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

EMERITUS CORPORATION
Brookdale Admiral Heights
2326 CALIFORNIA AVE SW
SEATTLE, WA 98116

RE: Brookdale Admiral Heights License # 2306

Dear Administrator:

This letter addresses Compliance Determination(s) 71857 (Completion Date 02/19/2026) and 69400 (Completion Date 12/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/19/2026 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-2100-2-a, WAC 388-78A-2100-2-b-ii, WAC 388-78A-2100-2-b-i, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-2, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2350-7-a, WAC 388-78A-2305-1, WAC 388-78A-2305-2, WAC 388-78A-2480-1, WAC 388-78A-2474-1, WAC 388-78A-2474-2-c, WAC 388-78A-2474-3, WAC 388-78A-3011-2-b

The Department staff who did the on-site verification:
Alma Duran, Licensor
Keiko Kitano, Licensor

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 the unannounced on-site full inspection on 12/01/2025 and 12/03/2025 of:

Brookdale Admiral Heights
2326 CALIFORNIA AVE SW
SEATTLE, WA 98116

The following sample was selected for review during the unannounced on-site visit: 8 of 39 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jeanie Sturgeon
Residential Care Services

12/29/2025
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)

1/7/26
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to use an appropriate tool to annually assess the special needs related to dementia (a group of symptoms that affects memory, thinking, and interferes with daily life) for 1 of 1 sampled resident (Resident 3) and for 1 of 1 sampled resident (Resident 6) who used a medical device This placed Residents 3 and 6 at risk for not receiving proper care.

Findings included...

NOTE: Washington Administration Code 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known

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.

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.

Administrator (or Representative) | Date

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(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to use an appropriate tool to annually assess the special needs related to dementia (a group of symptoms that affects memory, thinking, and interferes with daily life) for 1 of 1 sampled resident (Resident 3) and for 1 of 1 sampled resident (Resident 6) who used a medical device. This placed Residents 3 and 6 at risk for not receiving proper care.

Findings included…

NOTE: Washington Administration Code 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known

behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility. (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of: (c) Dementia. While screening a resident for dementia, the assisted living facility must:
(i) Base any determination that the resident has short-term memory loss upon objective evidence; and (ii) Document the evidence in the resident's record.

RESIDENT 3
Record review showed that the ALF admitted Resident 3 on [redacted]/2024 with multiple diagnoses including [redacted].

Review of Resident 3's active records showed that on 10/01/2024, the ALF assessed Resident 3's dementia condition with a "Brief Interview Mental Status" (BIMS, a short and standard tool to assess person's cognitive function) and rated a score of 11/15 indicating "moderate problems with thinkings or memory". There was no annual evaluation of Resident 3's dementia condition using the BIMS or other screening tool.

In an interview, on 12/03/2025 at 2:30 PM, Staff I (Health Plus Care Manager) acknowledged that there was no documentation showing that the ALF annually assessed Resident 3's dementia condition by utilizing any
test tools.

RESIDENT 6
Review of the ALF's Bedside Mobility Aids-AL (Assisted Living) policy, last revised 12/2025, showed, "Allowed the resident use of approved bedside mobility devices with an appropriate physician/licensed prescriber order in the Assisted Living and Dementia Care areas and after review by the District Director of Operations (DDO)/ Regional Vice President (RVP)/Designee and the District Director of Clinical Services (DDCS)/Designee. The use of bedside mobility devices should be reviewed at the time of the scheduled resident evaluation, re-evaluation, upon a change in condition, and during collaborative care review ("CCR") meetings as applicable."

NOTE: The Food and Drug Administration (FDA) has issued safety alerts regarding the use of transfer poles in long-term care facilities, emphasizing the potential hazards associated with their use. Transfer poles, also known as grab bars, are designed to assist seniors with limited mobility, but they can pose risks if not used properly. The FDA has highlighted the dangers of entrapment hazards, particularly when bed rails are involved, and has provided guidelines for their assessment and use in healthcare settings. It is crucial for caregivers to assess the need for transfer poles and ensure they are used safely to prevent falls and injuries.

