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) 47888 (Completion Date 09/26/2024) and 43018 (Completion Date 06/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/26/2024 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-2703

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

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

Sincerely,

Jody Just Jody Just Field Services Administrator signing for Cory Cisneros

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

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 # 43018
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 3	Licensee: Olympia Special Care LLC	06/25/2024

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 follow-up on 06/21/2024, 06/21/2024, and 06/25/2024 of:
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following SOD dated: 06/25/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 87 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

07/08/2024
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) 7/10/24 Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff locked the wheels on the residents' wheelchair during a transfer to prevent avoidable injuries for 1 of 2 residents (Resident 6) reviewed for safety measures. This failure placed Resident 6 at risk for sustaining avoidable injuries.

Findings included...

Review of Resident 6's face sheet showed the resident admitted to the facility on [redacted]/2023 with medical diagnoses including [redacted].

Review of Resident 6's negotiated service plan, dated 08/23/2023, documented the resident required staff assistance with her activities of daily living and transfers to and from their wheelchair.

On 06/21/2024 at 9:35 AM, Staff C, Caregiver, was observed assisting Resident 6 to transfer from the resident's wheelchair on to the toilet. Staff C did not lock the wheels on the resident's wheelchair.

In an interview on 06/21/2024 at 9:40 AM, Staff C said he did not lock the wheels on the resident's wheelchair during the transfer. Staff C stated he usually does not lock the wheels on the resident's wheelchair when assisting the resident to transfer on to the toilet because it was easier for him to pull the wheelchair back after the resident stood up. Staff C said he had been trained on wheelchair transfer safety and was not able to recall what he had been instructed.

Review of training record printed 06/21/2024 revealed Staff C had completed the "Transferring Safely" course.

In an interview on 06/21/2024 at 10:00 AM, Staff D and Staff E, Caregivers, said they had recently completed an online training on wheelchair transfer. Staff D and Staff E stated the

Administrator (or Representative) Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff locked the wheels on the residents' wheelchair during a transfer to prevent avoidable injuries for 1 of 2 residents (Resident 6) reviewed for safety measures. This failure placed Resident 6 at risk for sustaining avoidable injuries.

Findings included...

Review of Resident 6's face sheet showed the resident admitted to the facility on [redacted]/2023 with medical diagnoses including [redacted].

Review of Resident 6's negotiated service plan, dated 08/23/2023, documented the resident required staff assistance with her activities of daily living and transfers to and from their wheelchair.

On 06/21/2024 at 9:35 AM, Staff C, Caregiver, was observed assisting Resident 6 to transfer from the resident's wheelchair on to the toilet. Staff C did not lock the wheels on the resident's wheelchair.

In an interview on 06/21/2024 at 9:40 AM, Staff C said he did not lock the wheels on the resident's wheelchair during the transfer. Staff C stated he usually does not lock the wheels on the resident's wheelchair when assisting the resident to transfer on to the toilet because it was easier for him to pull the wheelchair back after the resident stood up. Staff C said he had been trained on wheelchair transfer safety and was not able to recall what he had been instructed.

Review of training record printed 06/21/2024 revealed Staff C had completed the "Transferring Safely" course.

In an interview on 06/21/2024 at 10:00 AM, Staff D and Staff E, Caregivers, said they had recently completed an online training on wheelchair transfer. Staff D and Staff E stated the

wheels on the resident's wheelchair should be locked.

In an observation on 06/21/2024 At 10:05 AM, Resident 6 was observed sitting in a wheelchair in the hallway and neatly groomed. Resident 6 was not able to provide additional details related to transfers and safety.

In an interview on 06/21/2024 at 11:45 AM, Staff B, Resident Care Coordinator, said staff had been trained to always lock the wheels on the residents' wheelchairs during transfers. Staff B stated staff members had completed an online transfer safety course. Staff B said she had been observing staff members assisting residents to transfer to ensure the residents were being transferred safely.

In an interview on 06/25/2024 at 9:15 AM, Staff A, Executive Director, said staff members had completed an online safety transfer and the wheels on the residents' wheelchairs should be locked. Staff A stated management staff members routinely observed staff members to ensure proper transfers were being done.

This was an uncorrected deficiency previously cited on 05/15/2024.

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) 7/11/24.

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

Lawrence Law — Administrator (or Representative)

7/9/24 — Date

wheels on the resident's wheelchair should be locked.

In an observation on 06/21/2024 At 10:05 AM, Resident 6 was observed sitting in a wheelchair in the hallway and neatly groomed. Resident 6 was not able to provide additional details related to transfers and safety.

In an interview on 06/21/2024 at 11:45 AM, Staff B, Resident Care Coordinator, said staff had been trained to always lock the wheels on the residents' wheelchairs during transfers. Staff B stated staff members had completed an online transfer safety course. Staff B said she had been observing staff members assisting residents to transfer to ensure the residents were being transferred safely.

