



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) 60869 (Completion Date 06/10/2025) and 53259 (Completion Date 01/17/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/10/2025 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-2120, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4

The Department staff who did the on-site verification:

Paul Aube, ALF NCI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.



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 # 53259
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 5	Licensee: Olympia Special Care LLC	01/17/2025

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 01/17/2025 of:

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

This document references the following SOD dated: 01/17/2025

The following sample was selected for review during the unannounced on-site visit: 2 of 81 current residents and 0 former residents.

The department staff that inspected 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

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 1111	Compliance Determination # 53259
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 2 of 5	Licensee: Olympia Special Care LLC	01/17/2025

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

01/29/2025

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.

Laura Hall
Administrator (or Representative)

2/9/25
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the memory care Assisted Living Facility (ALF) failed to take actions after falls occurred in the community which resulted in injuries, for 2 of 2 residents reviewed (Resident [R1], and Resident 2 [R2]). This failure placed R1, R2, and other residents in the facility who were at high fall risks at risk for repeated falls and injury.

Findings included...

In an undated facility policy titled, "Reporting Incidences" under the section titled, "Procedure," it stated, "Incident Report-An incident report will be prepared for any incident or accident involving a resident to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations. The following information will be gathered: ... n. Interventions to prevent reoccurrence." Under the section titled, "Documentation" it stated, "The staff will document on the incident report the actions related to the incident. The service plan may be amended to include preventative measures to assure safety."

During an interview on 01/17/2025 at 10:30AM, Staff A, Executive Director (ED), was asked to discuss their plan of correction regarding a previous citation for the facility failing to implement fall prevention interventions. Staff A stated, "We discussed injuries of unknowns, and interventions, and how they were not actually put into the service plans as well as the TSP's [Temporary Service Plans]." Staff A was asked if there were any new interventions generated, where they would be documented/communicated to the floor staff to implement. Staff A stated, "It is placed on the TSP for staff to review."

During an interview on 01/17/2025 at 12:15PM, Staff B, Resident Care Coordinator (RCC), was asked for every resident fall, if there would be an intervention that was generated to attempt to prevent future falls. Staff B stated, "Yes we do have interventions for all falls." Staff B was asked where these interventions were documented, and how they were communicated to the floor staff. Staff B stated, "Word of mouth, and adding it to TSPs as well."

<R1>

Review of R1's Face Sheet, dated 01/17/2025, showed R1 was admitted to the facility on [REDACTED]/2024.

Review of the Incident Report for R1's non-injury fall, dated 01/13/2025 at 6:30PM, stated, "Care staff responded to resident's pressure sensor alarm at approximately 0630 this morning." Under the section titled "Incident Investigation," it listed 45 previous fall interventions that were to be in place, all with associated dates of when they were to be implemented, dating from 07/04/2024 to 01/10/2025. Under "Resident Follow-up and Prevention" it stated, "Alert Charting, TSP in place, MD [Medical Doctor] and POA [Power of Attorney] notified." In the section titled "Resident Follow Up and Prevention: Fall Reduction Interventions Implemented" it stated, "non-injurious fall." Further review of the incident report showed there was no new interventions listed for preventative measures.

Review of the TSP for R1, dated 01/13/2025, showed a form with pre-filled text which read, "Recent Fall. Injuries (List):" Under this, the following was hand-written: "0 [Zero] Concerns. Fell from [their] bed in [their] bedroom." Under the section "Instructions to Caregiver/Med Tech" it listed additional pre-filled text which read:

1. Document all shifts – See what to chart.
2. Vital Signs – B/P [Blood Pressure] and Pulse at least daily.
3. Observe & report to nurse immediately any change in mentation; balance problems; or pain
4. Have all direct care givers read and sign this service plan.
5. Other:"

There was no handwritten or personalized resident information in this section. Review of the TSP showed multiple staff signatures to confirm that they had read the TSP, but there was no additional preventative interventions added to the TSP for staff to review/implement.