Record review, showed the ALF admitted Resident 6 on [redacted]/2022 with multiple

medically disabling diagnoses. Review of a Personal Service Plan (PSP – equivalent to Negotiated Service Agreement), dated 05/01/2025, showed Resident 6 had a heightened risk of falling requiring the use of a transfer pole (TP).

During an observation and interview in Resident 6's apartment, on 12/03/2025 at 11:15 AM, showed a floor-to-ceiling transfer pole positioned at the right side of the bed.

Review of the ALF's documents for Bedside Mobility Device Risk Evaluation (BMDRE), showed the form should be completed every six months to evaluate Resident 6 for mobility and transfer. The most recent BMDRE was completed on 09/12/2023.

During an exit interview, on 12/03/2025 at 3:00 PM, Staff I (Health Plus Care Manager) acknowledged the mobility device assessment was not updated to assess Resident 6's safe use of the transfer pole.

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 Admiral Heights is or will be in compliance with this law and / or regulation on (Date) 12/05/25 . 2/6/2026

JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) [signature] Date 1/7/26

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care

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

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Administrator (or Representative) Date

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(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care

or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) contained the information necessary to meet the care needs for 4 of 4 sampled residents (Residents 1, 4, 5, and 7). This placed Residents 1, 4, 5, and 7 at risk for not having their care needs met and placed them at risk for compromised health conditions.

Findings included…

NOTE: Washington Administrative Code (WAC) 388-78A-2290 Family assistance with medications and treatments. (3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum: (c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

NOTE: According to the 2025 Davis's Drug Guide for Nurses, January 2019, adverse reactions from anticoagulation therapy include unusual bleeding of the gums, bruising, black, tarry stools, nosebleeds, and vomiting blood.

RESIDENT 1
Record review showed the ALF admitted Resident 1 on [redacted]/2025 with multiple diagnoses including [redacted] and [redacted]. Review of the Service Report Plan (SPR – equivalent to Negotiated Service Agreement), dated 11/20/2025, showed Resident 1 required staff assistance with medication management.

Review of October and November 2025 electronic Medication Administration Record (eMARs), showed Resident 1 had a physician's order for Prevagen (is an over-the-counter (OTC) supplement that claims to support brain health and boost memory) daily.

During a medication pass and interview, on 12/03/2025 at 8:45 AM, Staff H (Medication Technician) stated Resident 1's Prevagen was supplied by Collateral Contact 1 (CC1- Family Member).

Review of Resident 4's SPR, dated 11/20/2025, showed no alternate plan for providing Prevagen to Resident 1 should CC1 be unavailable.

RESIDENT 4
Record review showed the ALF admitted Resident 4 on [redacted]/2025 with multiple diagnoses including [redacted] and [redacted]. Review of a Service Plan Report (SPR – equivalent to Negotiated Service Plan), dated 11/20/2025, showed Resident 4 managed their medication independently with family support.

Observation and interview, on 12/01/2025 at 1:00 PM, Resident 4 stated that a Collateral Contact 2 (CC2 - Family Member) ordered and delivered all their medications to the ALF, then placed them in a Monday through Sunday medication organizer.

Review of Resident 4's SPR, dated 11/20/2025, showed no alternate plan for providing medication service to Resident 4 should CC2 be unavailable.

Record review of electronic Medication Administration Records (eMARs) for September, October, and November 2025 showed Resident 4 received daily aspirin and clopidogrel (blood thinner medications that prevented heart attack and blood clots).

Review of Resident 4's SPR, dated 11/20/2025, showed the ALF did not have interventions in place to alert staff of the side effects and risks of bruising or bleeding related to the use of blood thinners, or what to do if bleeding or bruising were present.

RESIDENT 5
Records review showed that the ALF admitted Resident 5 on [redacted]/2025 with multiple diagnoses, including [redacted].

Records review showed that Resident 5 was required to monitor their blood sugar (BS) three times a day.

In an interview, on 12/01/2025 at 1:55 PM, Staff H (Medication Technician (MT)) stated that Resident 5's BS had been monitored by a device called Dexcom (a continuous glucose monitoring system; a sensor attaches to the skin and lasts for up to 10 days before requiring replacement), that connected to a computer tablet. Staff H stated that Resident 5's spouse had been changing the Dexcom sensor every 10 days.