In an interview on 06/25/2024 at 9:15 AM, Staff A, Executive Director, said staff members had completed an online safety transfer and the wheels on the residents' wheelchairs should be locked. Staff A stated management staff members routinely observed staff members to ensure proper transfers were being done.

This was an uncorrected deficiency previously cited on 05/15/2024.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 41348
Investigator: Phan Pham
Investigation Date(s): 05/15/2024 through 05/15/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 127987
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of care - Named resident sustained an injury to her leg during a transfer.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 5 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named resident, residents and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An investigation was conducted, and allegation identified in the intake related accident and injuries, care and services were reviewed. The facility failed to ensure staff members locked the wheels on the residents' wheelchairs during transfers to prevent avoidable injuries. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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

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 05/15/2024, 05/15/2024 and 05/15/2024 of:

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

This document references the following complaint number(s): 127987, 129022, 129911

The following sample was selected for review during the unannounced on-site visit: 5 of 80 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

05/20/2024
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) — Date: 5/23/24

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff members locked the wheels on the residents' wheelchairs during transfers to prevent avoidable injuries for 2 of 2 current sampled residents (Resident 4 and Resident 5) reviewed for safety measures. This failure placed Resident 4 and Resident 5 at risk for sustaining avoidable injuries.

Findings included...

Resident 4

Review of Resident 4's face sheet showed the resident admitted to the facility on [redacted]/2021 with medical diagnoses including [redacted].

Review of Resident 4's negotiated service plan, dated 03/15/2024, documented Resident 4 required staff assistance with her activities of daily living and transfers.

On 05/15/2024 at 9:21 AM, Staff C, Caregiver, was observed assisting Resident 4 to transfer from the resident's wheelchair on to the toilet. Staff C did not lock the wheels on the resident's wheelchair.

In an interview on 05/15/2024 at 9:43 AM, Staff C said he had been trained to lock the wheels on the resident's wheelchair when transferring a resident into the wheelchair.

Administrator (or Representative) Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff members locked the wheels on the residents' wheelchairs during transfers to prevent avoidable injuries for 2 of 2 current sampled residents (Resident 4 and Resident 5) reviewed for safety measures. This failure placed Resident 4 and Resident 5 at risk for sustaining avoidable injuries.

Findings included...

Resident 4

Review of Resident 4's face sheet showed the resident admitted to the facility on [redacted]/2021 with medical diagnoses including [redacted].

Review of Resident 4's negotiated service plan, dated 03/15/2024, documented Resident 4 required staff assistance with her activities of daily living and transfers.

On 05/15/2024 at 9:21 AM, Staff C, Caregiver, was observed assisting Resident 4 to transfer from the resident's wheelchair on to the toilet. Staff C did not lock the wheels on the resident's wheelchair.

In an interview on 05/15/2024 at 9:43 AM, Staff C said he had been trained to lock the wheels on the resident's wheelchair when transferring a resident into the wheelchair.

On 05/15/2024 at 10:30 AM, Resident 4 was observed sitting in her wheelchair in the activity room. In an interview the resident was not able to provide additional information related safety and transfers.

Resident 5

Review of Resident 5's face sheet showed the resident admitted to the facility on [redacted]/2022 with medical diagnoses including [redacted].

Review of Resident 5's negotiated service plan, dated 04/26/2024, documented Resident 5 had lower extremities weakness and required staff assistance with her activities of daily living and transfers.

On 05/15/2024 at 10:11 AM, Staff D, Caregiver, was observed assisting Resident 5 to transfer from the resident's wheelchair on to the toilet. Staff D did not lock the wheels on the resident's wheelchair.

In an interview on 05/15/2024 at 10:15 AM, Staff D said she did not lock the wheels on Resident 5's wheelchair because it was easier for her to pull the resident's wheelchair away from the resident when Resident 5 stood up.

On 05/15/2024 at 10:23 AM, Resident 5 was observed sitting in her wheelchair in the activity room. In an interview the resident was not able to provide additional information related safety and transfers.

In an interview on 05/15/2024 at 10:53 AM, Staff B, Resident Care Coordinator, said staff had been trained to always lock the wheels on the residents' wheelchairs during transfers. Staff B stated she observed staff members assist residents to transfer when she was on the floor to ensure staff were correctly transferring the residents.

In an interview on 05/15/2024 at 11:00 AM, Staff A, Executive Director, said staff members had been trained on transfers and the wheels on the residents' wheelchairs should be locked. Staff A stated management staff members routinely observed staff members to ensure proper transfers were being done.

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) 6/10/24 .

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

Laumya Nath — Administrator (or Representative)

5/23/24 — 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