<R2>

Review of R2's Face Sheet, dated 01/17/2025, showed R2 was admitted to the facility on [REDACTED]/2024.

Review of an Incident Report for R2, dated 01/16/2025 at 4:30PM, stated, "Resident was found on the floor in the alcove between the staff bathroom and med tech office at approx. 4:30 pm [on] 1/16/25... ED aware, TSP generated to alert staff." Under the section titled, "Incident Investigation," it listed 10 previous fall interventions that were to be implemented, dating from 04/05/2024 to 11/10/2024. Under the section titled "Resident Follow Up and Prevention: Fall Reduction Interventions Implemented" it stated, "non-injurious fall." Further review of the incident report showed there was no new interventions listed for preventative measures.

Review of the TSP for R2, dated 01/16/2025, showed a form with pre-filled text which read, "Recent Fall. Injuries (List):" Under this, the following was hand-written: "0 [Zero] Concerns." Under the section "Instructions to Caregiver/Med Tech" it listed additional pre-filled text which read:

1. Document all shifts – See what to chart.
2. Vital Signs – B/P [Blood Pressure] and Pulse at least daily.
3. Observe & report to nurse immediately any change in mentation; balance problems; or pain
4. Have all direct care givers read and sign this service plan.
5. Other:"

There was no handwritten or personalized resident information in this section. Review of the TSP showed multiple staff signatures to confirm that they have read the TSP, but there was no additional preventative interventions added to the TSP for staff to review/implement.

During an interview on 01/17/2025 at 12:15PM, Staff B was asked why there were no additional preventative interventions documented and communicated to floor staff on the TSP's for R1, and R2. Staff B stated they were not sure why there was no intervention listed but did state that R2 had multiple falls and currently had multiple interventions in place. Staff B then stated that they understand that new interventions should be on the TSP for floor staff and was not sure why it is not listed.

This is an uncorrected deficiency previously cited on 12/04/2024.

Statement of Deficiencies

License #: 1111

Compliance Determination # 53259

Plan of Correction

GARDEN COURTE ALZHEIMER COMMUNITY

Completion Date

Page 5 of 5

Licensee: Olympia Special Care LLC

01/17/2025

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) 2/24/25.

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

Administrator (or Representative)

Date _____

This document was prepared by Residential Care Services for the Locator website



Residential Care Services Investigation Summary Report

Provider/Facility: GARDEN COURTE
ALZHEIMER COMMUNITY
License/Cert. #: 1111

Provider Type: Assisted Living Facility

Compliance Determination #: 51110

Intake ID: 157404

Investigator: Paul Aube

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 12/03/2024 through 12/04/2024

Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility report of a resident fall with injury in the community.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Management
Record Reviews:	Facility policies Incident investigation Resident Service Plans Progress Notes

Investigation Summary:

Quality of Care/Treatment: Facility made appropriate notifications to all parties and monitored resident per policy. Facility failed to identify and document preventative interventions on the Temporary Service Plans, and notify floor staff so they may be implemented. Failed practice identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: GARDEN COURTE
ALZHEIMER COMMUNITY
License/Cert.#: 1111

Provider Type: Assisted Living Facility

Compliance Determination #: 51110

Intake ID: 154893

Investigator: Paul Aube

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 12/03/2024 through 12/04/2024

Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility report of a resident fall with injury in the community.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Management
Record Reviews:	Facility policies Incident investigation Resident Service Plans Progress Notes

Investigation Summary:

Quality of Care/Treatment: Facility made appropriate notifications to all parties and monitored resident per policy. Facility failed to identify and document preventative interventions on the Temporary Service Plans, and notify floor staff so they may be implemented. Failed practice identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: GARDEN COURTE
ALZHEIMER COMMUNITY
License/Cert.#: 1111

Provider Type: Assisted Living Facility

Compliance Determination #: 51110

Intake ID: 156825

Investigator: Paul Aube

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 12/03/2024 through 12/04/2024

