rd floor; Laundry Room A, 2nd floor; Laundry Room B, 2nd floor; and Laundry Room, 1st floor), for 2 of 9 janitor's closets with mop sinks (2nd floor by Unit 285 and 1st floor by Activities Storage) and for 4 of 11 common bathrooms (Women's Room, 2nd floor by garbage room; Men's Room, 2nd floor by garbage room; Spa/Bathroom in Memory Care; and Common Bathroom closest to the Spa in Memory Care) and failed to ensure that 3 of 3 exterior benches were maintained with a safe and smooth finish. This failure placed all 100 residents at risk of poor air quality, respiratory distress, injury, and a diminished quality of life.

Findings included...

NOTE: Washington Administrative Code 388-78A-3030, Toilet Rooms and Bathrooms, showed (2) the assisted living facility must provide each toilet room and bathroom with: (e) mechanical ventilation to the outside; and WAC 388-78A-3040, Laundry, showed (5) the assisted living facility must ventilate laundry rooms and areas to the outside of the

assisted living facility.

Observation on 8/25/2025 at 1:17 PM, showed a nonfunctioning air exchange vent in Laundry Room A, 3rd floor. Observation on 8/25/2025 at 1:32 PM, showed a nonfunctioning air exchange vent in Laundry Room B, 3rd floor. Observation on 8/25/2025 at 2:09 PM, showed a nonfunctioning air exchange vent in Laundry Room A, 2nd floor. Observation on 8/25/2025 at 2:15 PM showed a nonfunctioning air exchange vent in Laundry Room B, 2nd floor. Observation on 08/25/2025 at 2:45 PM, showed a nonfunctioning air exchange vent Laundry Room, 1st floor. Observation on 08/25/2025 at 2:01 PM, showed a nonfunctioning air exchange vent in janitor's closet with mop sink, 2nd floor by Unit 285. Observation on 08/25/2025 at 2:43 PM, showed a nonfunctioning air exchange vent in janitor's closet with mop sink 1st floor by Activities Storage. Observation on 08/25/2025 at 2:33 PM, showed a nonfunctioning air exchange vent in Women's Room, 2nd floor by the garbage room. Observation on 08/25/2025 at 2:37 PM, showed a nonfunctioning air exchange vent in Men's Room, 2nd floor by the garbage room. Observation on 08/26/2025 at 12:08 PM, showed a nonfunctioning air exchange vent in Spa/Bathroom in Memory Care. Observation on 08/26/2025 at 12:14 PM, showed a nonfunctioning air exchange vent in the Bathroom near the Spa in Memory Care.

Observations during the environmental tour on 08/26/2025 at 12:35 PM, 12:42 PM, and 12:48 PM, showed three exterior benches that had worn and peeling paint.

Review of the facility's undated manual titled, "Asset Management Maintenance Manual" showed the policy that required the facility maintained an on-going history of "all" building equipment.

During an interview on 08/26/2025 at 12:30 PM, Staff I, Maintenance Director, stated that the facility had no policy and procedure related to air exchange vent maintenance. Staff I stated that other than cleaning the vents, the facility had no system to check the mechanical ventilation system was functioning.

During interviews on 08/26/2025 at 12:35 PM through 12:51 PM, Staff K, Maintenance Technician, stated that the facility had not maintained the mechanical vents with a "high quantity" that were nonfunctional. Staff K stated that the facility had not maintained the benches well enough to successfully repaint because they were "almost broke down".

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 11 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

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)

9-19-25
Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

- (a) By name, the family member who will provide the medication or treatment assistance or administration;
- (b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;
- (c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;
- (d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and
- (e) Other information determined necessary by the assisted living facility.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

- (a) The resident, if able;
- (b) The resident's representative, if any;
- (c) The resident's family member responsible for implementing the plan; and
- (d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

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(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 11 residents (Resident 6, Resident 7, Resident 8, and Resident 11) had a written plan for family assistance with medication management. This failure placed Resident 6, Resident 7, Resident 8, and Resident 11 at risk for unmet medication care needs.

Findings included...

