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

Olympia Special Care LLC
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

RE: GARDEN COURTE ALZHEIMER COMMUNITY License # 1111

Dear Administrator:

This letter addresses Compliance Determination(s) 25423 (Completion Date 06/14/2023) and 21411 (Completion Date 04/03/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/14/2023 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-2160

The Department staff who did the on-site verification:
Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 21411
Investigator: Celeste Vashey
Investigation Date(s): 03/31/2023 through 04/03/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 74863
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
1) Facility reported fall.

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Residents Family members Nursing staff
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:
1) Based on observation, interview, and record review failed practice found. In the NSA the resident was supposed to utlize bed and chair alarms. Observation of resident not utilizing a chair alarm to notify staff when the resident was attempting to get up.

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
AGING AND LONG-TERM SUPPORT ADMINISTRATION
6639 Capitol Blvd SW, Floor 1or 1, Tumwater, WA 98501

Statement of Deficiencies	License #: 1111	Compliance Determination #:21411
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 3	Licensee: Olympia Special Care LLC	04/03/2023

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 03/31/2023 and 04/06/2023 of:

GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 73969, 74863

The following sample was selected for review during the unannounced on-site visit: 3 of 85 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
6639 Capitol Blvd SW, Floor 1or 1
Tumwater, WA 98501

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.

Cory Cisneros
Residential Care Services

04/14/2023
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) 4/20/23 Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a chair alarm as agreed upon in the Negotiated Service Agreement for 1 of 3 sampled residents (Resident 1). This failure placed the resident at risk for increased risk of falls and injury.

Findings included...

Resident 1 (R1)

Record review of Resident Characteristic Roster, undated, showed R1 admitted to the facility on [redacted]2023.

Record review of R1's Service Plan, dated 04/04/2023, under the diagnoses section showed R1 had a diagnosis of [redacted] Under the mobility section showed R1 was a high fall risk and may attempt to stand from their wheelchair. R1 was provided with bed and chair alarms upon arrival to the facility.

Record review of R1's Assistive Device Assessment, dated 02/20/2023, under assistive device utilized showed R1 had half bedrails on their hospital bed, a fall mat, chair, and bed alarms ordered by the hospice MD (Doctor of Medicine) as an intervention to try and prevent R1 from falling.

Observation on 03/31/2023 at 10:37 AM, showed R1 sitting in the activity room in their Broda (specialty) wheelchair. R1 did not have a chair alarm underneath them.

In an interview on 03/31/2023 at 10:40 AM, Staff B, Caregiver, stated R1 had a recent fall on 03/23/2023. Staff B stated R1 had a bed alarm but was unsure if R1 had a chair alarm.

In an interview on 03/31/2023 at 10:41 AM, Staff C, Caregiver, stated R1 had a bed alarm

and did not utilize a chair alarm.

In an interview on 03/31/2023 at 10:42 AM, Staff D, Caregiver, stated R1 was supposed to have a bed alarm and a chair alarm. Staff D stated the alarm on the bed was supposed to be transferred to R1's Broda wheelchair when they were utilizing the Broda wheelchair.

In an interview on 03/31/2023 at 10:43 AM, Staff C confirmed R1 did not currently have a chair alarm underneath them.

In an interview on 03/31/2023 at 11:50 AM, Staff E, Medication Technician, stated R1 had a bed alarm and chair alarm. Staff E stated the alarm on the bed was supposed to be transferred to R1's Broda wheelchair when they were utilizing the Broda wheelchair.

In an interview on 04/03/2023 at 11:22 AM, Collateral Contact 1 (CC1), POA (Power of Attorney) for R1, stated R1 was supposed to have bed and chair alarms as a device for staff to utilize.

In an interview on 04/04/2023 at 10:50 AM, Staff A, Executive Director, stated R1 was supposed to have bed and chair alarms as a device for staff to utilize.

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) MAY 14th 2023

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

Laurie Hall — Administrator (or Representative)

4/17/23 — Date