Complainant Contact Date(s):

Allegation(s):

Injury of Unknown Origin: Facility report of a resident injury of unknown origin in the community.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Management
Record Reviews:	Facility policies Incident investigation Resident Service Plans Progress Notes

Investigation Summary:

Injury of Unknown Origin: Facility made appropriate notifications to all parties. Facility failed to conduct a complete a thorough investigation as to how the injury may have been sustained, or if potential abuse was suspected or ruled out, and also failed to document those investigative findings. Failed practice identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: GARDEN COURTE
ALZHEIMER COMMUNITY
License/Cert.#: 1111

Provider Type: Assisted Living Facility

Compliance Determination #: 51110

Intake ID: 154910

Investigator: Paul Aube

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 12/03/2024 through 12/04/2024

Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility report of a resident injury of unknown origin in the community.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Management
Record Reviews:	Facility policies Incident investigation Resident Service Plans Progress Notes

Investigation Summary:

Quality of Care/Treatment: Facility made appropriate notifications to all parties. Facility failed to conduct a complete a thorough investigation as to how the injury may have been sustained, or if potential abuse was suspected or ruled out, and also failed to document those investigative findings. Failed practice identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: GARDEN COURTE
ALZHEIMER COMMUNITY
License/Cert. #: 1111

Provider Type: Assisted Living Facility

Compliance Determination #: 51110

Intake ID: 154437

Investigator: Paul Aube

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 12/03/2024 through 12/04/2024

Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility report of a resident fall with injury in the community.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Management
Record Reviews:	Facility policies Incident investigation Resident Service Plans Progress Notes

Investigation Summary:

Quality of Care/Treatment: Facility made appropriate notifications to all parties and monitored resident per policy. Facility failed to identify and document preventative interventions on the Temporary Service Plans, and notify floor staff so they may be implemented. Failed practice identified.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



Residential Care Services Investigation Summary Report

Provider/Facility: GARDEN COURTE
ALZHEIMER COMMUNITY
License/Cert. #: 1111

Provider Type: Assisted Living Facility

Compliance Determination #: 51110

Intake ID: 154080

Investigator: Paul Aube

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 12/03/2024 through 12/04/2024

Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Facility report of a resident fall with injury in the community.

Investigation Methods:

Sample:	Total residents: 83 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Management
Record Reviews:	Facility policies Incident investigation Resident Service Plans Progress Notes

Investigation Summary:

Quality of Care/Treatment: Facility made appropriate notifications to all parties and monitored resident per policy. Facility failed to identify and document preventative interventions on the Temporary Service Plans, and notify floor staff so they may be implemented. Failed practice identified.

Conclusion / Action:

- ☒ 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 # 51110
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 10	Licensee: Olympia Special Care LLC	12/04/2024

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 12/03/2024 and 12/03/2024 of:

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

This document references the following complaint number(s): 154080, 154437, 156825, 154910, 154893, 157404

The following sample was selected for review during the unannounced on-site visit: 6 of 83 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

12/16/2024
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.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies

License #: 1111

Compliance Determination # 51110

Plan of Correction

GARDEN COURTE ALZHEIMER COMMUNITY

Completion Date

Page 2 of 10

Licensee: Olympia Special Care LLC

12/04/2024



Administrator (or Representative)

12/20/24

Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the memory care Assisted Living Facility (ALF) failed to evaluate and implement new preventative interventions after falls occurred in the community which resulted in injuries, for 4 of 4 residents reviewed (Resident 1 [R1], and Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]). This failure placed R1, R2, R3, R4, and other residents in the facility who are high fall risks at risk for repeated falls and injury.

Findings included...

In an undated facility policy titled, "Reporting Incidences" under the section titled, "Procedure," it stated, "Incident Report-An incident report will be prepared for any incident or accident involving a resident to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations. The following information will be gathered: ... n. Interventions to prevent reoccurrence." Under the section titled, "Documentation" it stated, "The staff will document on the incident report the actions related to the incident. The service plan may be amended to include preventative measures to assure safety."