Review of the facility's undated Disclosure of Services document showed the facility permitted family assistance with residents' medication services. Review of the facility policy titled, "Family Assistance with Medications", dated 07/01/2006, showed that a written plan for family assistance with medication administration is submitted to the Executive Director, and must be signed and dated by the resident or legally responsible party, the family member who submitted the plan, and the facility Executive Director or designee. The policy showed that the written plan and any subsequent changes should be documented in the residents' medical records.

RESIDENT 6

Observation on 08/26/2025 at 9:50 AM showed a blood sugar check kit and a box with insulin injection pen stored in Resident 6's bedside table. A half-filled sharps container (container for used needles and other medical-waste sharps) sat on top of the table.

Review of Resident 6's records showed the facility admitted Resident 6 on [REDACTED]/2021. Review showed Resident 6 was admitted with multiple diagnoses that included [REDACTED]. Review of Resident 6's Personal Service Plan (PSP), dated 07/30/2025 showed the facility staff assisted with some medications and the spouse monitored Resident 6's blood sugar levels and administered the insulin injection. Review of the plan showed no instructions about a back-up diabetes management plan when Resident 6's spouse was unavailable to fulfill their responsibilities.

RESIDENT 7

Review of Resident 7's records showed the facility admitted Resident 7 on [REDACTED]/2024. Review of Resident 7's PSP, dated 03/05/2025, showed that Resident 7 was assessed to be independent with their medication management. The document showed that the family assisted with coordinating and ordering of Resident 7's medications.

Review of Resident 7's records showed no documentation of any family plan for the assistance with medication management services. The records showed no list of family members involved with the medication assistance services, no description of the assistance with Resident 7's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance. The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in

effect, or by a representative of the facility, as required.

During an interview on 08/27/2025 at 10:47 AM, Resident 7 stated that they order and manage their own medications with help from their family. Resident 7 stated that they kept their medications secured in their room.

RESIDENT 8

Review of Resident 8's records showed the facility admitted Resident 8 on [REDACTED]/2022. Review of Resident 8's PSP, dated 07/30/2025, showed that Resident 8 was assessed to be independent with their medication management. The document showed that the family assisted with managing Resident 8's medications.

Review of Resident 8's records showed no documentation of any family plan for assistance with medication management services. The records showed no list of family members involved with the medication assistance services, no description of the assistance with Resident 8's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance. The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in effect, or by a representative of the facility, as required.

During an interview on 08/27/2025 at 11:15 AM, Resident 8's spouse stated that they manage their medications with help from their family. Resident 8's spouse stated that they kept their medications secured in their room.

RESIDENT 11

Review of Resident 11's records showed the facility admitted Resident 11 on [REDACTED]/2024. Review of Resident 11's PSP, dated 06/20/2025, showed that Resident 11 was assessed to require medication management to be provided by facility staff. Review of Resident 11's record showed no documentation that the family assisted with managing Resident 11's medications.

During an interview on 08/28/2025 at 11:15 AM, Resident 11's representative stated that Resident 11's family ordered medications from their preferred pharmacy and delivered Resident 11's medications to the facility. Resident 11's representative stated that the facility stored Resident 11's medications. Resident 11's representative stated that the facility staff assisted Resident 11 with medication administration.

Review of Resident 11's records showed no documentation of a family plan for assistance with medication management services. The records showed no list of family members involved with the medication assistance services, no description of the assistance with Resident 11's medication services, and no alternative plan if the family member was unable to fulfill the duties in the primary plan for medication assistance.

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 14 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in effect, or by a representative of the facility, as required.

During an interview on 08/27/2025 at 2:35 PM, Staff A, Executive Director/Administrator, and Staff H, Corporate Nurse, stated that they were aware of the family plan requirements for family assistance with resident medication services. Staff A and Staff H stated that they were unaware that Resident 6, Resident 7, Resident 8, and Resident 11 did not have written plans for family assistance with medication services, as required.

Plan/Attestation Statement

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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;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 11 residents (Resident 5, Resident 6, Resident 8, and Resident 11) or their representatives agreed to and signed their Personal Service Plan (equivalent to the negotiated service agreement) at least annually. This failure placed Resident 5, Resident 6, Resident 8, and Resident 11 at risk of being uninformed about their assessed care and services and having unmet care needs.

The records showed no signature and date by the resident, the resident's representative or family member responsible for putting the medication service plan in effect, or by a representative of the facility, as required.