In an interview, on 12/03/2025 at 9:28 AM, Staff I (Health Plus Care Manager) confirmed that Resident 5's spouse had been replacing the Dexcom sensor every 10 days.

In an interview, on 12/03/2025 at 10:35 AM, Resident 5 stated that their spouse had been changing the equipment but did not know how often.

Review of a Service Plan Report (SPR – equivalent to NSA), dated 09/16/2025, showed no plan indicating that Resident 5's spouse would replace the Dexcom sensor every 10 days, and no alternate plan stating what the ALF staff were required to do when Resident 5's spouse would not be able to provide necessary care and services for Resident 5.

In an interview, on 12/03/2025 at 2:40 PM, Staff I acknowledged there was no plan in Resident 5's SPR regarding Resident 5's Dexcom's sensor replacement by their spouse and no alternate plan for if Resident 5's spouse would not be available to do it.

RESIDENT 7
Record review showed the ALF admitted Resident 7 on [redacted]/2025 with multiple disabling diagnoses including [redacted] and [redacted]. Review of a SPR, dated 09/17/2025, showed Resident 7 required assistance with medication management.

Observation and interview, on 12/01/2025 at 1:50 PM, showed Resident 7 had noticeable bruising on the right side of their face. When asked, Resident 7 stated, "Oh, I got that because I am taking a blood thinner."

Record review of eMARs for September, October, and November 2025 showed Resident 7 received Eliquis (a medication used to prevent and treat blood clots and lower the risk of stroke) twice a day.

Review of Resident 7's SPR, dated 09/17/2025, showed the ALF did not have interventions in place to alert staff of the side effects and risks of bruising or bleeding related to the use of blood thinners, or what to do if bleeding or bruising were present.

During an exit interview, on 12/03/2025 at 3:00 PM, Staff B (Health and Wellness Director) acknowledged the SPRs for Residents 4 and 7 should include care plans related to the use of blood thinner medications, and an alternate plan for Residents 1 and 4 medication services when FMs were unavailable.

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 Admiral Heights is or will be in compliance with this law and / or regulation on (Date) 12/10/25 . 2/6/2026

JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) 12/10/25 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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems to promote safe medication services for 2 of 2 sampled residents (Resident 2 and 5) who required staff assistance with medications. This resulted in Resident 2 and 5 not receiving medications as prescribed and placed them at risk for compromised health conditions.

Findings included...

Records review showed that the ALF admitted Resident 2 on [redacted]/2023 with multiple diagnoses including [redacted] Review of a Personal Service Plan (PSP – equivalent to Negotiated Service Agreement), dated 10/01/2025, showed that Resident 2 required staff assistance with medication services.

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 Admiral Heights is or will be in compliance with this law and / or regulation on (Date)_____ .

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

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Administrator (or Representative) Date

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(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems to promote safe medication services for 2 of 2 sampled residents (Resident 2 and 5) who required staff assistance with medications. This resulted in Resident 2 and 5 not receiving medications as prescribed and placed them at risk for compromised health conditions.

Findings included…

Records review showed that the ALF admitted Resident 2 on [redacted]/2023 with multiple diagnoses including [redacted]. Review of a Personal Service Plan (PSP – equivalent to Negotiated Service Agreement), dated 10/01/2025, showed that Resident 2 required staff assistance with medication services.

Review of a Personal Services Assessment (PSA – equivalent to a Full Assessment), dated 10/01/2025, under the section for Skin Care, showed that Resident 2 experienced itching, and scabs were noted on their arms and legs. The Assessment stated Resident 2 had an ointment to help with the itching.

Review of the September, October, and November 2025 electronic Medication Administration Records (eMARs) showed that Resident 2 was prescribed multiple topical medications, including an anti-itch lotion four times a day. The eMARs showed that on multiple occasions, Staff P (Medication Technician) put a chart code of “18”, an indication to “See Medication Note”, in the columns for the anti-itch lotion.

Review of Progress Notes (PN), from 09/01/2025 through 11/30/2025, showed that Staff P documented the anti-itch lotion had been held 42 times in September 2025, 42 times in October 2025, and 25 times in November 2025.

