STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 75613 (Completion Date 04/09/2026) and 71487 (Completion Date 02/10/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/09/2026 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-2240, WAC 388-78A-2660, WAC 388-78A-2660-1, WAC 388-78A-2660-2

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, RN

Clinton Fridley, Community 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: 207881
Compliance Determination #: 71487
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 01/15/2026 through 02/10/2026
Complainant Contact Date(s):

Allegation(s):

Resident/Patient/Client Neglect: Public allegation of facility failing to administer medications as prescribed.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 7 Closed records sample size: 1
Observations:	Residents Identified resident Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Family members Nursing staff Management Business office manager
Record Reviews:	Medical Records Hospital Records Incident Investigation Facility Policies Medication Administration Records Negotiated Service Agreements Temporary Service Plans Progress Notes/Alert Charting Billing

Investigation Summary:

Resident/Patient/Client Neglect: Facility failed to obtain and administer resident medication as prescribed. 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: 209168
Compliance Determination #: 71487
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 01/15/2026 through 02/10/2026
Complainant Contact Date(s):

Allegation(s):

Financial Exploitation: Public report alleging that facility is failing to re-imburse resident family after resident discharged from facility.

Investigation Methods:

Sample:
Total residents: 58
Resident sample size: 7
Closed records sample size: 1

Observations:
Residents
Identified resident
Activities
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Family members
Nursing staff
Management
Business office manager

Record Reviews:
Medical Records
Hospital Records
Incident Investigation
Facility Policies
Medication Administration Records
Negotiated Service Agreements
Temporary Service Plans
Progress Notes/Alert Charting
Billing

Investigation Summary:

Financial Exploitation: Facility failed to re-imburse resident/resident representative within 30 days. Failed practice 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 01/15/2026 and 02/10/2026 of:

Brookdale Olympia West
420 YAUGER WAY SW
OLYMPIA, WA 985028660

This document references the following complaint number(s): 205875, 207881, 207965, 208592, 208801, 209353, 209168

The following sample was selected for review during the unannounced on-site visit: 7 of 58 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

02/13/2026
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)

2/24/2026
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to obtain resident medications in a timely manner for 1 of 2 residents (Resident 1 [R1]). This failure resulted in R1 not receiving their medication, increased blood sugar levels requiring treatment at a hospital and placed the resident at risk for health complications and a decreased quality of life.

Findings included...

Record review of a facility policy titled "Medication & Treatment - Administration/Assistance," last reviewed on 07/2024, stated that medications shall be provided in a safe and timely manner as ordered by a health care professional.

Record review of a facility policy titled "Medications & Treatments – Availability," last reviewed on 07/2025, stated that the facility was responsible for getting new and refill medications for residents who receive medication assistance/administration and that medications had to be available to ensure no interruption in medication administration/assistance.

Review of facility resident records showed that R1 admitted to the facility on [redacted]2025 with diagnoses that included [redacted] and that R1 received medication administration

from the facility.

Record review of R1's Medication Administration Record (MAR) for December 2025 and January 2026, showed an order for Trulicity (injection used to treat diabetes) to be given once per week. The MAR showed that R1 did not receive Trulicity, because the medication was not available, on 12/21/2025, 12/28/2025, and 01/04/2026.

Record review of progress notes for R1, dated 12/21/2025 at 10:09 AM, documented that Trulicity was not available and that staff ordered the medication on 12/14/2025.

Record review of progress notes for R1, dated 12/28/2025 at 1:34 PM, documented that staff reached out to the pharmacy about R1's Trulicity medication non-availability, but the pharmacy hung up on staff. No other documentation about follow up on R1's Trulicity with the pharmacy noted.

Record review of progress notes for R1, dated 12/29/2025 at 5:53 AM, documented that R1 returned from the hospital after being treated for high blood sugar levels.

Record review of progress notes for R1, dated 12/29/2025 at 9:15 AM, documented staff called the pharmacy to inquire about R1's missing Trulicity and the pharmacy stated they never received the order. Staff stated facility records showed it was faxed, facility re-faxed the order to the pharmacy.