During an interview on 12/03/2024 at 12:15PM, Staff B, the Resident Care Coordinator (RCC), was asked to explain the process or steps staff were to follow when a resident in the facility falls and an injury was suspected. Staff B stated, "If there is an obvious injury, they are not to move that resident, period. They call the Med Tech [Medication Technician]; The Med Tech comes to check on them. If they have a significant injury, vitals are taken. The caregivers stay with them, and the Med Tech calls 911. The Med Tech will report to EMS [Emergency Medical Services] what is going on, and EMS assesses the resident and decides if they need to go to the hospital." Staff B was asked what type of documentation was required to be completed when incidents like this occurred. Staff B stated, "Incident Report, and a chart note. They have to get a witness report for whoever found the resident. They do the incident report on-line, if there is an

injury they do a state report online, and then document all of the notifications. We do a TSP [Temporary Service Plan] also." Staff B was asked if new, preventative interventions were put into place after each resident fall. Staff B agreed this was correct. Staff B was asked how the new interventions were communicated to all the floor staff so the interventions could be implemented, and where they were documented. Staff B stated, "The TSP would show the new intervention. Staff are to look at this every day. It needs to go on there." Staff B was asked if there was any other location floor staff were to look for any updates to resident care. Staff B stated that the care plan/Service Plan would show other care needs and updates and stated that staff were also to check it daily.

During an interview on 12/03/2024 at 12:45PM, Staff C, a caregiver, was asked what type of documentation was required of them to be completed when incidents such as a fall with injury occurred. Staff C stated, "We do a witness statement for this, and write down everything that we saw, and give it to the Med Tech." Staff C was asked if new, preventative interventions were put into place after each resident fall. Staff C stated, "Yes." Staff C was asked where they would look to find that information. Staff C stated, "In the TSP book." Staff C was asked where they would go to find out information on additional care needs of all residents, or other interventions/instructions. Staff C stated, "The care plans, which are located in the med [medication] room." Staff C was asked how often the care plan was checked for any updates for residents. Staff C stated, "If there is a new resident, or if the Med Tech or shift change reported any changes in the resident, we would look at it. But we check TSP's every day."

During an interview on 12/03/2024 at 12:54PM, Staff D, a caregiver, was asked if new, preventative interventions were put into place after each resident fall and where they would go to find this information. Staff D stated, "We have a Temporary Service Plan binder. It says in there the updates when there was a change in the resident." Staff D was asked how often the Temporary Service Plan Binder is checked. Staff B stated, "Every day."

<R1>

Review of R1's Face Sheet, dated 12/03/2024, showed that the resident was admitted to the facility on [REDACTED]/2024.

Review of a progress note for R1, dated 11/28/2024 at 9:21PM, showed, "Resident have been added to alert due to a minor injury fall that happened today 11/28/24 around 2030 Hours (8:30PM) in [R1's] bedroom apartment... resident was found on the floor laying down with [their] face facing down and [they] had a bruise on [their] left arm and a very minor one on [their] fore head... TSP developed, resident paced on alert and progress note made."

Review of the Incident Report for R1's injury fall, dated 11/28/2024, under the section titled "Incident Investigation," it listed 36 previous fall interventions that were to be in place, all with associated dates of when they were to be implemented, dating from 07/04/2024 to 11/21/2024. Under the section titled "Resident Follow Up and Prevention: Fall Reduction Interventions Implemented" it stated, "Frequent Checks." There was no

specific information documented on the timing and frequency to which the resident would be checked.

Review of a TSP for R1, dated 11/28/2024, showed a form with pre-filled text which read, "Recent Fall. Injuries (List):" Under this, the following was hand-written: "Bruise, left hand/elbow. Bruise, forehead. Minor Bruise Injury Forehead." Under the section "Instructions to Caregiver/Med Tech" it listed additional pre-filled text which read:

"1. Document all shifts – See what to chart.