Review of Resident 2’s active records, as of 12/02/2025, showed no physician’s order to hold the anti-itch lotion or no documentation indicating that the ALF had evaluated Resident 2’s skin condition or notified the physician that it had been held.

In an interview, on 12/02/2025 at 10:50 AM, when asked why the anti-itch lotion had been continuously held, Staff A (Executive Director/Administrator) stated that they were not aware that Staff P had been holding it. In a second interview, on 12/03/2025 at 8:10 AM, Staff A stated that because Resident 2 said their skin was not itchy, Staff P did not give the lotion and documented “held” in the eMARs.

In a follow-up telephone interview, on 12/15/2025 at 12:33 PM, Staff B (Health and Wellness Director) stated that they were not aware that Staff P had been holding the anti-itch lotion until the Department Representative brought the issue to their attention. When asked whether they had evaluated Resident 2’s skin condition, Staff B said, “No”, because Resident 2’s regular skin assessment was not due yet.

Resident 5
Records review showed the ALF admitted Resident 5 on [redacted]/2025 with multiple diagnoses including [redacted]. Review of a Service Plan Report (SPR – equivalent to Negotiated Service Agreement), dated 09/16/2025, showed that Resident 5 required staff assistance with medication services.

Review of Resident 5’s September, October, and November 2025 electronic Medication Administration Records (eMARs) showed Resident 5 was prescribed multiple medications, including losartan (used to treat high BP) once a day. The eMAR showed Resident 5’s physician ordered that losartan be held when their systolic BP (high reading of BP) was lower than 100 AND/OR pulse/heart rates (PR/HR) were lower than 60.

Review of the September, October, and November 2025 eMARs showed that the MTs, on multiple occasions, did not hold losartan when Resident 5's PR/HR were lower than 60. In September 2025, losartan was not held as ordered eight times. In October 2025, losartan was not held as ordered six times. In November 2025, losartan was not held as ordered 13 times.

When reviewing of the September, October, and November 2025 eMARs with Staff I (Health Plus Care Manager), on 12/03/2025 at 9:07 AM, Staff I stated that MTs should have held Resident 5's losartan when their PR/HRs were lower than 60.

In an interview, on 12/03/2025 at 9:28 AM, Staff H (MT) stated that MTs were required to take BP and PR/HR before giving BP medications to Resident 5 and to follow the instructions for the BP and PR/HR parameters in the eMARs.

In an interview, on 12/03/2025 at 2:40 PM, Staff I acknowledged, on multiple occasions, MTs had not held losartan when Resident 5's PR/HRs were lower than 60.

Plan/Attestation Statement

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JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) 1/7/26 Date

WAC 388-78A-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to follow a dietary order from the external provider for 1 of 1 sampled resident (Resident 8). This resulted in Resident 8 not receiving the prescribed diet since June 2025 and placed them at risk for a compromised health condition.

Review of the September, October, and November 2025 eMARs showed that the MTs, on multiple occasions, did not hold losartan when Resident 5's PR/HR were lower than 60. In September 2025, losartan was not held as ordered eight times. In October 2025, losartan was not held as ordered six times. In November 2025, losartan was not held as ordered 13 times.

When reviewing of the September, October, and November 2025 eMARs with Staff I (Health Plus Care Manager), on 12/03/2025 at 9:07 AM, Staff I stated that MTs should have held Resident 5's losartan when their PR/HRs were lower than 60.

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In an interview, on 12/03/2025 at 2:40 PM, Staff I acknowledged, on multiple occasions, MTs had not held losartan when Resident 5's PR/HRs were lower than 60.

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Administrator (or Representative) Date

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(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to follow a dietary order from the external provider for 1 of 1 sampled resident (Resident 8). This resulted in Resident 8 not receiving the prescribed diet since June 2025 and placed them at risk for a compromised health condition.

Findings included…

Records review showed that the ALF admitted Resident 8 on [redacted]/2024 with multiple diagnoses, including [redacted] and [redacted].

