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

03/17/2026

EMERITUS CORPORATION
Brookdale Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

RE: Brookdale Olympia East # 2275

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 74409 (Completion Date 03/17/2026) and 70996 (Completion Date 01/22/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/17/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

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;

The Department staff who did the On Site verification:

Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Olympia East
Provider Type: Assisted Living Facility

License/Cert.#: 2275
Intake ID: 207490
Compliance Determination #: 70996
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 01/06/2026 through 01/22/2026
Complainant Contact Date(s):

Allegation(s):

Pharmaceutical services: Report of facility not having residents medications available for administration.
Resident/Patient/client neglect: Report of facility not having residents medications available for administration.
Quality of Care/Treatment: Report of facility not having residents medications available for administration.

Investigation Methods:

Sample:	Total residents: 62 Resident sample size: 5 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	State reporting log Incident investigation Facility policies Progress Notes Care Plan Medication Administration Record Face Sheet Staff List

Investigation Summary:

Pharmaceutical services: Facility failed to obtain residents medications timely to avoid a lapse in administration. Failed practice identified.
Resident/Patient/client neglect: Facility failed to obtain residents medications timely to avoid a lapse in administration. Failed practice identified.
Quality of Care/Treatment: Facility failed to obtain residents medications timely to avoid a lapse in administration. Failed practice identified.

Conclusion / Action:

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

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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 01/06/2026 and 01/22/2026 of:

Brookdale Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 207490, 206280

The following sample was selected for review during the unannounced on-site visit: 5 of 62 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

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

01/28/2026
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.

Bob Chase
Administrator (or Representative)

2·6·26
Date

WAC 388-78A-2210 Medication services.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure prescribed medications were available for 3 of 5 residents (Resident 2 [R2], Resident 4 [R4] and Resident 5 [R5]). This failure resulted in R2, R4 and R5 not receiving medications as ordered, R2 being worried about not getting required medications and placed R2, R4 and R5 at risk for medical complications and unmet care needs.

Findings Included...

Record review of facility policy titled, "Medications & Treatments-Availability," dated 07/2025, showed medications ordered by a physician/healthcare provider will be available to the resident for administration or assistance with administration. The community Health and Wellness Director (HWD)/nurse/designee is responsible for obtaining newly ordered medication or refills for medications and treatment orders.

R2

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

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-2210 Medication services.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure prescribed medications were available for 3 of 5 residents (Resident 2 [R2], Resident 4 [R4] and Resident 5 [R5]). This failure resulted in R2, R4 and R5 not receiving medications as ordered, R2 being worried about not getting required medications and placed R2, R4 and R5 at risk for medical complications and unmet care needs.

Findings Included…

Record review of facility policy titled, “Medications & Treatments-Availability,” dated 07/2025, showed medications ordered by a physician/healthcare provider will be available to the resident for administration or assistance with administration. The community Health and Wellness Director (HWD)/nurse/designee is responsible for obtaining newly ordered medication or refills for medications and treatment orders.

R2

Review of R2's face sheet, dated 01/06/2026, showed that R2 was admitted to the facility on [redacted]/2025 with diagnosis of [redacted] and [redacted].

Record review of R2's Personal Service Plan (facility's version of the negotiated service agreement), dated 08/22/2025, showed the facility will order and coordinate medications between family, healthcare providers and pharmacy.

Record review of R2's Medication Administration Record (MAR), dated 12/2025 and 01/2026, showed that R2 missed the following medications:

- On 12/30/2025 did not receive Dupixent (medication used to treat COPD) – administered every 14 days.
- Between 12/31/2025 and 01/05/2026 did not receive a daily dose of Escitalopram (medication used to treat depression).
- Between 12/30/2025 and 01/05/2026 did not receive daily dose of Montelukast (medication used to treat COPD).
- Between 12/28/2025 and 01/05/2026 did not receive the daily dose of Bupropion (used to treat depression).
- Between 01/01/2026 and 01/06/2026 did not receive the daily dose of Trelegy inhaler (used to treat venous thrombosis).

