



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

EMERITUS CORPORATION  
Brookdale Fishers Landing  
17171 SE 22ND DR  
VANCOUVER, WA 98683

RE: Brookdale Fishers Landing License # 2261

Dear Administrator:

This letter addresses Compliance Determination(s) 58925 (Completion Date 05/02/2025) and 53921 (Completion Date 03/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/02/2025 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-2210-1-b

The Department staff who did the on-site verification:  
Yvonne Chitekwe

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just, Field Services Administrator  
Region 3, Unit I  
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.



## Residential Care Services Investigation Summary Report

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**Provider/Facility:** Brookdale Fishers Landing    **Provider Type:** Assisted Living Facility

**License/Cert. #:** 2261

**Intake ID:** 156972

**Compliance Determination #:** 53921

**Region/Unit #:** RCS Region 3 / Unit I

**Investigator:** Yvonne Chitekwe

**Investigation Date(s):** 01/29/2025 through 03/07/2025

**Complainant Contact Date(s):**

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### Allegation(s):

1. Quality of care / Treatment: allegation that the facility is not following the medication administration services correctly by not observing resident take their medications as ordered and agreed in the negotiating service agreement.

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### Investigation Methods:

|                        |                                                                                                                                                                     |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 83<br>Resident sample size: 4<br>Closed records sample size: 0                                                                                     |
| <b>Observations:</b>   | Identified resident<br>Residents<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions<br>Medication administration              |
| <b>Interviews:</b>     | Identified resident<br>Identified staff<br>Nursing staff<br>Residents<br>Family members<br>Medication technicians                                                   |
| <b>Record Reviews:</b> | Resident characteristic Roster<br>Staff List<br>Medication administration record<br>Negotiated service plans<br>Face sheets<br>Medical records<br>Facility policies |

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### Investigation Summary:

1. Quality of care / Treatment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, there is a failed facility practice that was

substantiated during the investigation when the facility failed to follow the medication administration service by not observing resident take their medications as ordered and as agreed in the negotiated service agreement.

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**Conclusion / Action:**

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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|                           |                                |                                  |
|---------------------------|--------------------------------|----------------------------------|
| Statement of Deficiencies | License #: 2261                | Compliance Determination # 53921 |
| Plan of Correction        | Brookdale Fishers Landing      | Completion Date                  |
| Page 1 of 3               | Licensee: EMERITUS CORPORATION | 03/07/2025                       |

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 01/29/2025 of:

Brookdale Fishers Landing  
17171 SE 22ND DR  
VANCOUVER, WA 98683

This document references the following complaint number(s): 156972

The following sample was selected for review during the unannounced on-site visit: 4 of 83 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Yvonne Chitekwe

From:  
DSHS, Aging and Long-Term Support Administration  
Residential Care Services, Region 3 , Unit I  
800 NE 136th Ave Ste 200  
Vancouver, WA 98684

This document was prepared by Residential Care Services for the Locator website.

3.19.2025 16:28:59

State of Washington

### Statement of Deficiencies

License #: 2261

Compliance Determination # 53921

### Plan of Correction

### Brookdale Fishers Landing

Completion Date

Page 2 of 3

Licensee: EMERITUS CORPORATION

03/07/2025

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.

Clinton Fridley  
Residential Care Services

03/19/2025

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)

3/28/2025  
Date

**WAC 388-78A-2210 Medication services.**

- (b) Develop and implement systems that support and promote safe medication service for each resident.

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the facility failed to develop and implement systems that supported and promoted safe medication service when 1 of 4 residents (Resident 1) had medications that were left, and not observed ingested, in a residents' room. This failure placed resident at risk of harm from inconsistency medication services.

### Findings included...

Record review of a facility policy, titled, "Medication & Treatment - Administration/ Assistance", dated 07/2024, stated that individual assisting with the medication should observe the resident ingesting the medication prior to documenting the administration/assistance on the resident's Medication Record, or Electronic Medication Administration Record it immediately after medication assistance.

Record review of Resident 1's (R1) Medication Administration Record (MAR), dated 01/2025, documented that R1 had multiple diagnoses including [REDACTED] ([REDACTED])

(b) (7)(C), (b) (7)(D)

This document was prepared by Residential Care Services for the Locator website

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

03/19/2025

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)

Date \_\_\_\_\_

**WAC 388-78A-2210 Medication services.**

- (1) An assisted living facility providing medication service, either directly or indirectly, must:
- (b) Develop and implement systems that support and promote safe medication service for each resident.

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the facility failed to develop and implement systems that supported and promoted safe medication service when 1 of 4 residents (Resident 1) had medications that were left, and not observed ingested, in a residents' room. This failure placed resident at risk of harm from inconsistency medication services.

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[illegible]

Statement of Deficiencies

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Brookdale Fishers Landing

Completion Date

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Licensee: EMERITUS CORPORATION

03/07/2025

Record review of R1's Medication Administration Record (MAR), dated 01/2025, documented that R1 is to be supervised with medication administration.

Record review of R1's Negotiated Service Agreement (NSA), dated 08/12/2024, documented that R1 needed assistance with medication administration.

During an unannounced visit to facility on 01/29/2025 at 11:21AM while interviewing R1, medications were observed sitting on the resident table in their room, R1 reported that a medication technician left their medication on the table in their apartment for them to take later.

On 01/29/2025 at 11:35 AM, Staff A, medication technician, stated that they had prepared R1's morning medications into a medication cup and placed them at R1's bedside table and left the room. Staff A stated that they did not wait to observe R1 take their medications.

During an interview on 01/29/2025 at 11:46AM, Staff B, Health and Wellness Director, stated that it was their expectation that medication technicians were to ensure the residents had taken their medications. Staff B indicated that Staff A should have observed R1 take their medications, and they should not have left them at bedside.

This is a recurring deficiency previously cited on 11/21/2024.

**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 Fishers Landing is or will be in compliance with this law and / or regulation on (Date) 3/28/2025.

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



Administrator (or Representative)

3/28/2025

Date

\_\_\_\_\_).

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On 01/29/2025 at 11:35 AM, Staff A, medication technician, stated that they had prepared R1's morning medications into a medication cup and placed them at R1's bedside table and left the room. Staff A stated that they did not wait to observe R1 take their medications.

During an interview on 01/29/2025 at 11:46AM, Staff B, Health and Wellness Director, stated that it was their expectation that medication technicians were to ensure the residents had taken their medications. Staff B indicated that Staff A should have observed R1 take their medications, and they should not have left them at bedside.

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\_\_\_\_\_  
Administrator (or Representative)

\_\_\_\_\_  
Date