STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

BKD Clare Bridge of Olympia LLC
Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

RE: Brookdale Olympia West License # 2497

Dear Administrator:

This letter addresses Compliance Determination(s) 65789 (Completion Date 09/18/2025) and 63850 (Completion Date 08/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/18/2025 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

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

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2497
Intake ID: 188304
Compliance Determination #: 63850
Region/Unit #: RCS Region 3 / Unit E
Investigator: Clinton Fridley
Investigation Date(s): 08/08/2025 through 08/08/2025
Complainant Contact Date(s):

Allegation(s):

1. Injury of Unknown Origin: Facility report of a resident sustained injury of unknown origin.
2. Nursing Services: Facility report of a resident sustained injury of unknown origin.
3. Quality of Care/Treatment: Facility report of a resident sustained injury of unknown origin.

Investigation Methods:

Sample:	Total residents: 51 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:	Residents Identified resident Family members Nursing staff Management
Record Reviews:	Incident investigation Facility policies Progress Notes/Alert Charting Negotiated Service Agreements Temporary Service Plans

Investigation Summary:

1. Injury of Unknown Origin: Facility failed to follow policies and procedures for abuse/neglect, investigate the incident, and document investigative findings. Failed practice identified.
2. Nursing Services: Facility failed to follow policies and procedures for

abuse/neglect, investigate the incident, and document investigative findings. Failed practice identified.
3. Quality of Care/Treatment: Facility failed to follow policies and procedures for abuse/neglect, investigate the incident, and document investigative findings. Failed practice identified.

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 West
Provider Type: Assisted Living Facility

License/Cert.#: 2497
Intake ID: 188276
Compliance Determination #: 63850
Region/Unit #: RCS Region 3 / Unit E
Investigator: Clinton Fridley
Investigation Date(s): 08/08/2025 through 08/08/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a resident sustained injury of unknown origin.

Investigation Methods:

Sample:	Total residents: 51 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:	Residents Identified resident Family members Nursing staff Management
Record Reviews:	Incident investigation Facility policies Progress Notes/Alert Charting Negotiated Service Agreements Temporary Service Plans

Investigation Summary:
Quality of Care/Treatment: Facility failed to follow policies and procedures for abuse/neglect, investigate the incident, and document investigative findings. Failed practice identified.

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 West
Provider Type: Assisted Living Facility

License/Cert.#: 2497
Intake ID: 189432
Compliance Determination #: 63850
Region/Unit #: RCS Region 3 / Unit E
Investigator: Clinton Fridley
Investigation Date(s): 08/08/2025 through 08/08/2025
Complainant Contact Date(s):

Allegation(s):
Injury of Unknown Origin: Facility report of a resident sustained injury of unknown origin.

Investigation Methods:

Sample:	Total residents: 51 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:	Residents Identified resident Family members Nursing staff Management
Record Reviews:	Incident investigation Facility policies Progress Notes/Alert Charting Negotiated Service Agreements Temporary Service Plans

Investigation Summary:
Injury of Unknown Origin: Facility failed to follow policies and procedures for abuse/neglect, investigate the incident, and document investigative findings. 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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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 08/08/2025 of:

Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following complaint number(s): 188841, 188304, 188276, 188846, 189432, 189339

The following sample was selected for review during the unannounced on-site visit: 5 of 51 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI
Clinton Fridley, Adult Family Home Nurse Field Manager

From:
DSHS, Aging and Long-Term Support 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
Residential Care Services

08/21/2025
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.

Administrator (or Representative)

9/8/2025 - Orig. Sig 8/31/2025
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on record review and interview, the memory care facility failed to investigate, document investigative actions/findings, and protect residents after becoming aware of injuries to residents in the community of which the origin was unknown, for 3 of 3 incidents reviewed. This failure placed Resident 1 [R1] and Resident 2 [R2] at risk for ongoing physical abuse.

Findings Included...

Review of the memory care facility policy titled, "Abuse, Neglect & Exploitation Policy" last reviewed on 05/2021, stated, "Upon learning of alleged abuse, neglect or exploitation, the Executive Director or supervisor on duty should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of abuse, neglect or exploitation while a determination on the matter is pending.... The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community... The investigation should be initiated as soon as practicable upon

becoming aware of an incident… The Executive Director or designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time, name of person being questioned and an impartial report of the facts."

<Resident 1>

Review of Department Records showed the following two reports made by the memory care facility to the Department, that reported two injuries of unknown origin for R1 on 07/26/2025, and 08/04/2025.