In an interview on 01/06/2025 at 10:40 AM, R2 stated the facility was changing pharmacy's and was given paperwork to fill out. R1 stated their was no one to help fill out the paperwork and R1 filled it out incorrectly. R1 stated they turned the paperwork into the receptionist at the front desk in October and nobody let them know it was filled out incorrectly until last week. This caused a delay in getting their medications. R1 stated they are worried about not getting their medications. R1 stated they don't trust the facility. R1 stated the nurse should have looked over the forms to make sure they were filled out correctly so there wasn't a lapse in administration of the medication.

R4

Review of R4's face sheet, dated 01/06/2026, showed that R4 admitted to the facility on [redacted]/2023 with diagnosis of [redacted]

Record review of R4's Personal Service Plan (facility's version of the negotiated service agreement), dated 11/03/2025, showed the facility will order and coordinate medications between family, healthcare providers and pharmacy.

Record review of R4's MAR, dated 12/2025 and 01/2026, showed that R4 missed the following medications:

- Between 12/30/2025 and 01/04/2026 did not receive daily dose of Atorvastatin (medication used to treat hyperlipemia).
- On 12/30/2025 and 12/31/2025 did not receive daily dose of Cetirizine (medication used to treat allergies).
- Between 01/03/2026 and 01/05/2026 did not receive daily dose of Losartan (mediation used to pulmonary hypertension).

R5

Review of R5's face sheet, dated 01/06/2026, showed that R5 admitted to the facility on [redacted]/2023 with diagnosis of [redacted].

Record review of R5's Personal Service Plan (facility's version of the negotiated service agreement), dated 12/12/2025 showed the facility will order and coordinate medications between family, healthcare providers and pharmacy.

Record review of R5's MAR, dated 12/2025 and 01/2026, showed R5 missed the following medications:

- Between 12/31/2025 and 01/06/2026 did not receive daily dose of Pantoprazole (medication used to treat GERD).
- Between 12/31/2025 and 01/06/2026 did not receive daily dose of Sertraline (medication used to treat depression).

In an interview on 01/06/2026 at 1:35 PM, Staff B, Health and Wellness Director, stated the facility recently changed pharmacy's and the residents were given a form to fill out. Staff B stated some of the residents filled the form out incorrectly. After the form was filled out, the facility faxed it to the pharmacy. Staff B stated that a medication technician (med tech) or nurse should have reviewed the form for accuracy before sending it off to the pharmacy. Staff B stated there was a failure with the transition between pharmacy's and that residents did not get the service of medication administration per their contract due to the unorganized process. Staff B was asked who

was responsible to ensure there wasn't a lapse in a resident getting their medications, they stated the med techs and themselves.

In an interview on 01/21/2026 at 10:20 AM, Staff A, Executive Director, stated the facility transitioned to a new pharmacy and it was not a smooth process. Staff A was asked if anyone from the facility was reviewing the forms for accuracy, they stated not all of them. Staff A stated the facility was responsible to ensure residents received their prescribed medications and it was unacceptable for there to be a lapse in a resident receiving their medications. Staff A stated they should have looked at the forms to ensure they were filled out correctly before they were sent off to the pharmacy.

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 Olympia East is or will be in compliance with this law and / or regulation on (Date) 3·9·26.

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

Administrator (or Representative) — Date: 2·6·26

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;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement and follow the facility policy and procedure for alert charting for 3 of 5 residents (Resident 2 [R2], Resident 4 [R4], and Resident 5 [R5]). This failure placed residents at risk for unmet care needs when they didn't get their medications as prescribed.

Findings included...

Review of the facility policy titled, "Alert Charting Policy," dated 08/2024, showed associates should document in the resident record those events which include changes of condition that require nurse notification, additional monitoring, or specific

was responsible to ensure there wasn't a lapse in a resident getting their medications, they stated the med techs and themselves.