Review of an After Visit Summary (AVS) from the cardiologist (a medical doctor specializing in diagnosing, treating, and preventing diseases of the heart and blood vessels) visit, dated 06/25/2025, showed that the cardiologist ordered Resident 8 to limit sodium intake to less than 2 grams (gm) a day. Staff I (Health Plus Care Manager) signed and dated the AVS form indicating as they have noted the order.

In an interview, on 12/03/2025 at 11:40 AM, Staff K (Dining Services Director) stated that when any resident required a special diet, the dietary information would come from a nurse and it would be posted on the board to alert the kitchen staff. Staff K stated that there were currently no residents requiring a sodium restricted diet.

Observation, on 12/03/2025 at 11:50 AM, showed that the information of a 2 gm sodium limit diet for Resident 8 was not posted on the board in the kitchen.

Review of a Personal Service Assessment (PSA – equivalent to a Full Assessment), dated 11/10/2025, under the section of Nutrition, showed “Regular Diet” in response to the question of what diet do you or your physician believe you need. Review of a Service Plan Report (SPR – equivalent to Negotiated Service Agreement), dated 11/10/2025, showed that Resident 8 would receive a “REGULAR” diet.

In an interview, on 12/03/2025 at 2:45 PM, Staff L (District Director of Clinical Services) stated that the ALF was able to provide a 2gm sodium limited diet when it was prescribed by a physician.

In an interview, on 12/03/2025 at 2:50 PM, Staff I confirmed they had signed the AVS form for Resident 8’s dietary order but were unable to recall what they had done after that. Staff I acknowledged that the physician’s dietary order for Resident 8 had not been followed.

Statement of Deficiencies	License #: 2306	Compliance Determination # 69400
Plan of Correction	Brookdale Admiral Heights	Completion Date
Page 12 of 18	Licensee: EMERITUS CORPORATION	12/23/2025

Plan/Attestation Statement

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JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) Date 1/7/26

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure cold food temperatures (FTs) in the salad bar were maintained at a temperature of 41 degrees Fahrenheit (°F) or less and failed to ensure that 1 of 1 staff member (Staff O) had a valid food card. This placed 39 vulnerable residents at risk of foodborne illness.

Findings included...

COLD FOOD TEMPERATURES

NOTE: Washington Administrative Code (WAC) 246-215-03525 Temperature and time control—Time/temperature control for safety food, hot and cold holding (Food and Drug Administration Food Code 3-501.16). (1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained: (b) At 41°F (5°C) or less.

During lunch observation and interview, on 12/03/2025 at 12:30 PM, showed the ALF had a salad bar in the main dining room (MDR). Residents were observed to dish up their own food from the salad bar. There were two servers (Staff M and Staff N) in the MDR who served food to residents requiring assistance. When questioned on how

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 Admiral Heights is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure cold food temperatures (FTs) in the salad bar were maintained at a temperature of 41 degrees Fahrenheit (°F) or less and failed to ensure that 1 of 1 staff member (Staff O) had a valid food card. This placed 39 vulnerable residents at risk of foodborne illness.

Findings included…

COLD FOOD TEMPERATURES

NOTE: Washington Administrative Code (WAC) 246-215-03525 Temperature and time control—Time/temperature control for safety food, hot and cold holding (Food and Drug Administration Food Code 3-501.16). (1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained: (b) At 41°F (5°C) or less.

During lunch observation and interview, on 12/03/2025 at 12:30 PM, showed the ALF had a salad bar in the main dining room (MDR). Residents were observed to dish up their own food from the salad bar. There were two servers (Staff M and Staff N) in the MDR who served food to residents requiring assistance. When questioned on how

frequent food temperatures (FTs) in the salad bar were checked, Staff N stated every two hours.

Observation of the FTs taken by Staff N at 12:45 PM, with Staff K (Dining Services Manager) present, FTs showed the following readings: lettuce at 54°F, tomatoes at 48°F, fruits at 45°F, cottage cheese at 43.8°F, cheese at 46°F, cucumbers at 43.5°F, and apple sauce at 46°F. Observation showed the kitchen staff did not remove any of these foods after they were found to be above 41°F.

In an interview, on 12/03/2025 at 12:55 PM, about proper FT for cold food, Staff M and N stated they should be 41°F or below. Staff M stated when the FTs were above 41 °F, they would report to Staff K.