- 07/26/2025: "The resident [R1] was noted this morning at about 10 a.m. to have purple bruising to both of [their] wrists. No specific shape and it the bruising extends from about 1/3 of the way upper forearm from [their] wrist down, down to the wrist and a little bit onto the back of [their] hands."
- 08/04/2025: "Sometime after breakfast and before lunch today (8/4/25), [R1] suffered a skin tear to [their] right wrist in a crescent moon shape just smaller than a dime."

Review of R1's face sheet showed that R1 was admitted to the memory care facility on [redacted]/2022.

Review of R1's progress notes showed the following:

- 07/26/2025 at 2:40PM: "Notified… of purple bruising to bilateral wrists. Unknown origin…"
- 08/04/2025 which stated, "[R1] has a new skin tear of unknown origin on [their] right wrist. It is a crescent moon shape, approx[imately] 1cm long x 0.5cm wide."

During an interview with Staff C, the Health and Wellness Coordinator, on 08/08/2025 at 10:11AM, Staff C was asked what steps were taken after the facility became aware of the injury of unknown origin for R1 on 07/26/2025. Staff C stated, "I interviewed the staff that were on and none of them knew what happened. [R1] got put on alert [charting] and put on a Temporary Service Plan." Staff C was asked if they the outcome of the investigation, and if they knew how the bruising occurred. Staff C stated that the nursing management still do not know what happened, or how R1 sustained the bruises. Staff C was then asked to discuss the results of the investigation regarding the injury of unknown origin for R1 on 08/04/2025. Staff C stated that R1 spent a lot of time in their wheelchair and often did not navigate corners well. Staff C stated, "I am guessing [R1] bumped it." Staff C was asked to provide the incident reports and respective investigations, including any resident/staff interviews for both incidents regarding R1's reported injuries of unknown origin for review. The incident reports, investigations and

interviews for both incidents were not provided.

During an interview with Staff B, the Health and Wellness Director, on 08/08/2025 at 12:18PM, Staff B was asked if there were any incident reports completed for R1 and their 2 injuries of unknown origin, as they were not provided for review. Staff B stated that there were no incident reports or investigations completed for these incidents. Staff B stated, “There are definitely some things that we missed, and that we need to work on.”

<Resident 2>

Review of Department Records showed a report made to the Department by the memory care facility regarding an injury of unknown origin for R2 on 07/26/2025 which stated, “Resident had a small skin tear on left wrist with and abrasion and some discoloration that was blue in color. First aid was applied; hand was bandaged.”

Review of R2’s face sheet showed that R2 was admitted to the memory care facility on [redacted]/2023.

Review of R2’s incident report for the injury of unknown origin, dated 07/26/2025, stated, “small skin tear noted by med-tech [Medication Technician] … after dinner in TV room, bruising also present to left wrist.” Under “Nature of Incident” it stated, “Incident of Unknown Origin.” Further review of incident report showed no additional investigation made by the facility.

During an interview with Staff C, the Health and Wellness Coordinator, on 08/08/2025 at 10:11AM, Staff C was asked to explain the facility process of investigations, and if the investigation/summaries would normally be attached to the respective incident reports. Staff C stated, “Generally I just write a progress note with what I found at the time.” Staff C was asked if they normally completed a summary of the investigations. Staff C stated that they do not complete any written summaries of investigations. Staff C was asked if they, or Staff B ever conducted and documented any investigation for injuries of unknown origin to rule out any possibility of ongoing abuse or neglect. Staff C stated, “Not really.”

During an interview with Staff A, the Executive Director, Staff B, Staff C, and Staff D, the Area Nurse Manager, all present on 08/08/2025 at 1:33PM, Staff B was asked if any residents or staff were interviewed regarding these 3 separate incidents. Staff B stated that they conducted a verbal interview with the residents. Staff B was asked if any of these interviews were documented. Staff B stated they were not. Staff A, Staff B, Staff C, and Staff D were asked if they can rule out the possibility of any abuse or neglect for the 3 injuries of unknown origin involving R1 and R2. Staff A, Staff B, Staff C, and Staff D all stated that they cannot, and expressed that they agreed that there were no investigations conducted by the facility.

This is a recurring deficiency previously cited on 03/26/2024 and 12/18/2023.

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 West is or will be in compliance with this law and / or regulation on (Date) 9/12/2025.

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

Administrator (or Representative)

9/8/2025 - Dwg. Sej 8/31/2025
Date