During an interview on 08/27/2025 at 2:35 PM, Staff A, Executive Director/Administrator, and Staff H, Corporate Nurse, stated that they were aware of the family plan requirements for family assistance with resident medication services. Staff A and Staff H stated that they were unaware that Resident 6, Resident 7, Resident 8, and Resident 11 did not have written plans for family assistance with medication services, as required.

Plan/Attestation Statement

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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;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 4 of 11 residents (Resident 5, Resident 6, Resident 8, and Resident 11) or their representatives agreed to and signed their Personal Service Plan (equivalent to the negotiated service agreement) at least annually. This failure placed Resident 5, Resident 6, Resident 8, and Resident 11 at risk of being uninformed about their assessed care and services and having unmet care needs.

Findings included...

RESIDENT 5

Review of Resident 5's records showed the facility admitted Resident 5 on [REDACTED]/2023. Review showed no documentation of agreement or signatures by Resident 5 or their representative to current or past Personal Service Plans (PSP).

During an interview on 08/28/2025 at 3:25 PM, Resident 5 stated that they could not remember if any PSP was reviewed with them. Resident 5 stated they could not remember signing any PSP.

RESIDENT 6

Review of Resident 6's records showed the facility admitted Resident 6 on [REDACTED]/2021. Review showed no documentation of agreement or signatures by Resident 6 or their representative to current or past PSP's.

RESIDENT 8

Review of Resident 8's records showed the facility admitted Resident 8 on [REDACTED]/2022. Review showed no documentation of agreement or signatures by Resident 8 or their representative to current or past PSP's.

RESIDENT 11

Review of Resident 11's records showed the facility admitted Resident 11 on [REDACTED]/2024. Review showed no documentation of agreement or signatures by Resident 11 or their representative to current or past PSP's.

During an interview on 08/28/2025 at 11:20 AM, Resident 11's representative stated that they were unaware if any PSP was reviewed with them. Resident 11's representative stated they could not remember signing any PSP.

During an interview on 08/27/2025 at 2:35 PM, Staff A, Executive Director/Administrator, stated that they were aware the PSP's required agreement and signatures from the facility staff, residents, or resident's representatives at least annually. Staff A stated that they were unaware that the PSP's of Resident 5, Resident 6, Resident 8, and Resident 11 were not signed and dated by facility staff, residents, or their representatives, as required.

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 16 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

Plan/Attestation Statement

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9/19/25
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues;

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to complete 6 of 6 sampled residents (Resident 4, Resident 6, Resident 7, Resident 8, Resident 9, and Resident 10) assessments that included the required full assessment components. This failure placed Resident 4, Resident 6 and Resident 10 at risk of potential entrapment and injury when using the medical device. This failure placed Resident 4, Resident 7, Resident 8, Resident 9 and Resident 10 at risk of potential decline in health from unidentified care needs and self-administration practices.

Findings included...

BEDSIDE MOBILITY DEVICE

Review of the facility's policy titled, "Bedside Mobility Device Policy", revised August 2025, defined the bedside mobility device (BMD) as devices used to help the resident reposition themselves within the bed or assist with mobility and transfer to and from a bed or chair. The facility allowed residents to use approved BMD and required a physician order prior to its use. The facility's assigned nurse assessed residents and required BMD risk evaluation. The policy stated that the BMD use was documented in the residents' Personal Service Plan (PSP) with monitoring instructions. The facility's maintenance was responsible for the BMD safety check and document in TELS (maintenance tracking platform). The facility's approved mobility devices included floor-to-ceiling transfer pole (FTCP), free standing overbed trapeze bar, and hospital bed with mattress and attached halo safety ring. The policy stated the facility prohibited side

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WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to complete 6 of 6 sampled residents (Resident 4, Resident 6, Resident 7, Resident 8, Resident 9, and Resident 10) assessments that included the required full assessment components. This failure placed Resident 4, Resident 6 and Resident 10 at risk of potential entrapment and injury when using the medical device. This failure placed Resident 4, Resident 7, Resident 8, Resident 9 and Resident 10 at risk of potential decline in health from unidentified care needs and self-administration practices.

Findings included...

