STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

BROOKDALE SENIOR LIVING COMMUNITIES INC
Brookdale Yakima
4100 W ENGLEWOOD
YAKIMA, WA 98908

RE: Brookdale Yakima License # 1695

Dear Administrator:

This letter addresses Compliance Determination(s) 71835 (Completion Date 01/23/2026) and 68646 (Completion Date 12/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/23/2026 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

The Department staff who did the on-site verification:
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Yakima
Provider Type: Assisted Living Facility
License/Cert.#: 1695
Compliance Determination #: 68646
Intake ID: 200252
Investigator: Felicia Cantu
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/13/2025 through 12/01/2025
Complainant Contact Date(s): 12/01/2025

Allegation(s):

1) A named resident appeared unkept and uncared for.
2) A named resident's apartment is not cleaned by housekeeping.
3) A named resident is not getting their medication as ordered.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 3 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Facility environment Resident rooms Staff to resident interactions
Interviews:	Identified resident Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Resident records (face sheets, care plans, assessments, medication administration records, doctor orders).

Investigation Summary:

1) Observations showed that the named resident and other residents were dressed and groomed. Interviews showed that care staff attended to their care needs. No failed practice identified.
2) Observations showed that the named resident's room and other resident rooms appeared cleaned by housekeeping. Interviews showed that residents were satisfied with their housekeeping services at the facility. No failed practice identified.
3) Observations showed that staff to resident interactions appeared safe, respectful, and helpful. Interviews and record review showed that the named resident and other sampled residents missed doses of their ordered medication. Failed practice

identified. WAC 388-78-2240

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 Yakima
Provider Type: Assisted Living Facility
License/Cert.#: 1695
Compliance Determination #: 68646
Intake ID: 201687
Investigator: Felicia Cantu
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/13/2025 through 12/01/2025
Complainant Contact Date(s):

Allegation(s):
1) A named resident is not receiving their medications as ordered.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 3 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Facility environment Resident rooms Staff to resident interactions
Interviews:	Identified resident Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Facility policies Resident records (face sheet, care plan, assessments, chart notes, doctor orders, medication administration records)

Investigation Summary:
Observations showed that staff to resident interactions appeared safe, helpful, and respectful. Interviews with facility staff and record review of the medication administration record showed that the named resident and other residents missed doses of their ordered medications. Failed practice identified. WAC 388-78A-2240

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 1695	Compliance Determination # 68646
Plan of Correction	Brookdale Yakima	Completion Date
Page 1 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	12/01/2025

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 11/13/2025 of:

Brookdale Yakima
4100 Englewood Ave
Yakima, WA 98908

This document references the following complaint number(s): 200262, 200252, 201687

The following sample was selected for review during the unannounced on-site visit: 3 of 71 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

Statement of Deficiencies	License #: 1695	Compliance Determination # 68646
Plan of Correction	Brookdale Yakima	Completion Date
Page 2 of 4	Licensee: BROOKDALE SENIOR LIVING COMMUNITIES INC	12/01/2025

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.

Laura Williams-Davis — 12/05/2025
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.

Lisa Owen — 12.5.25
Administrator (or Representative) — 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 interviews and record reviews, the facility failed to implement a safe medication system that ensured medication orders were followed and ordered as prescribed for 2 of 3 residents (Resident 1and 2). This failure resulted in residents missing doses of their ordered medications that put them at risk of further decline in their health conditions such as increased pain for Resident 1 and increased hand tremors for Resident 2.

Findings included...

Record review of the facility's policy titled "General Guidelines for Medication Administration/Assistance", revised 07/01/2025, showed that facility staff may assist residents with ordering and administering medication per physician orders and per state regulation.

Resident 1

Record review of Resident 1's undated demographic sheet showed that Resident 1 moved into the facility on [redacted]/2025, with a primary diagnosis of [redacted] and [redacted].

Record review of Resident 1's Negotiated Service Agreement (NSA), dated 10/14/2025, showed that the facility staff would provide Resident 1 with assistance in ordering and administering medications.

Record review of Resident 1's Medication Administration Record (MAR), dated October 2025, showed that Lyrica (medication that treats nerve pain) 50 mg tabs three times a day were ordered. The MAR showed that Resident 1 missed a total of 8 doses between the dates 10/20/20/2025 and 10/23/2025 due to the medication not available and required pharmacy action.
Record review of Resident 1's MAR, dated October 2025, showed that Divalproex (medication to treat Parkinson's disease and mood disorder, missed doses can lead to irritability, depression, unsteadiness, and seizures) 125 mg tabs two times a day had been ordered. The MAR showed that Resident 1 missed a total of ten doses between the dates 10/15/2025 and 10/27/2025 due to the medication not available and required pharmacy action.

Record review of Resident 1's facility chart notes, dated 10/23/2025, showed that Resident 1 requested to go to the emergency room due to not having their prescriptions over the last week. Resident 1 was complaining that their "legs were on fire" and had a visible left-hand tremor.

During an interview on 11/12/2025 at 10:50 AM, Resident 1 stated that their medications were "off" and that the facility had a hard time getting their pain medication ordered and felt depressed.

During an interview on 11/26/2025 at 9:10 AM Staff A, Medication Technician Aide, stated that Resident 1 arrived at the facility with limited supply of Lyrica and Divalproex and it was a challenge to receive the medications from the pharmacy Resident 1 used.

Resident 2

Record review of Resident 2's undated demographic sheet showed that they moved into the facility on [redacted]/2025, with a diagnosis of [redacted] and [redacted] diagnosed on 9/18/2025.

Record review of Resident 2's NSA, dated 11/06/2025, showed that the facility staff would provide Resident 1 with assistance with ordering and administering medications.

Record review of Resident 2's MAR, dated September 2025, showed that Methocarbamol (medication to treat muscle spasms) 500 mg tabs four times a day was ordered. The MAR showed that Resident 2 missed a total of ten doses between the dates 09/28/2025 and 09/30/2025 due to the medication not available and required

pharmacy action.

During an interview on 11/26/2025 at 9:10 AM, Staff A stated that they recalled running out of Resident 2's methocarbamol quickly due to Resident 2 receiving the medication four times a day.

During an interview on 12/01/2025 at 3:02 PM Collateral Contact 2 (CC2), Resident 2's Representative, confirmed that Resident 2 missed an unknown amount of medication for 1-2 days due to pharmacy ordering issues.

During an interview on 12/01/2025 at 4:31 PM Staff B, Administrator, acknowledged that Resident 1 and 2 had missed doses on their MAR's. Additionally, Staff B expressed that the facility was working on a system to improve their ordering and medication system to prevent residents from missing any ordered medications.

This is a recurring deficiency previously cited on 11/14/2024.

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 Yakima is or will be in compliance with this law and / or regulation on (Date) 1.2.2025 .

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

Administrator (or Representative) Lisa Owen Date 12.5.25