Review of the FT log for 11/01/2025 through 12/03/2025, showed FT readings were above consistently above 41°F. There was no documentation the foods were removed following the reading of above 41°F.

In an interview, on 12/03/2025 at 1:10 PM, Staff K acknowledged that the FTs in the salad bar were out of range, due to lack of oversight of the servers, and FT log monitoring.

FOOD WORKER CARD
Record review showed the ALF hired Staff O (Server) on 09/04/2023. Staff O's record showed that their food card expired on 08/28/2025. Review of kitchen schedules, showed Staff O worked on 12/07/2025.

In a follow-up interview, on 12/12/2025 at 9:40 AM, Staff A (Executive Director) confirmed that servers must have valid food cards because they dish up food for residents.

Plan/Attestation Statement

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JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) Date 1/7/27

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In an interview, on 12/03/2025 at 12:55 PM, about proper FT for cold food, Staff M and N stated they should be 41°F or below. Staff M stated when the FTs were above 41 °F, they would report to Staff K.

Review of the FT log for 11/01/2025 through 12/03/2025, showed FT readings were above consistently above 41°F. There was no documentation the foods were removed following the reading of above 41°F.

In an interview, on 12/03/2025 at 1:10 PM, Staff K acknowledged that the FTs in the salad bar were out of range, due to lack of oversight of the servers, and FT log monitoring.

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In a follow-up interview, on 12/12/2025 at 9:40 AM, Staff A (Executive Director) confirmed that servers must have valid food cards because they dish up food for residents.

Plan/Attestation Statement

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Administrator (or Representative) Date

Statement of Deficiencies	License #: 2306	Compliance Determination # 69400
Plan of Correction	Brookdale Admiral Heights	Completion Date
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WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 4 sampled staff members (Staff A) were screened for tuberculosis (TB) within three days of employment. This placed 39 residents at risk of exposure to a communicable disease.

Findings included...

Record review of personnel files showed the ALF hired Staff A (Current Executive Director) as the Business Office Manager/ Human Resources on 08/19/2024. Record review showed Staff A had a first step TB test given on 08/28/2024, nine days after hired date.

In an interview, on 12/03/2025 at 10:30 AM, Staff A (Executive Director) acknowledged that their TB test was late and did not meet regulation.

This is a deficiency previously cited on 06/11/2024.

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 Admiral Heights is or will be in compliance with this law and / or regulation on (Date) ~~12/3/25~~ 2/6/2026

JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) Date 1/7/26

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 4 sampled staff members (Staff A) were screened for tuberculosis (TB) within three days of employment. This placed 39 residents at risk of exposure to a communicable disease.

Findings included…

Record review of personnel files showed the ALF hired Staff A (Current Executive Director) as the Business Office Manager/ Human Resources on 08/19/2024. Record review showed Staff A had a first step TB test given on 08/28/2024, nine days after hired date.

In an interview, on 12/03/2025 at 10:30 AM, Staff A (Executive Director) acknowledged that their TB test was late and did not meet regulation.

This is a deficiency previously cited on 06/11/2024.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited

to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 2 of 2 sampled newly hired staff members (Staff B and C) received the facility orientation before having routine interaction with residents and 1 of 1 (Staff E) had specialty training for mental health. This placed 39 of 39 residents at risk of not receiving proper care and services from staff who did not complete training requirements.

Findings included…

NOTE: Washington Administrator Code (WAC) 388-78A-2450 Staff. (3) The assisted living facility must: (d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:
(i) Staff orientation and training or certification pertinent to duties, including, but not limited to: (A) Training required by chapter 388-112A WAC;

FACILITY ORIENTATION

NOTE: Washington Administrative Code (WAC) 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

Review of staff records showed the ALF hired Staff B (Health and Wellness Director) on 10/21/2025. Record showed Staff B had not completed the facility orientation.

Review of staff records showed the ALF hired Staff C (Caregiver) on 06/01/2025. Record showed Staff C had not completed the facility orientation.

SPECIALTY TRAINING

NOTE: WAC 388-78A-2500 - Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

Review of 8 sampled residents' records showed four of eight residents (Residents 1, 5, 7, and 8) had [redacted] diagnosis.