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Review of the facility's policy titled, "Bedside Mobility Device Policy", revised August 2025, defined the bedside mobility device (BMD) as devices used to help the resident reposition themselves within the bed or assist with mobility and transfer to and from a bed or chair. The facility allowed residents to use approved BMD and required a physician order prior to its use. The facility's assigned nurse assessed residents and required BMD risk evaluation. The policy stated that the BMD use was documented in the residents' Personal Service Plan (PSP) with monitoring instructions. The facility's maintenance was responsible for the BMD safety check and document in TELS (maintenance tracking platform). The facility's approved mobility devices included floor-to-ceiling transfer pole (FTCP), free standing overbed trapeze bar, and hospital bed with mattress and attached halo safety ring. The policy stated the facility prohibited side

rails of any length.

RESIDENT 4

Observation of Resident 4's apartment on 08/26/2025 at 9:30 AM, showed a hospital bed, an overhead trapeze and two floor-to-ceiling transfer poles (FTCPs) one on the right side of the bed and the other near the toilet. Observation showed a raised full-length bedrail and was attached near the head of the bed, along the right side.

During an interview on 08/26/2025 at 9:34 AM, Resident 4 stated that they used an overhead trapeze, FTCPs, and bedside rail for repositioning. Resident 4 was unable to recall if any nurse assessed and explained the potential risks of using the BMDs. Resident 4 was unaware that the facility prohibited the use of a bed rail. Resident 4 stated that the facility was aware of the bed rail.

Review of Resident 4's records showed that the facility admitted Resident 4 in [REDACTED] 2024. Review of Resident 4's combined Personal Service Assessment (PSA) and Personal Service Plan (PSP), dated 08/16/2025 showed no documentation that Resident 4 was assessed to safely use the overhead trapeze, FTCPs, and bedrail and no risk evaluation was completed.

RESIDENT 6

Observation of Resident 6's apartment on 08/26/2025 at 1:43 PM, showed FTCP near the recliner chair. Collateral Contact 1 (CC1, resident representative), who was present during the observation, stated that the FTCP provided Resident 6's stability for safe standing, sitting, and transferring between the recliner chair and wheelchair. CC1 stated that the FTCP was installed around the time Resident 6's functional decline became obvious in 2023.

Review of Resident 6's records showed that the facility admitted Resident 6 in [REDACTED] 2021. Review of Resident 6's PSA, dated 06/02/2025 and PSP, dated 07/30/2025, showed no documentation that Resident 6 was assessed to safely use the FTCP and no risk evaluation was completed.

RESIDENT 10

Observation of Resident 10's apartment on 08/27/2025 at 10:15 AM, showed installed FTCP near a chair in the living room, on the right side of the bed, and near the toilet.

During an interview on 08/27/2025 at 10:30 AM, Resident 10 stated their sister installed the poles. Resident 10 stated that the FTCP supported and helped their stability between the chair, bed, and toilet.

Review of Resident 10's records showed that the facility admitted Resident 10 in [REDACTED] 2025. Review of Resident 10's PSA, dated 03/28/2025 and PSP, dated 05/17/2025, showed documentation that Resident 10 used transfer poles. The records showed no

documentation Resident 10 was assessed to safely use the FTCPs and no risk evaluation was completed upon move-in.

MECHANICAL LIFT

Review of the facility's policy titled, "Mechanical Lift Policy" revised July 2025, showed mechanical lifts, such as Hoyer lift required assessment and evaluation upon move-in and periodically. The policy stated that staff were responsible for reporting equipment malfunctions or safety concerns to a supervisor.

RESIDENT 10

Review of Resident 10's PSP, dated 05/17/2025, showed Resident 10 required mechanical lift for transfer. The records showed no documentation that Resident 10 was assessed to safely use the mechanical lift upon move-in.

During the interview on 08/28/2025 at 10:26 AM, Staff H, Corporate Nurse, stated that the facility required an assessment and a risk evaluation for any medical device. Staff H was unaware that Resident 4 had a bedrail. Staff H stated they were unaware that Resident 4, Resident 6, and Resident 10 were not assessed and evaluated for safe medical device use. Staff H provided no additional information.