2. Vital Signs – B/P [Blood Pressure] and Pulse at least daily.

3. Observe & report to nurse immediately any change in mentation; balance problems; or pain

4. Have all direct care givers read and sign this service plan.

5. Other:"

There was no handwritten or personalized resident information in this section. Review of the TSP showed multiple staff signatures to confirm that they have read the TSP, but there were no additional (or historical) preventative interventions added to the TSP for staff to review/implement.

Review of R1's Service Plan Agreement, last signed on 11/14/2024, showed no additional fall prevention interventions after their fall on 11/28/2024.

<R2>

Review of R2's Face Sheet, dated 12/03/2024, showed that the resident was admitted to the facility on [REDACTED]/2023.

Review of an Incident Report for R2, dated 11/05/2024 at 7:00AM, it stated, "Resident had just gotten up for day. Caregiver reports [they] turned back to resident to grab [their] glasses, and as [they] turned around, [they] observed [R2] loose balance and fall over... Caregiver reports resident fell on right side, producing skin tear above right elbow, hit head causing small bump... TSP generated and resident was added to alert." Under the section titled, "Incident Investigation," it listed 9 previous fall interventions that were to be in place, which were not dated. Under the section titled "Resident Follow Up and Prevention: Fall Reduction Interventions Implemented" it stated, "Other: Help resident stand."

Review of a TSP for R2, dated 11/05/2024, showed a form with pre-filled text which read, "Recent Fall. Injuries (List):" Under this, the following was hand-written: "Bump to Head, Skin Tear to right elbow." Under the section "Instructions to Caregiver/Med Tech" it listed additional pre-filled text which read:

"1. Document all shifts – See what to chart.

2. Vital Signs – B/P [Blood Pressure] and Pulse at least daily.

3. Observe & report to nurse immediately any change in mentation; balance problems; or pain

4. Have all direct care givers read and sign this service plan.

5. Other:"

Under numeral 5, there was a handwritten note that stated, "monitor s/sx (signs and symptoms) pain." Review of the TSP showed multiple staff signatures to confirm that

they have read the TSP, but there were no additional (or historical) preventative interventions added to the TSP for staff to review/implement.

Review of R2's Service Plan Agreement, last signed on 11/14/2024, showed no additional fall prevention interventions after their fall on 11/05/2024.

<R3>

Review of R3's Face Sheet, dated 12/03/2024, showed that the resident was admitted to the facility on [REDACTED]/2023.

Review of an Incident Report for R3, dated 11/02/2024 at 4:03PM, under the section titled, "Incident Investigation," it stated, "Resident had a fall where [they] [were] found lying down on the floor in the hallway near the break room where [they] [were] found by one of the care staff. Med tech checked and observed [R3] on the floor and called 911." It listed 21 previous fall interventions that were to be in place, all with associated dates of when they were to be implemented, dating from 12/29/2023 to 10/31/2024. There was a 22nd intervention listed which stated, "Hospice to evaluate medications." Under the section titled "Resident Follow Up and Prevention: Fall Reduction Interventions Implemented" it stated, "Other: Place in recliner to sleep."

Review of a TSP for R3, dated 11/02/2024, showed a form with pre-filled text which read, "Recent Fall. Injuries (List):" Under this, the following was hand-written: "0 [zero]." Under the section "Instructions to Caregiver/Med Tech" it listed additional pre-filled text which read:

1. Document all shifts – See what to chart.
2. Vital Signs – B/P [Blood Pressure] and Pulse at least daily.
3. Observe & report to nurse immediately any change in mentation; balance problems; or pain
4. Have all direct care givers read and sign this service plan.
5. Other:"

There was no handwritten or personalized resident information in this section. Review of the TSP showed multiple staff signatures to confirm that they have read the TSP, but there were no additional (or historical) preventative interventions added to the TSP for staff to review/implement.

