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 Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

RE: Brookdale Olympia East License # 2275

Dear Administrator:

This letter addresses Compliance Determination(s) 76891 (Completion Date 05/05/2026) and 72471 (Completion Date 03/10/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/05/2026 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-2660-1, WAC 388-78A-2660-2

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

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

Sincerely,

Laurie Anderson for Clinton Fridley

Laurie Anderson, Community 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: 210229
Compliance Determination #: 72471
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 02/05/2026 through 03/10/2026
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Report of resident not receiving agreed upon care and services.
Physical environment: Report of resident not having raised toilet seat installed.
Resident/Patient/Client Rights: Report of resident being told they cannot use their scooter in the community.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Nurse Executive Director
Record Reviews:	State reporting log Incident investigation Facility policies Progress Notes Care Plan Face Sheets Screen shot of tasks for care staff

Investigation Summary:
Quality of Care/Treatment: Facility failed to answer call lights within a reasonable

amount of time. Failed practice identified.
Physical environment: Based on interview and observation, raised toilet seat in place at time of on site visit. Unable to substantiate failed practice.
Resident/Patient/Client Rights: Based on interview and observation, resident able to move about the community with use of power scooter. Unable to substantiate failed practice.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2275
Intake ID: 209002
Compliance Determination #: 72471
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 02/05/2026 through 03/10/2026
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of resident falling in the community and calling 911.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Nurse Executive Director
Record Reviews:	State reporting log Incident investigation Facility policies Progress Notes Care Plan Face Sheets Screen shot of tasks for care staff

Investigation Summary:
Quality of Care/Treatment: Facility failed to ensure call lights were answered within a reasonable amount of time. Failed practiced identified.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

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 02/05/2026 of:

Brookdale Olympia East
616 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 210229, 209002, 211943

The following sample was selected for review during the unannounced on-site visit: 5 of 67 current residents and 0 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

03/23/2026
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.

Bob C
Administrator (or Representative)

4/1/26
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to promote care for residents that maintained residents dignity by not responding timely when summoned by residents activating call lights for 4 of 5 residents (Resident 1 (R1), Resident 2 (R2), Resident 4 (R4) and Resident 5 (R5)). This failure resulted in these four residents having unreasonable delays in receiving care after summoning staff for help and being distressed due to unmet care needs and this contributed to Resident 4 soiling themselves while awaiting response from staff and placed all residents at risk for harm.

Findings included...

RCW 70.129.140 Quality of life---Rights.
(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Record review of facility policy titled "Resident Call Systems and Door Alarm Response," dated 12/2025, showed staff should respond to resident call system alerts in a reasonable and timely manner. If the associate is unable to respond in a timely manner, he or she should request assistance from another associate.

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

03/23/2026
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)

Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to promote care for residents that maintained residents dignity by not responding timely when summoned by residents activating call lights for 4 of 5 residents (Resident 1 (R1), Resident 2 (R2), Resident 4 (R4) and Resident 5 (R5)). This failure resulted in these four residents having unreasonable delays in receiving care after summoning staff for help and being distressed due to unmet care needs and this contributed to Resident 4 soiling themselves while awaiting response from staff and placed all residents at risk for harm.

Findings included...

RCW 70.129.140 Quality of life—Rights.
(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Record review of facility policy titled "Resident Call Systems and Door Alarm Response," dated 12/2025, showed staff should respond to resident call system alerts in a reasonable and timely manner. If the associate is unable to respond in a timely manner, he or she should request assistance from another associate.

<R1>

Record review of facility resident records showed that R1 admitted on [redacted]2025 with a diagnosis of [redacted] Personal Service Plan, dated 12/24/2025, documented R1 needs help in the bathroom, requires physical assistance related to an inability to stand independently during bathroom tasks, and is incontinent of bowel.

Record review of facility document titled "All Alarms Report," undated, had a date range 01/06/2026 through 02/05/2026 which showed R1 had activated their call light on 01/13/2026 at 11:50 PM. The response time documented was one hour and 15 minutes.