SELF MEDICATION ADMINISTRATION

Review of the facility's document titled, "Medications & Treatment-Self-Administration of Medication Policy", revised January 2023, showed that the facility required completion of an assessment initially, quarterly, or as per state regulation and with any change in resident's condition.

RESIDENT 4

Review of Resident 4's PSP, dated 08/16/2025, showed Resident 4 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 4's ability to self-manage their medications.

RESIDENT 7

Review of Resident 7's records showed the facility admitted Resident 7 on [REDACTED]/2024. Review of Resident 7's PSP, dated 03/05/2025, showed Resident 7 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 7's ability to self-manage their medications.

During an interview on 08/27/2025 at 10:47 AM, Resident 7 stated that they order and managed their own medications with help from their family. Resident 7 was unable to recall if any nurse conducted their self-administration medication review assessment.

RESIDENT 8

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 19 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

Review of Resident 8's records showed the facility admitted Resident 8 on [REDACTED]/2022. Review of Resident 8's PSP, dated 07/30/2025, showed Resident 8 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 8's ability to self-manage their medications.

RESIDENT 9

Review of Resident 9's records showed the facility admitted Resident 9 on [REDACTED]/2023. Review of Resident 9's PSP, dated 04/27/2025, showed Resident 8 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 9's ability to self-manage their medications.

RESIDENT 10

Review of Resident 10's PSP, dated 05/17/2025, showed Resident 10 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 10's ability to self-manage their medications.

During an interview on 08/27/2025 at 10:35 AM, Resident 10 stated that they were able to take the oral medications from the medication container used to organize medication doses. Resident 10 stated that the containers were filled by Home Health nurse every two weeks. Resident 10 was unable to recall if any nurse conducted their self-administration medication assessment upon move-in.

During an interview on 08/27/2025 at 2:15 PM, Staff H stated that they were unaware Resident 4, Resident 8, and Resident 9's self-medication administration assessment was not part of their annual assessment.

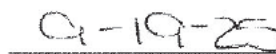
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Administrator (or Representative)



Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any

Review of Resident 8's records showed the facility admitted Resident 8 on [REDACTED]/2022. Review of Resident 8's PSP, dated 07/30/2025, showed Resident 8 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 8's ability to self-manage their medications.

RESIDENT 9

Review of Resident 9's records showed the facility admitted Resident 9 on [REDACTED]/2023. Review of Resident 9's PSP, dated 04/27/2025, showed Resident 8 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 9's ability to self-manage their medications.

RESIDENT 10

Review of Resident 10's PSP, dated 05/17/2025, showed Resident 10 self-manages their medications including self-administering, ordering, coordinating and safe storage. The records showed no documentation of any assessment of Resident 10's ability to self-manage their medications.

During an interview on 08/27/2025 at 10:35 AM, Resident 10 stated that they were able to take the oral medications from the medication container used to organize medication doses. Resident 10 stated that the containers were filled by Home Health nurse every two weeks. Resident 10 was unable to recall if any nurse conducted their self-administration medication assessment upon move-in.

During an interview on 08/27/2025 at 2:15 PM, Staff H stated that they were unaware Resident 4, Resident 8, and Resident 9's self-medication administration assessment was not part of their annual assessment.

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Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any

resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(b) Chapter 18.88A RCW, Nursing assistants;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement a safe nursing services when non-licensed staff administered medications without a nurse delegation program to 3 of 3 residents (Resident 1, Resident 2, and Resident 3). This places Resident 1, Resident 2, and Resident 3 at risk for compromised health status.

Findings included...

Note: WAC 246-840-930 Criteria for delegation. (1) In community-based and in-home care settings, before delegating a nursing task, the registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. ASSESS (10) If the registered nurse delegator determines delegation is appropriate, the nurse: (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized Certified on 7/9/2024 WAC 246-840-930 Page 1 representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process. IMPLEMENT (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). EVALUATE (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.

Review of the facility's Disclosure of Services showed the facility provided intermittent nursing services.

Review of the facility's policy titled, "Nurse Delegation-WA27", dated 01/20/2023, showed the delegation process were to be done in accordance with the State requirements. The policy showed that the nurse delegation process included assessment of the resident's delegation needs and determination of capabilities of the delegated staff. The policy showed the Registered Nurse was responsible to review and understand the Washington Delegation rules in the Nursing Practice Act and follow them.