Review of R3's Service Plan Agreement, last signed on 10/09/2024, showed no additional fall prevention interventions after their fall on 11/02/2024.

<R4>

Review of R4's Face Sheet, dated 12/03/2024, showed that the resident was admitted to the facility on [REDACTED]/2022.

Review of an Incident Report for R4, dated 11/01/2024 at 10:30AM, it stated, "Resident had a found on floor with injury. Resident was found on the floor in [their] room, laying on [their] right side. Resident stated that [they] did hit [their] head and shoulder. Vitals

were taken and paramedics were called. Resident has mark on the right side of [their] temple that was bleeding.” Under the section titled, “Incident Investigation,” it listed 24 previous fall interventions that were to be in place, which were not dated. Under the section titled “Resident Follow Up and Prevention: Fall Reduction Interventions Implemented” it stated, “Walker next to bedside.”

Review of TSP for R4, dated 11/01/2024, showed a form with pre-filled text which read, “Recent Fall. Injuries (List):” Under this, the following was hand-written: “Mark on Right side of temple. Fall with Injury.” Under the section “Instructions to Caregiver/Med Tech” it listed additional pre-filled text which read:

- “1. Document all shifts – See what to chart.
2. Vital Signs – B/P [Blood Pressure] and Pulse at least daily.
3. Observe & report to nurse immediately any change in mentation; balance problems; or pain
4. Have all direct care givers read and sign this service plan.
5. Other:”

There was no handwritten or personalized resident information in this section. Review of the TSP showed multiple staff signatures to confirm that they have read the TSP, but there were no additional (or historical) preventative interventions added to the TSP for staff to review/implement.

Review of R4’s Service Plan Agreement, last signed on 10/16/2024, showed no additional fall prevention interventions after fall on 11/01/2024.

During an interview on 12/03/2024 at 12:15PM, Staff B was asked why there were no additional preventative interventions documented and communicated to floor staff on the TSP’s for R1, R2, and R3. Staff B stated that they were not sure why it was not on the TSP and stated that it should be documented there. Staff B was asked how floor staff would know to implement fall prevention interventions if it was not documented for them to review on the TSP. Staff B stated that they agreed that the floor staff would not know to implement them.

During an interview on 12/03/2024, at 1:04PM, Staff A, the Executive Director, was asked if new, preventative interventions were created for all resident falls. Staff A confirmed this was the expectation of staff. Staff A was asked where the new interventions were documented, and how they were communicated to floor staff to implement. Staff A stated, “That should be put in the TSP, and placed in the TSP book, which staff are to check every shift.” Staff A was notified that new interventions were not included on the reviewed resident TSP’s. Staff A was asked how staff could implement new interventions to prevent resident falls if those interventions were not effectively communicated to them. Staff A stated that they noticed the lack of interventions when providing the TSP’s for Department review, and stated, “I agree.”

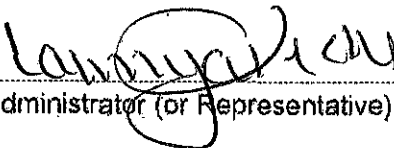
This is a recurring deficiency, previously cited on 01/11/2024 for subsection (4).

This document was prepared by Residential Care Services for the Locator website.

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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) 11/01/25.

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


Administrator (or Representative)

12/20/24
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

- (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the memory care Assisted Living Facility (ALF) failed to document and determine the investigative findings to rule out the possibility of abuse or neglect, and failed to document preventative measures to prevent recurrence, for 2 of 2 residents reviewed (Resident 5 [R5], and Resident 6 [R6]). These failures placed R5, R6, and other residents in the facility who experienced injuries of unknown origin at risk for ongoing or unidentified abuse or neglect.

Findings included...

