STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

EMERITUS CORPORATION
Brookdale Fishers Landing
17171 SE 22ND DR
VANCOUVER, WA 98683

RE: Brookdale Fishers Landing License # 2261

Dear Administrator:

This letter addresses Compliance Determination(s) 78809 (Completion Date 06/15/2026) and 72698 (Completion Date 04/16/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/15/2026 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-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-1, WAC 388-78A-2210

The Department staff who did the on-site verification:
Yvonne Chitekwe

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

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Fishers Landing **Provider Type:** Assisted Living Facility

License/Cert.#: 2261
Intake ID: 210899
Compliance Determination #: 72698
Region/Unit #: RCS Region 3 / Unit E
Investigator: Yvonne Chitekwe
Investigation Date(s): 02/10/2026 through 04/16/2026
Complainant Contact Date(s):

Allegation(s):

1. Pharmaceutical Services: Allegation resident's medications were not ordered on time.
2. Misappropriation of Property: Allegation staff are using other resident's medications instead of re-ordering.
3. Quality of Care/Treatment: Allegation a resident was given a borrowed insulin from another resident who had a surplus.
4.. Falsification of Records/Report: Allegation staff are documenting medications are available when they are not.

Investigation Methods:

Sample:
Total residents: 87
Resident sample size: 6
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Identified resident
Identified staff
Nursing staff
Residents
Family members

Record Reviews:
Medical records
Incident investigation
Facility policies
Resident Characteristic Roster
Staff List
Progress notes

This document was prepared by Residential Care Services for the Locator website.

Face sheet
Negotiated service agreement

Investigation Summary:

1. Pharmaceutical Services: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice in the allegation that resident's medications were not ordered on time was substantiated during the investigation.

2. Misappropriation of Property: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice in the allegation that staff were using other residents' medications instead of re-ordering from pharmacy was substantiated during the investigation.

3. Quality of Care/Treatment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, a failed facility practice in the allegation a resident was given a borrowed insulin from another resident who had a surplus was substantiated during the investigation.

4. Falsification of Records/Report: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice in the allegation staff were documenting medications are available when they are not was substantiated during the investigation.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 02/10/2026 of:

Brookdale Fishers Landing
17171 SE 22ND DR
VANCOUVER, WA 98683

This document references the following complaint number(s): 210899, 211173, 212138

The following sample was selected for review during the unannounced on-site visit: 6 of 87 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Yvonne Chitekwe

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

This document was prepared by Residential Care Services for the Locator website.

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.

Clinton Fridley, RN
Residential Care Services

04/23/2026
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

previously signed 5/1/26
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were provided in a safe manner by administering an insulin pen belonging to one resident to a different resident for 2 of 6 residents (Resident 1 and 2) reviewed. This failure resulted in R2 not receiving medications as ordered and placed both Resident 1 and Resident 2 at risk for harm.

Findings included...

Record review of facility policy titled "Medication & Treatment – Administration/Assistance," last revised 07/2024, showed that the individuals assisting with medication administration and or treatment shall provide the assistance in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider. Policy showed that individuals assisting and administering the medications should check the labels three times to verify the right medication, right dosage, right time and right method of administration before giving the medication.

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As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services | Date

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Record review of the Medication Administration Record (MAR), dated 02/2026, showed Resident 1 (R1) admitted to facility on [redacted]/2022 with diagnoses that included [redacted]. R1's MAR showed an order for NPH insulin (intermediate-acting insulin used to manage blood sugar levels) pen-injector 100 units/mL (milliliters), inject 20 units every morning and at bedtime.

Record review of the MAR, dated 02/2026, showed Resident 2 (R2) admitted to facility on [redacted]/2025 with diagnoses that included [redacted]. R2's MAR showed an order for NPH insulin (intermediate-acting insulin used to manage blood sugar levels) pen-injector 100 units/mL, ordered inject 35 units subcutaneous time in the evening.

On 02/10/2026 at 10:41 AM, Staff B, Resident Care Coordinator/Medication Technician (Med Tech), stated that R2 ran out of ordered NPH insulin on 01/08/2026. Staff B stated that R1 had the same order for NPH insulin and had a backup supply that was stored in the medication room refrigerator. Staff B stated that on 01/30/2026 they found an insulin pen, labelled for R2, on the medication cart. Review of that insulin pen revealed a lot number that matched R1's prescription lot number as noted on R1's backup supply pharmacy label.

On 02/10/2026 at 11:09 AM, Staff D, Med Tech, stated that R2 ran out of NPH insulin and did not have an account set up with the facility pharmacy so it could be reordered. Staff C stated when they returned to work the following day a full NPH insulin pen, labeled with R2's room number, name, date opened was found in the medication cart for R2.

On 02/10/2026 at 12:04 PM, Staff A, Registered Nurse (RN), stated that R2 ran out of NPH insulin. Staff A stated that a Med Tech borrowed another NPH insulin pen from R1's backup supply and gave it to R2.

On 02/10/2026 at 2:53 PM, Staff C, Med Tech, stated that on 01/09/2026, during the medication pass, they noticed R2 ran out of NPH insulin. Staff C stated that they contacted management for advice and were told to borrow an insulin pen from R1's backup supply. Staff C stated that they followed management's direction and pulled the NPH insulin pen from R1's backup supply and used R1's backup up insulin pen for R2 and placed it in the med cart.

On 02/10/2026 at 11:18 AM, R2 stated they were not aware staff had to borrow an insulin pen from another resident to be given to them. R2 stated they would not have approved of that and hoped that it would not happen to them.

On 02/10/2026 at 11:30 AM, R1 stated they were not aware staff took an insulin pen from their supply and used it for another resident. R1 stated they did not give permission for anyone to take their supply of insulin pens.

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Record review of the facility investigation summary findings, completed by Staff A, Registered Nurse/Health and Wellness Director, undated, showed that "an insulin pen was allegedly removed from one resident supply to be used for another resident. This allegation was confirmed through staff interview."

Staff A stated they did not reimburse R1 when staff took an insulin pen for another resident because R1 moved out of the facility.

This is a recurring deficiency previously cited on 03/07/2025 and 10/18/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Brookdale Fishers Landing is or will be in compliance with this law and / or regulation on (Date) 5/31/2026.

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

Administrator (or Representative)

previously signed 5/1/26
Date

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Record review of the facility investigation summary findings, completed by Staff A, Registered Nurse/Health and Wellness Director, undated, showed that “an insulin pen was allegedly removed from one resident supply to be used for another resident. This allegation was confirmed through staff interview.”

Staff A stated they did not reimburse R1 when staff took an insulin pen for another resident because R1 moved out of the facility.

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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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