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

01/17/2025

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

RE: GARDEN COURTE ALZHEIMER COMMUNITY # 1111

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 53258 (Completion Date 01/17/2025) and 47873 (Completion Date 09/30/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/17/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

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 #: 47873
Investigator: Paul Aube
Investigation Date(s): 09/27/2024 through 09/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 148766
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Resident/Patient/Client Abuse: Public allegation of sexual abuse towards a resident by facility staff.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Management
Record Reviews:	Facility policies Incident investigation Personnel files Staff training records Staff Schedules Resident Care Plans Resident Progress Notes/Alert Charting

Investigation Summary:
Resident/Patient/Client Abuse: Facility started an investigation after allegations were made, but failed to make a report to the Department. Failed practice identified.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Statement of Deficiencies	License #: 1111	Compliance Determination # 47873
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 3	Licensee: Olympia Special Care LLC	09/30/2024

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 09/27/2024 and 10/02/2024 of:

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

This document references the following complaint number(s): 148766, 148770

The following sample was selected for review during the unannounced on-site visit: 2 of 89 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

10/08/2024
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.

Laumya Keau 10/15/24

Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the memory care Assisted Living Facility (ALF) failed to make a report to the Department when they became aware of an allegation of sexual abuse from a staff person to residents in the community for 2 of 2 residents reviewed (Resident 1, [R1], and Resident 2, [R2]). This failure resulted in the Department being unable to investigate the allegations/actions taken by the facility, and placed R1, R2, and other residents in the facility at risk for ongoing emotional distress, and sexual abuse.

Findings included...

Record review of an undated facility policy titled, "Policy and Procedure: Abuse", under the section titled, "Definition of Abuse and Neglect". it defined sexual contact as, "including fondling of a resident by an employee, agent or other resident by force, threat duress or coercion, or sexual contact with a resident who has no ability to consent." Under the section titled "What to do if you witness or suspect abuse has occurred" it stated, "Ensure the safety of the resident. Separate the resident and the person allegedly abusing the resident. Immediately report the alleged abuse to your supervisor/manager on duty or Adult Protective Services."

Review of Department records showed a reported concern, dated 09/26/2024, that stated R1 was seen guarding their genital area during care and reported that R1 complained that their genital area hurt after Staff B, a caregiver, cared for them. Further review of Department records showed no report made by the facility for any allegations of sexual abuse of a resident.

During an interview with Staff A, the Executive Director, on 09/27/2024 at 10:36AM, Staff A was asked if they were aware of any allegations of sexual abuse of a resident involving Staff B. Staff A stated "Yes, Monday [09/23/2024] a staff member came to us." Staff A continued, "We have a couple of different stories. We have a story from [a staff member] that said there were things that [Staff B] was doing, and making the resident

feel uncomfortable like rubbing on [their] arms etc. They felt [Staff B] was very touchy, like rubbing residents' arms and touching their face. There was also an incident where a staff said that it appeared [Staff B] kissed another resident on the mouth." When asked which resident this was involving, Staff A stated, "[Resident 1]." Staff A was asked which resident Staff B was alleged to have kissed. Staff A stated that Staff B was alleged to have kissed [Resident 2]. Staff A was asked if there was any report made to them of R1 guarding their genital area or reporting that their genital area was hurt/sore after Staff B cared for them. Staff A stated "No one has said anything about that to me. [Staff] felt [R2] is sore when they have done care. But they were talking more about [R2's] legs." Staff A was asked why the allegations were not reported to the Department after they became aware on 09/23/2024. Staff A stated, "I was going to report it, but I was waiting to get all of the information." Staff A was asked within what time frame allegations of abuse should be reported. Staff A stated, "I planned on reporting it this morning [09/27/2024], that allegations were made."

During another interview with Staff A on 09/27/2024 at 1:05PM, Staff A was asked if a staff person kissing a memory care resident would be considered sexual abuse. Staff A stated, "It could." Staff A was asked within what time frame the sexual allegations should have been reported to the Department. Staff A stated, "I understand, in hindsight, that the allegation should have been reported [to the Department] right away."

This is a recurring deficiency previously cited on 11/29/2021.

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) 10/22/24

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

[signature] 10/15/24

Administrator (or Representative) Date