In an undated facility policy titled, "Policy and Procedure Abuse," under the "Purpose" it stated, "To ensure that all residents are treated with respect and dignity and live in a community that is free of verbal, sexual, or physical abuse, corporal punishment, neglect, involuntary seclusion, misappropriation of funds, or theft of property by any person." Under "Definition of Abuse and Neglect" it defined physical abuse as, "Any physical injury to a resident caused by other than an accident. Physical injuries include injuries that a reasonable and prudent person would be able to prevent such as hitting, pinching or striking, or injury resulting from rough handling or corporal punishment. Instances of abuse are presumed to have caused physical injury including pain to the resident who including resident are incapable of expressing injury or pain." Under the section "Conclusion of Analysis of Investigation," it stated, "Administrator, licensed nurse/ RCM (Resident Care Manager) and others as deemed appropriate by Administrator will review the documentation and determine if: Investigation was thorough and complete, if allegation of abuse is substantiate [SIC]"

During an interview on 12/03/2024 at 12:15PM, Staff B, the Resident Care Coordinator (RCC), was asked to explain the process or steps staff are to follow when a resident is found to have an injury with an unknown origin. Staff B stated, "If staff finds a bruise (or other injury), they alert the Med Tech (Medication Technician), they [also] alert me. We put [the resident] on alert [charting]. We notify the MD (Medical Doctor), or Hospice to come see the resident. We make sure they haven't had any falls to make sure that may have caused the bruising [or other injury]. I have a form that I have staff fill out, an "Injury of Unknown Source" form. We rule out abuse, or any possibility of a resident-to-resident [altercation], or if [the injury] was visualized." Staff B was asked who was responsible at the facility to conduct the investigation. Staff B stated that they themselves conduct investigations for residents on the South Side of the facility, and another RCC conducts the investigations for the North Side residents. Staff B was asked where the investigation findings were documented after the investigation was completed. Staff B stated that they were trained to place the summary of the investigation in the "Incident Investigation" section of the Incident Report in the comments section, to which it should include all of the investigative findings.

During an interview on 12/03/2024, at 1:04PM, Staff A, the Executive Director, was asked to explain the process and expectation for the investigation into a resident's injury of unknown origin. Staff A stated that in the past they did not have a clear process to show all of the steps taken during an investigation. Staff A stated, "We created an extra form for injuries of unknown origin to interview all staff that were on shift and try and investigate what happened." Staff A stated that staff who had worked with the resident in previous days would be interviewed and asked if they knew how this injury occurred. Staff A stated that typically, through most of the investigations and injuries, "we figure out." Staff A was asked where the investigation findings would be documented once the investigation was completed. Staff A stated they were to be documented in the ending portion of the Incident Report."

Review of R5's Face Sheet, dated 12/03/2024, showed that the resident was admitted to the facility on [REDACTED]/2024.

Review of an Incident Report for R5, dated 11/23/2024 at 4:35PM, under the section titled, "Initial Record of Incident", under the subheading "Describe what you saw and heard" it stated, "Floor was clear of clutter. Floor was dry. Sitting in common hallway by the medication room." Under "Were there apparent injuries?" it stated, "Yes. Bruise found." Under the section titled, "Incident Investigation," under the subheading, "Contributing Factors" it listed, "Dementia, Impaired safety Judgement, Lack of safety awareness." At the end of the Incident Report, under the "Comments" section it stated, "Resident has a large bruise on right side of head in hairline and a medium bruise by the right outer eye. Caregiver informed Med Tech about the bruising. Resident was asked what had happened, resident was unable to verbalize incident due to being a poor historian. Med tech checked resident for other injuries with none found. Med tech asked LPN (Licensed Practical Nurse) to look at resident, LPN found no further injuries." Further review of the "Incident Investigation" portion of the incident report showed no additional investigation as to how the injury may have been sustained, or if potential abuse was suspected or ruled out.