Review of Resident 1's service plan, dated 01/13/2025; Resident 2's service plan, dated 08/23/2025; and Resident 3's service plan, dated 05/28/2025, received nurse delegation services for medication administration from the facility's nursing assistants.

ASSUMPTION OF DELEGATION

Review of the facility's nurse delegation records showed no documentation of any Registered Nurse's assumption of responsibility and accountability for the delegated tasks for Resident 1, Resident 2, and Resident 3.

CONSENTS

Review of the facility's nurse delegation documentation showed there were no signed consents for nurse delegation services for Resident 1, Resident 2, and Resident 3.

NURSE DELEGATION MONITORING and NURSING TASKS

Review of the facility's nurse delegation visit records showed no documentation of nurse supervision for delegation, no documentation of delegation training for facility staff, and no record of delegated staff for Resident 1, Resident 2, and Resident 3.

During an interview on 08/26/2025 at 12:51 PM, Staff L, Medication Technician (unlicensed staff who dispenses medications), stated that they were nurse delegated. Staff L stated they were unable to remember the last RND supervisory visit.

Observation on 08/28/2025 at 7:46 AM showed Staff M, Medication Technician, applied medication patch to Resident 3's right shoulder. During an interview at this time, Staff M stated their nurse delegation training was from another facility.

During an interview on 08/28/2025 at 10:15 AM, Staff H, Corporate Nurse, stated that the facility allowed nursing assistants under the delegation of a Registered Nurse provide some medication administration in their memory care unit. Staff H stated that they were aware of the requirements for nurse delegated services. Staff H stated that they were aware facility-employed nurse delegator was accountable for the delivery of nurse delegated tasks. Staff H was unaware that the nurse delegation consents were not signed by the residents who received nurse delegation services, or their representatives. Staff H stated that they were unaware that the nurse delegation services had not been correctly initiated and continued, as required.

Statement of Deficiencies	License #: 1917	Compliance Determination # 64483
Plan of Correction	Brookdale Foundation House	Completion Date
Page 22 of 25	Licensee: BLC FEDERAL WAY LH LLC	09/08/2025

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 Foundation House is or will be in compliance with this law and / or regulation on (Date) 10/23/25.

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


Administrator (or Representative)

9/19/25
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

- (1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:
 - (b) Identifies the resident's immediate needs; and
 - (c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.
- (4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 4 of 11 residents (Resident 2, Resident 3, Resident 4, and Resident 5) service agreements a plan to monitor and address interventions required to meet the current clinical needs. This failure placed Resident 2, Resident 3, Resident 4, and Resident 5 at risk for unmet care needs and potential harm.

Findings included...

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 on [REDACTED] /2025. Resident 2's record showed multiple diagnoses which included [REDACTED]

[REDACTED], and [REDACTED].
The records showed Resident 2 received medication assistance services from facility staff.

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Date

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 - (c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.
- (4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in 4 of 11 residents (Resident 2, Resident 3, Resident 4, and Resident 5) service agreements a plan to monitor and address interventions required to meet the current clinical needs. This failure placed Resident 2, Resident 3, Resident 4, and Resident 5 at risk for unmet care needs and potential harm.

Findings included...

RESIDENT 2

Review of Resident 2's records showed the facility admitted Resident 2 on [REDACTED] /2025. Resident 2's record showed multiple diagnoses which included [REDACTED]

[REDACTED] and [REDACTED]

The records showed Resident 2 received medication assistance services from facility staff.

Review of Resident 2's June 2025, July 2025, and August 2025 Medication Administration Record (MAR) showed that Resident 2 received 81 mg of Aspirin (medication used to prevent blood clots) daily, by mouth, for history of heart disease; 25 mg of Metoprolol (medication used to treat high blood pressure) 1 tablet, by mouth, every day; and 40 mg of Furosemide (medication used to treat fluid retention caused by congestive heart failure) 1 tablet twice daily, by mouth, for congestive heart failure (condition where the heart doesn't pump blood as well as it should).