Record review of progress notes for R1, dated 12/29/2025 at 10:15 AM, documented staff called pharmacy to follow up that they received the re-faxed order, pharmacy stated they did not receive it. Staff elevated issue to Staff B, Wellness Director.

Record review of progress notes for R1, date range 12/21/2025 – 12/29/2025, the only documentation regarding R1's missing Trulicity medication is noted above.

Record review of R1's hospital records, dated 12/30/2025, showed that R1 presented to the emergency department for treatment of elevated blood sugars and that R1's blood sugar level was four times the normal range.

In an interview on 01/28/2026 at 10:28 AM, Staff B stated there was an issue with the pharmacy obtaining R1's Trulicity medication, and that the facility had repeatedly asked for the medication to be sent. Staff B stated there was no system in place to ensure missed medications were follow-up on appropriately when this event happened.

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) 3/13/2026.

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

Administrator (or Representative) — Date: 2/24/2026

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 record review and interview, the facility failed to issue a refund within 30 days after a resident passed away and all belongings were removed from the facility for 1 of 1 residents (Resident 3 (R3)). This failure resulted in the refund being delayed and causing R3's representative increased frustration during their time of grieving.

Findings Included...

Review of RCW 70.120.150 documents that "If a resident dies or is hospitalized or is transferred to another facility for more appropriate care and does not return to the original facility, the facility shall refund any deposit or charges already paid less the facility's per diem rate for the days the resident actually resided or reserved or retained a bed in the facility notwithstanding any minimum stay policy or discharge notice requirements, except that the facility may retain an additional amount to cover its reasonable, actual expenses incurred as a result of a private-pay resident's move, not to exceed five days' per diem charges, unless the resident has given advance notice in compliance with the admission agreement. All long-term care facilities or nursing facilities covered under this section are required to refund any and all refunds due the resident or resident representative to the extent provided by law, within thirty days from the resident's date of discharge from the facility."

In an interview on 01/27/2026 at 11:52 AM, Collateral Contact 1 (CC1), R3's representative, stated that the memory care facility owed them a refund after R3 passed away in the hospital. CC1 stated R3 was sent to the hospital by the facility on

[redacted]2025. CC1 stated that during R3's hospitalization, it was determined by hospital staff that R3 was going to pass away. CC1 stated that they then notified the facility and removed all of R3's belongings from the facility on 09/18/2025. CC1 stated that R3's monthly expenses were paid at the beginning of the month, and since the R3 was not in the facility for the month, that the facility should owe them a refund. CC1 stated that on 09/18/2025, they spoke with Staff B, former Business Office Manager. CC1 stated that Staff B stated there was some discrepancy on the bill and would have to get it clarified before issuing the refund. Since then, CC1 stated that they have reached out to the facility multiple times over the next few months with no progress on the issue. CC1 stated that they have still not received a refund from the facility.

During an interview on 01/28/2026 at 10:28 AM, Staff A, Executive Director, stated that the "care charges" stop when a resident passes away and that "room and board" charges are still billed until all belongings are removed from the resident's room. Staff A stated that they were unsure if the facility refunded the money due to CC1 after R3 passed away as it was Staff B's responsibility and they no longer are employed. Staff A stated that they thought there was a dispute about the refund amount and would have to review the details of the issue.

Review of the facility billing ledger for R3 dated 01/28/2026, showed that CC1 was owed a refund in the amount of $4,305.66.

In an interview on 02/03/2026 at 3:33 PM, Staff A stated that R3 was sent to the hospital on [redacted]2025 and that R3's belongings were removed from the facility on 09/19/2025. Staff A stated that R3 passed away in the hospital on [redacted]2025. Staff A stated the delay in refund was due to an initial confusion on R3's passing date, and a confusion on the date to which R3's belongings were removed from the facility. Staff A stated that Staff B was confused as to these dates and did not enter the correct dates when submitting the refund request, which generated a dispute. Staff A stated, "that is why nothing was paid out, because the dates were incorrect, and they didn't know how much to cut the check for."

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) 3/13/2026.

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

Administrator (or Representative) — Date: 2/24/2026