Review of the Injury of Unknown Origin forms for R5, dated 11/23/2024, showed five separate questionnaires given to staff to answer. The pre-typed questions included:

1. Did you witness the incident?
2. Did the resident state what happened to you?
3. Did you notice any injury or injuries?
4. Was anyone else around?
5. Any concerns of abuse or neglect?
6. Anything significant at the time that you noticed?
7. Did or is the resident complaining of pain?
8. Any witnessed or report of Resident-to-Resident [Altercation] with reported resident at the time of injury/suspected injury?

Review of all five forms collected from five different staff, showed a handwritten response of "No" listed as the answer for all 8 questions. Further review of the Injury of Unknown Origin forms showed that there was no other additional information included.

Review of R6's Face Sheet, dated 12/03/2024, showed that the resident was admitted to the facility on [REDACTED]/2021.

Review of an Incident Report for R6, dated 11/10/2024 at 9:30AM, under the section titled, "Initial Record of Incident", under the subheading "Describe what you saw and heard" it stated, "Resident has 1 small bruise on front of left hip, and 1 medium bruise on left lower leg (Bruise on side of calf)." Under the section titled, "Incident Investigation," under the subheading, "Contributing Factors" it listed, "Altered mental status, Cognitive impairment, Fragile Skin, frequently self-transfers, Gait/balance impairment, history of bruising easily, Impaired mental status, Impaired mobility, Impaired self judgement." At the end of the Incident Report, under the "Comments" section it stated, "Staff have noted a small bruise on left front of hip, as well as a medium sized bruise on side of left shin from 11/10/24. While assisting resident with a shower, staff observed skin injury. Resident reluctant to take a shower, a second caregiver assisted, and resident did agree to shower. Upon med tech skin check, it was noticed that resident has a small bruise on left front of hip, and a medium sized bruise on side of left shin. Resident denied pain associated with, and states [they] [were] not sure how they got there." Further review of the "Incident Investigation" portion of the incident report showed no additional investigation as to how the injury may have been sustained, or if potential abuse was suspected or ruled out.

Review of the Injury of Unknown Origin forms for R6, dated 11/10/2024, showed five separate questionnaires given to staff to answer. The pre-typed questions included:

1. Did you witness the incident?
2. Did the resident state what happened to you?
3. Did you notice any injury or injuries?
4. Was anyone else around?
5. Any concerns of abuse or neglect?
6. Anything significant at the time that you noticed?
7. Did or is the resident complaining of pain?
8. Any witnessed or report of Resident-to-Resident [Altercation] with reported resident at the time of injury/suspected injury?

Review of all five forms collected from five different staff, showed a handwritten

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response of "No" listed as the answer for all 8 questions. Further review of the Injury of Unknown Origin forms showed that there was no other additional information included.

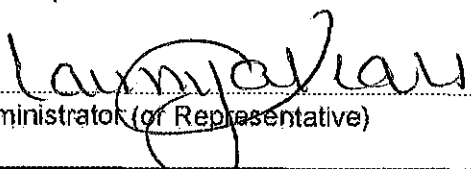
During an interview on 12/04/2024, at 1:52PM, Staff A was asked if they felt that the investigations into R5, and R6's injuries of unknown origin represented a complete, and thorough investigation. Staff A stated, "It doesn't give a complete summary afterwards." Staff A was notified upon review of the Incident Report, that the "Incident Investigation" section did not indicate any investigation was completed. Staff A was again asked if they felt the investigations were thorough and complete. Staff A stated, "No, it's not complete... There should be a clear A to Z of the conclusion of what we think the injury came from. There is not a clear conclusion." Staff A was asked if they felt that the possibility of abuse of R5, and R6 could definitively be ruled out after the investigation. Staff A stated, "After going over that with [the RCC] and the residents, yeah." Staff A was asked if they could provide any documentation to validate this, including those resident interviews. Staff A stated, "I can't because it was not complete."

This is a recurring deficiency previously cited on 08/04/2023 and 06/14/2022.

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) 11/01/25.

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


Administrator (or Representative)

12/20/24
Date