Review of Resident 2's Service Plan Report, dated 05/01/2025, showed no documentation that provided the care staff to monitor Resident 2 for signs and symptoms related to hypertension, congestive heart failure, depressive disorder, diabetes, and peripheral neuropathy. The plan showed no instructions for staff behaviorally based supportive actions to take when Resident 2 exhibited signs and symptoms of depression. There was no documentation that provided the care staff with guidance about possible side effects from Metoprolol, Furosemide, and Aspirin. The plan showed no guidance or instructions for care staff to report signs and symptoms depression, hypertension, congestive heart failure, and peripheral neuropathy to the nurse.

RESIDENT 3

Review of Resident 3's records showed the facility admitted Resident 3 on [REDACTED]/2025. Resident 3's record showed multiple diagnoses which included [REDACTED]

[REDACTED] and [REDACTED]. Review of Resident 3's record showed that Resident 3 demonstrated exit-seeking behaviors and paranoia. The records showed Resident 3 received medication assistance services from facility staff.

Review of Resident 3's July 2025 and August 2025 Medication Administration Record (MAR) showed that Resident 3 received 10 mg of Escitalopram (medication used to treat major depressive disorder) 1 tablet daily, by mouth, for depression and anxiety; 25 mg of Quetiapine (medication used to treat extreme restlessness, mental health, and behavioral disorders) a half a tablet (12.5 mg) by mouth, 3 times every day; and 100 mg capsules, (give 2 capsules, 200 mg) of Gabapentin (medication used to treat pain) by mouth 3 times every day.

Review of Resident 3's Service Plan Report, dated [REDACTED]/2025, showed no documentation that provided the care staff to monitor Resident 3 for signs and symptoms related to anxiety and depressive disorder. The plan showed no instructions for staff behaviorally based supportive actions to take when Resident 3 exhibited signs and symptoms of anxiety, depression, exit-seeking behavior, and paranoia. There was no documentation that provided the care staff with guidance about possible side effects from Escitalopram, Quetiapine, and Gabapentin. The plan showed no guidance or instructions for care staff to report signs and symptoms depression, anxiety, exit-seeking behavior, and paranoia to the nurse.

RESIDENT 4

Review of Resident 4's records showed the facility admitted Resident 4 in [REDACTED] 2024 with the medical diagnosis of [REDACTED]

and [REDACTED].

Review of June 2025, July 2025, and August 2025 Medication Records (MARs), showed Resident 4 received 0.075 milligrams (mg) of Digoxin, half a tablet every day, by mouth for A-Fib.

Review of Resident 4's Service Plan Report, dated 08/16/2025, showed no documentation that Resident 4 received Digoxin medication. The plan showed no instructions about the possible side effects from daily use of digoxin commonly referred to as digoxin toxicity. The plan showed no instructions for staff about when to report the signs and symptoms of digoxin toxicity.

During an interview on 08/26/2025 at 9:15AM, Resident 4 stated they received digoxin for heart issues and had regular blood tests for serum digoxin levels. Resident 4 was aware that digoxin has a narrow range between a therapeutic and a toxic dose. Resident 4 stated that they were unaware what symptoms to report for digoxin toxicity.

RESIDENT 5

Review of Resident 5's records showed that the facility admitted Resident 5 in [REDACTED] 2023 with the medical diagnosis of [REDACTED].

Review of Resident 5's combined Assessment and Service Plan Report, dated 05/21/2025, showed Resident 5 received dialysis (a medical treatment that artificially supports the kidney and filter out waste and excess water from the blood). Review of the plan showed no information about Resident 5's dialysis access site. The plan showed no staff instructions about what actions to take if Resident 5's access site showed signs and symptoms of infection. The plan showed no documentation of an alternative plan in the event Resident 5 was unable to monitor their own symptoms. The plan showed no documentation that provided staff with guidance about the possible complications after dialysis treatment.

During an interview on 08/28/2025 at 2:23 PM, Staff A, Executive Director, stated that they were unaware of the need to provide care staff with guidance and directions for resident care in the negotiated service agreement. Staff A stated that they were unaware of the comprehensive components required for a negotiated service agreement for assisted living residents.

Statement of Deficiencies

License #: 1917

Compliance Determination # 64483

Plan of Correction

Brookdale Foundation House

Completion Date

Page 25 of 25

Licensee: BLC FEDERAL WAY LH LLC

09/08/2025

Plan/Attestation Statement

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