STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

04/29/2026

EMERITUS CORPORATION
Brookdale Monroe
15465 179TH AVE SE
MONROE, WA 98272

RE: Brookdale Monroe # 2284

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 76399 (Completion Date 04/29/2026) and 71585 (Completion Date 02/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/29/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

The Department staff who did the Off Site verification:
Michelle Mcglon, Nursing Consultant Institutional

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Monroe
Provider Type: Assisted Living Facility
License/Cert.#: 2284
Compliance Determination #: 71585
Intake ID: 207535
Investigator: Michelle Mcglon
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 01/16/2026 through 02/26/2026
Complainant Contact Date(s):

Allegation(s):

1. The Named Staff (NS) reported to Named Staff 1 (NS1) that Named Resident had passed away at Assisted Living Facility (ALF) without verification from a medical professional.
2. The Named Staff 2 (NS2) was observed going into the NR's apartment, while they were hospitalized.
3. The NR was admitted to the hospital with a pressure ulcer.

Investigation Methods:

Sample:	Total residents: 74 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members
Record Reviews:	State reporting log Facility policies Resident Records Hospital records

Investigation Summary:

1. Interview and record review showed that the ALF failed to called 911 prior to notifying the NR's family representative and providing incorrect information about the resident's status. In an interview, NS1 confirmed they had reported to the NR's family the resident was deceased without a physical assessment. The facility failed to ensure staff were trained to implement the medical emergency policy. See Statement of Deficiency dated 02/26/2026.
2. In an interview, the NR's family representative confirmed nothing was taken from the apartment. In an interview, the maintenance assistant stated that the facility did not have a special lock for apartments, when the resident was in the hospital. Observation showed the ALF apartments had key locks in place. Unable to substantiate. No failed practice identified.

3. Record review of hospital records showed that the NR had impaired skin integrity. In an interview, the ALF's Health and Wellness Director stated the NR did not have a pressure ulcer. The ALF staff reported no skin concerns were observed while providing the NR with care. Unable to determine when the NR's impaired skin integrity appeared. No 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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Statement of Deficiencies	License #: 2284	Compliance Determination # 71585
Plan of Correction	Brookdale Monroe	Completion Date
Page 1 of 3	Licensee: EMERITUS CORPORATION	02/26/2026

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 01/29/2026 and 01/16/2026 of:

Brookdale Monroe
15465 179TH AVE SE
MONROE, WA 98272

This document references the following complaint number(s): 207535

The following sample was selected for review during the unannounced on-site visit: 3 of 74 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2284	Compliance Determination # 71585
Plan of Correction	Brookdale Monroe	Completion Date
Page 2 of 3	Licensee: EMERITUS CORPORATION	02/26/2026

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.

Jessie Singer
Residential Care Services

2/26/2026
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)

3/4/26
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 staff (Staff B, C, D) were trained to implement their medical emergency policy to notify 911 immediately during a suspected medical emergency. This failure placed 74 residents at risk of delayed emergency medical evaluation.

Findings include...

Record review of the ALF's policy, CPR (Cardiopulmonary Resuscitation) Policy, revised 06/2025, (provided to the Department by Staff A ((Executive Director)) as their Medical Emergency Policy) showed that in the event a resident was found to have no pulse and or not breathing an associate should call 911 immediately.

In an interview, on 01/20/2026 at 10:50 AM, Staff B (Medication Technician) confirmed that recently she had not called 911 immediately when she thought a resident was not breathing. Staff B stated she instead contacted Staff A (Health and Wellness Director). Staff B was not able to identify that 911 should be called immediately in the event a resident was found to have no pulse or not breathing.

In an interview, on 01/16/2026 at 11:57 AM, when asked what they would do if a

resident was found to have no pulse or not breathing, Staff C (Medication Technician) stated they would notify the ALF nurse. Staff C stated that they would not do anything more.

In an interview, on 01/16/2026 at 12:43 PM, when asked what they would do if a resident was found to have no pulse or not breathing, Staff D (Caregiver) stated that they would notify the nurse or medication technician. Staff C stated that they would not call 911 and would leave the responsibility to the ALF nurse or medication technician.

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 Monroe is or will be in compliance with this law and / or regulation on (Date) 4/12/2026 .

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

Administrator (or Representative) 3/4/26 Date