Record review showed the ALF hired Staff E (Certified Nursing Assistant / Medication Technician) on 10/06/2009. Record review showed Staff E had not complete the required mental health specialty training.

During the exit interview, on 12/03/2025 at 3:00 PM, Staff A acknowledged Staff B and C did not complete the facility orientation, and Staff E's mental health specialty training should have been completed and kept in their records.

Plan/Attestation Statement

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JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) Date 1/8/26

WAC 388-78A-3011 Resident unit furnishings.

(2) The assisted living facility may use or allow use of carpets and other floor coverings only when the carpet is:

(b) Kept clean and free of hazards, such as curling edges or tattered sections.

This requirement was not met as evidenced by:

NOTE: WAC 388-78A-2500 - Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

Review of 8 sampled residents' records showed four of eight residents (Residents 1, 5, 7, and 8) had [redacted] diagnosis.

Record review showed the ALF hired Staff E (Certified Nursing Assistant / Medication Technician) on 10/06/2009. Record review showed Staff E had not complete the required mental health specialty training.

During the exit interview, on 12/03/2025 at 3:00 PM, Staff A acknowledged Staff B and C did not complete the facility orientation, and Staff E's mental health specialty training should have been completed and kept in their records.

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-3011 Resident unit furnishings.

(2) The assisted living facility may use or allow use of carpets and other floor coverings only when the carpet is:

(b) Kept clean and free of hazards, such as curling edges or tattered sections.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the environment in 2 of 8 sampled resident apartments (Resident 6 and 7) received as-needed maintenance when observation showed significant areas of dirt and staining on the carpeting. This failure resulted in Residents 6 and 7 living in unclean conditions and placed them at risk of a diminished quality of life from a non-homelike environment.

Findings included…

RESIDENT 6
Record review of an undated Resident Characteristic Roster showed the ALF admitted Resident 6 on [redacted]/2022.

Observation and interview, on 12/03/2025 at 10:45 AM, showed Resident 6 seated in a recline chair with Collateral Contact 3 (CC3 - Family Member) present. The carpeting in Resident 6's apartment was heavily stained and covered in dark spots that resembled spills and drips. When questioned about the condition of the carpet, Resident 6 stated that the housekeepers dusted around and vacuumed the carpet weekly. CC3 stated that the carpet could use some cleaning.

In an interview, on 12/03/2025 at 3:40 PM, Staff A (Executive Director) and Staff Q (Maintenance Manager), acknowledged the stained condition of Resident 6's carpeting. Staff Q was unable to state when Resident 6's carpet last shampooed.

Resident 7
Record review of an undated RCR showed the ALF admitted Resident 7 on [redacted]/2025.

Observation and interview, on 12/03/2025 at 10:25 AM, showed Resident 7 seated in their apartment. Observation showed the carpet was unclean to sight, with three to four round shaped dark stains in the living room. When questioned about the condition of the carpeting Resident 7 stated, "The housekeepers just vacuum the carpet every week and that's all."

In an interview, on 12/03/2025 at 3:40 PM, Staff A and Staff Q acknowledged that Residents 6 and 7 apartment carpeting must be deep cleaned.

This is a deficiency previously cited on 06/11/2024.

Statement of Deficiencies	License #: 2306	Compliance Determination # 69400
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Plan/Attestation Statement

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JS confirmed amended POC with Provider on 2/4/2026.

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

Administrator (or Representative) Date 1/8/26

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Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

EMERITUS CORPORATION
Brookdale Admiral Heights
2326 CALIFORNIA AVE SW
SEATTLE, WA 98116

RE: Brookdale Admiral Heights # 2306

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 12/23/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

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

eFax: (206) 971-6791
Email: rcsregion2email@dshs.wa.gov
Optional method:
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

The Assisted Living Facility failed to secure a spray bottle of disinfectant in the ice cream bar in the main dining room accessible to 10 ambulatory residents with cognitive impairment potentially causing inadvertent ingestion and harm. This was corrected prior to the exit interview.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o You can make an IDR request and find directions on the IDR web page at:
    https://www.dshs.wa.gov/altsa/idr

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

Enclosure