Record review of R1's incident investigation, dated 01/15/2026, showed on 01/14/2026 at about 1:00 AM, R5 (spouse to R1) attempted to transfer R1 out of a wheelchair and they both fell to the floor. Staff responded to this fall. R5 was reminded to call staff for assistance. On 01/14/2026 at 11:15 PM R1 called 911 themselves and was sitting in their wheelchair in the hallway waiting for the medics. The medics arrived and assessed R1 and took them to the hospital. R1 returned to the community after being diagnosed with [redacted].

Record review of R1's progress notes dated 01/14/2026 11:58 PM, showed R1 called EMT's (emergency medical technicians) because they had fallen. R1 had an elevated temperature and was taken to the hospital. R1's call light was not activated during time of call to EMT's.

In a joint interview on 02/05/2026 at 10:07 AM, R1 stated they called 911 recently because they had fallen down. R1 stated they did not call for staff when they fell because it has been a problem for quite awhile with wait times being too long after the call light was activated. R5 stated they now refuse to lift R1 because they had injured themselves when they attempted to lift R1. R5 stated the wheelchair hit their toes and their finger and now their toes are swollen.

Record review of All Alarms Report, undated, had a date range 01/06/2026 through 02/05/2026 showed R1 had call light response times, greater than 45 minutes, 57 times. R1 had a call light response time as long as four hours and 24 minutes on 01/26/2026 at 2:10 AM.

In an interview on 02/05/2026 at 3:05 PM, R5 stated they typically call for staff to tell them if R1 needs help using the toilet, transferring, or if its time for them to shower. R5 stated they wait 45 minutes or more and are frustrated. R5 stated R1 is a one person assist and were trying to assist R1 recently after waiting for help which then resulted in both R1 and R5 falling down together. R5 stated they called for help and it took staff awhile to get there to help them.

<R5>

Record review of facility records show that R2 admitted on [redacted]/2025.

Record review of R5's incident report, dated 01/14/2026 at 1:00 AM, showed R5 stated that they were attempting to transfer R1 out of their wheelchair and they both fell to the floor. R5 was reminded to call staff for assistance. On 02/06/2026, R5 was seen at urgent care where it was discovered that they had a fracture to their middle finger. R5 had not had any other falls and is believed to have been fractured when they fell to the floor assisting R1.

Record review of R5's urgent care notes, dated 02/06/2026, showed R5 was diagnosed with [redacted] and [redacted].

Record review of R5's incident investigation, dated 02/07/2026, showed R5 went to urgent care because they were having pain in their foot. R5 returned to the community with a boot on their left foot and a splint on their middle finger of their left hand. R5 stated they had not fallen since 01/14/2026.

Record review of All Alarms Report, undated, had a date range 01/06/2026 through 02/05/2026 showed R5 had a call light response time as long as one hour and 18 minutes on 01/15/2026 at 10:44 AM.

<R2>

Record review of facility records show that R2 admitted on [redacted]2026.

Record review of R2's Service Plan, undated, showed on 02/16/2026 R2 required assistance with velcro compression wraps (designed to manage chronic swelling and leg wounds) to be applied in the morning and removed at night prior to bedtime.

Record review of R2's progress notes dated 01/27/2026, showed R2 wore black Velcro compression wraps over their socks that were to be placed on R2's legs in the morning and removed at bedtime.

In an interview on 02/05/2026 at 1:32 PM, R2 stated that they had pushed their call light two days ago for assistance with their compression wraps for their legs and it took 50 minutes for staff to arrive to assist them. R2 stated they know it was 50 minutes because they timed it. R2 stated if it had been an emergency they could have been found dead. R2 stated the response time is very slow and it takes a long time to get

help. R2 stated they were upset and feels like there is not enough staff at the facility to respond fast enough to the emergency button.

Record review of All Alarms Report, undated, had a date range 01/06/2026 through 02/05/2026 showed R2 pressed their call light on 02/03/2026 and had call light response time of 50 minutes. R2 had a call light response time as long as one hour and 49 minutes on 02/04/2026 at 8:47 PM.