In an interview on 01/21/2026 at 10:20 AM, Staff A, Executive Director, stated the facility transitioned to a new pharmacy and it was not a smooth process. Staff A was asked if anyone from the facility was reviewing the forms for accuracy, they stated, not all of them. Staff A stated the facility was responsible to ensure residents received their prescribed medications and it was unacceptable for there to be a lapse in a resident receiving their medications. Staff A stated they should have looked at the forms to ensure they were filled out correctly before they were sent off to the pharmacy.

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-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;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement and follow the facility policy and procedure for alert charting for 3 of 5 residents (Resident 2 [R2], Resident 4 [R4], and Resident 5 [R5]). This failure placed residents at risk for unmet care needs when they didn't get their medications as prescribed.

Findings included…

Review of the facility policy titled, "Alert Charting Policy," dated 08/2024, showed associates should document in the resident record those events which include changes of condition that require nurse notification, additional monitoring, or specific

intervention and documentation.

In an interview on 01/06/2026 at 1:35 PM, Staff B, Health and Wellness Director, stated if a resident were to miss their medications they would be placed on alert for at least 72 hours or until the medication comes in to monitor them for adverse side effects from missing the medications.

R2

Review of R2's face sheet, dated 01/06/2026, showed that R2 admitted to the facility on [redacted]/2025 with diagnosis of [redacted]

Record review of R2's Medication Administration Record (MAR), dated 12/2025 and 01/2026, showed R2 missed daily administration of one to five medications, due to an error when the facility changed pharmacies, between 12/28/2025 and 01/06/2026. These medications varied and used to treat COPD, depression and prevent venous thrombosis and/or embolism.

Record review of R2's progress notes, dated range 12/06/2025-01/06/2026, showed no entries related to monitoring for adverse reactions due to R2's missing medications between 12/28/2025 and 01/06/2026.

R4

Review of R4's face sheet, dated 01/06/2026, showed that R4 admitted to the facility on [redacted]/2023 with diagnosis of [redacted]

Record review of R4's MAR, dated 12/2025 and 01/2026, showed R4 missed daily administration of one to three medications between 12/30/2025 and 01/05/2026. These missed medications varied and used to treat hyperlipidemia, allergies and pulmonary hypertension.

Record review of R4's progress notes, dated range between 12/06/2025 and 01/06/2026, showed no entries related to monitoring for adverse reactions due to R4's missing medications between 12/30/2025 and 01/05/2026.

R5

Review of R5's face sheet, dated 01/06/2026, showed that R5 admitted to the facility on [redacted]/2023 with diagnosis of [redacted].

Record review of R5's MAR, dated 12/2025 and 01/2026, showed R5 missed daily administration of two medications between 12/31/2025 and 01/06/2026. The missed mediations were being used to treat GERD and depression.

Record review of R5's progress notes, dated range between 12/01/2025 and 01/06/2026, showed no entries related to monitoring for adverse reactions due to R5's missing medications between 12/31/2025 and 01/06/2026.

In an interview on 01/06/2026 at 1:35 PM, Staff B stated when the med techs see that there were missing medications for residents, they are to let them know and they will be placed on alert to monitor them. Staff B stated they were never made aware of R2, R4 and R5 missing medications until yesterday [01/05/2026] and stated they should have been placed on alert sooner.

Refer to WAC 388-78A-2210(2)

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: 2·6·26

R5

Review of R5's face sheet, dated 01/06/2026, showed that R5 admitted to the facility on [redacted]/2023 with diagnosis of [redacted].

Record review of R5's MAR, dated 12/2025 and 01/2026, showed R5 missed daily administration of two medications between 12/31/2025 and 01/06/2026. The missed mediations were being used to treat GERD and depression.

Record review of R5's progress notes, dated range between 12/01/2025 and 01/06/2026, showed no entries related to monitoring for adverse reactions due to R5's missing medications between 12/31/2025 and 01/06/2026.

In an interview on 01/06/2026 at 1:35 PM, Staff B stated when the med techs see that there were missing medications for residents, they are to let them know and they will be placed on alert to monitor them. Staff B stated they were never made aware of R2, R4 and R5 missing medications until yesterday [01/05/2026] and stated they should have been placed on alert sooner.

Refer to WAC 388-78A-2210(2)

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