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) 48595 (Completion Date 10/11/2024) and 45544 (Completion Date 08/14/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/11/2024 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-2260, WAC 388-78A-2260-2, WAC 388-78A-2260-2-d

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

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 #: 45544
Investigator: Paul Aube
Investigation Date(s): 08/13/2024 through 08/14/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 140016
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Quality of Care/Treatment: Facility report of resident entering a staff office and ingesting another resident's medications.
2. Physical Environment: Facility report of resident entering a staff office and ingesting another resident's medications.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication Rooms
Interviews:	Nursing staff Management
Record Reviews:	Incident investigation Facility policies Negotiated Service Agreements Temporary Service Plans Progress Notes/Alert Charting Respiratory Protection Program

Investigation Summary:

1. Quality of Care/Treatment: Facility failed to follow policies and store medication properly, which resulted in resident ingesting another resident's medication. Failed practice identified.
2. Physical Environment: Facility failed to follow policies and store medication properly, which resulted in resident ingesting another resident's medication. Failed practice identified.

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

800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 1111	Compliance Determination # 45544
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 4	Licensee: Olympia Special Care LLC	08/14/2024

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 08/13/2024 and 08/14/2024 of:

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

This document references the following complaint number(s): 140016, 141788, 142246, 142243

The following sample was selected for review during the unannounced on-site visit: 5 of 90 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

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

08/21/2024
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)

8/23/24
Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on interview, and record review, the memory care facility failed to properly secure medications in a locked compartment only accessible to staff for 1 of 1 resident, (Resident 1 [R1]). This failure resulted in R1 consuming another resident's medication and placed them at risk for adverse reactions and potential injury.

Findings included...

Review of an undated facility policy titled "Security and Storage of Medications," stated, "It is the policy of the community to ensure that all medications are stored in such a way as to provide safety, security and proper environment... All medications shall be stored in locked cabinets, rooms or carts and shall be accessible only to authorized resident and personnel."

Review of R1's face sheet, dated 08/13/2024, showed R1 was admitted to the facility on [redacted]/2024.

Review of R1's Negotiated Service Plan, signed by the resident representative and a facility representative on 07/23/2024, under "Time/Place/Orientation" stated, "[R1] is alert to self only. [They have] short- and long-term memory loss." Under the section titled, "Wandering" stated, "[R1] has frequent wandering tendencies... Staff to monitor [R1] while wandering and provide redirection as needed." Under the section titled "Medication" stated "The resident's medications will be set up for administration in accord with the physician's medication/treatment orders. Community to provide medication set-up services to support safe and effective medication administration practices."

Review of an incident report for R1, dated 07/24/2024 at 4:00PM, stated, "Med tech [Medication Technician] observed this resident seated in RCM [Resident Care Manager] office at the table with a medication bottle in hand. Bottle read Escitalopram 20mg tablets. As med tech entered the room, resident was placing two pills in [their] mouth

Administrator (or Representative) Date

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and screwing the lid off the bottle back on. [Staff B, the Licensed Practical Nurse] and [Staff C, the Marketing Director] present in room with resident at the time."

Review of R1's Progress Notes, dated 07/24/2024 at 7:35PM, stated, "Med Tech attempted to get resident to spit out medication and [R1] did not comprehend the request. Resident was encouraged to drink water, eat a spoonful of peanut butter, and assisted to a safe area. Medication was identified as belonging to a family member of [another] resident that had been removed from that resident's room earlier in the day and was awaiting pickup by owner."

During an interview with Staff D, a Medication Technician, on 08/13/2024 at 11:00AM, Staff D was asked the process/location medications were kept when awaiting pick up from family. Staff D stated, "I always have it locked in the med [medication] cart. Regardless, I lock it in the med cart. You never know. Preferably double locked, in the locked med room. I would wait for the family to come to the facility, and I would get them already at that time. That way it won't get mixed up with any medications and is kept away from residents."

During an interview with Staff E, a Medication Technician, on 08/13/2024 at 11:18AM, Staff E was asked the process/location medications were kept when awaiting pick up from family, and if they were aware of the incident regarding R1. Staff E stated, "Yes, I am aware of that." Staff E was asked if they could explain the events that occurred that day regarding the incident. Staff E stated, "I was not there that day, I only heard what happened. It was in the RCM office. This resident is known to go into offices and stuff. [R1] got it and grabbed the bottle and took it." Staff E was asked if the RCM office was normally locked. Staff E stated, "The RCM office is usually locked when they were not in there. What I was told is that [Staff B] and [Staff C] was sitting in the office, and they did not see [R1] grab the bottle." Staff E was asked what they would do if they were awaiting medication pick up from a family, and where those medications would be kept. "For me I would take it to the front desk. Away from residents. That way I know the residents can't get it [because it is a locked unit]."

During an interview with Staff A, the Executive Director on 08/13/2024 at 1:15PM, Staff A was asked if they could explain the circumstances behind the incident involving R1 ingesting another resident's medications. Staff A stated, "We were admitting a resident and we set those meds out. Staff B was talking, and [R1] came in a sat down and [they] helped [themselves] to the bottle on the table. Which was not a normal thing, but [R1] was very quick." Staff A was asked if it is normal protocol for these medications to be left out, or where they should be kept elsewhere, in a locked area away from residents. Staff A stated, "All the medications are locked in the med room. The only reason they were in the RCM office that day, is that they [Staff B] were going through [doctor] orders and going through them on the table. Normally they would not be left unattended. [Staff B] just had the meds on the table because [they were] going through the medications of a new admit and matching them to the orders. There were 3 things going on at the same time and they were just not paying attention."

Statement of Deficiencies	License #: 1111	Compliance Determination # 45544
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 4 of 4	Licensee: Olympia Special Care LLC	08/14/2024

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, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 9/15/24 .

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

Lawrence Lau — Administrator (or Representative)

8/23/24 — Date

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)_____ .

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

_____ _____

Administrator (or Representative) Date