<R4>

Record review of facility records show that R4 admitted on [redacted]/2025 with a diagnosis of [redacted].

Record review of R4's Service Plan, dated 12/29/2025, showed R4 requires assistance in the bathroom, changing protective undergarments and requires physical assistance related to the inability to stand independently during bathroom tasks. R4 is incontinent of his bladder and needs assistance with changing and cleansing two to three times a shift.

In an interview on 02/05/2026 at 2:40 PM, R4 stated there have been times that it took staff awhile to get to them after they have hit their call light when they have had to use the restroom. R4 stated they hit their call light yesterday about 1:15 AM due to waking and needing to use the restroom. R4 stated they soiled themselves waiting for help because nobody came. R4 stated it's very frustrating because when they hit the button for help, they expect someone to come help them. R4 stated that someone placed a urinal next to their recliner. R4 stated they require assistance to get up and have had to get up on their own because they were waiting so long for help.

Record review of All Alarms Report, undated, had a date range 01/06/2026 through 02/05/2026 showed R4 pressed their call light on 02/04/2026 at 1:14 AM and had a call light response time of four hours and nine minutes.

In an interview on 02/05/2026 at 1:10 PM, Collateral Contact 1 (CC1) stated staffing is an issue and they were swamped today. CC1 stated there have been times they have come in for their shift and call lights have not been answered. CC1 stated there was a resident (R6) whose call light had been activated and not answered for 2 hours today. CC1 stated that R6 wanted to use the restroom and get up for the day.

Record review of All Alarms Report, undated, had a date range 01/06/2026 through 02/05/2026 showed on 02/05/2026, R6's call light was activated on 02/05/2026 at 4:57 AM and had a response time of one hour and 58 minutes.

In an interview on 02/05/2026 at 2:11 PM, Staff B, health and wellness director, stated the goal is to have staff answer the call light no later than 20 minutes. Staff B stated the residents on admission are instructed to use the pendant for emergency's, but can use it for help transferring or for toileting. Staff B stated residents waiting 45 minutes or more is too long to be waiting for assistance. Staff B was asked if there is enough staff to provide the services the residents pay for, they stated that is a hard question to answer and they don't know.

In an interview on 02/05/2026 at 3:45 PM, Staff A, executive director, stated staff should answer call lights within a half an hour. Staff A was asked if it was acceptable for someone who fell to wait 30-45 minutes for help, they stated no it is not our standard. Staff A stated they could have multiple call lights go off at the same time and they are answered in the order they are received. Staff A was asked if it was acceptable for someone who needs toileting assistance from staff to have to soil themselves because they were waiting for help from staff, Staff A stated no.

This is a recurring deficiency previously cited on 03/27/2025.

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 Olympia East is or will be in compliance with this law and / or regulation on (Date) 4-24-26.

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

Bob C

Administrator (or Representative)

4/1/26

Date

In an interview on 02/05/2026 at 2:11 PM, Staff B, health and wellness director, stated the goal is to have staff answer the call light no later than 20 minutes. Staff B stated the residents on admission are instructed to use the pendant for emergency's, but can use it for help transferring or for toileting. Staff B stated residents waiting 45 minutes or more is too long to be waiting for assistance. Staff B was asked if there is enough staff to provide the services the residents pay for, they stated that is a hard question to answer and they don't know.

In an interview on 02/05/2026 at 3:45 PM, Staff A, executive director, stated staff should answer call lights within a half an hour. Staff A was asked if it was acceptable for someone who fell to wait 30-45 minutes for help, they stated no it is not our standard. Staff A stated they could have multiple call lights go off at the same time and they are answered in the order they are received. Staff A was asked if it was acceptable for someone who needs toileting assistance from staff to have to soil themselves because they were waiting for help from staff, Staff A stated no.

This is a recurring deficiency previously cited on 03/27/2025.

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 Olympia East 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