STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 75501 (Completion Date 04/07/2026) and 70904 (Completion Date 02/19/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/07/2026 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-2600-1-b

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

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

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community Nurse 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 #: 70904
Investigator: Pamela Horlick
Investigation Date(s): 01/05/2026 through 02/19/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 206976
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Report of resident being found on the floor with an injury.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 6 Closed records sample size: 1
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Resident care manager Business office manager
Record Reviews:	State reporting log Incident investigation Facility policies assessment careplan services provided face sheet Medication administration record Temporary care plan (TSP) staff list staff schedule

Investigation Summary:
Quality of Care/Treatment: Facility failed to follow the residents care plan and document safety checks being completed. Failed practice identified.

Conclusion / Action:

- [x] 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
Compliance Determination #: 70904
Investigator: Pamela Horlick
Investigation Date(s): 01/05/2026 through 02/19/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 206730
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Injury of unknown origin: Report of a resident sustaining an injury with an unknown origin.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 6 Closed records sample size: 1
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Resident care manager Business office manager
Record Reviews:	State reporting log Incident investigation Facility policies assessment careplan services provided face sheet Medication administration record Temporary care plan (TSP) staff list staff schedule

Investigation Summary:
Injury of unknown origin: Facility failed to provide safety checks in accordance with the residents care plan. Failed practice identified.

Conclusion / Action:

- [x] 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
Compliance Determination #: 70904
Investigator: Pamela Horlick
Investigation Date(s): 01/05/2026 through 02/19/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 206083
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Restraints/Seclusion: Report of resident being restrained with medication.
2. Quality of Care/Treatment: Report of resident sustaining injury.
3. Falsification of records/reports: Report of facility falsifying documents.
4. Resident/patient/client neglect: Report of resident not being monitored.
5. Death- General: Report of resident passing away.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 6 Closed records sample size: 1
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Resident care manager Business office manager
Record Reviews:	State reporting log Incident investigation Facility policies assessment careplan services provided face sheet Medication administration record Temporary care plan (TSP) staff list staff schedule

Investigation Summary:

1. Restraints/Seclusion: Facility followed directive from provider when administering medications. Unable to substantiate failed practice.
2. Quality of Care/Treatment: Facility failed to monitor resident appropriately after sustaining an injury from a fall. Failed practice identified.
3. Falsification of records/reports: After interview and record review, unable to substantiate failed practice.
4. Resident/patient/client neglect: Facility failed to follow the negotiated services agreement in regard to safety checks. Failed practice identified.
5. Death- General: Facility followed their process by contacting appropriate parties when a resident on hospice passed. Unable to substantiate failed practice.

Conclusion / Action:

- [x] 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
Compliance Determination #: 70904
Investigator: Pamela Horlick
Investigation Date(s): 01/05/2026 through 02/19/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 208355
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Facility report of resident falling and sustaining injury.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 6 Closed records sample size: 1
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Resident care manager Business office manager
Record Reviews:	State reporting log Incident investigation Facility policies assessment careplan services provided face sheet Medication administration record Temporary care plan (TSP) staff list staff schedule Physician orders Laboratory test/results

Investigation Summary:

Quality of Care/Treatment: Facility failed to follow physician orders after resident had multiple falls. 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
HOME AND COMMUNITY LIVING ADMINISTRATION
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 01/05/2026 and 01/15/2026 of:

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

This document references the following complaint number(s): 206083, 206730, 206976, 207494, 208012, 208355, 208565

The following sample was selected for review during the unannounced on-site visit: 6 of 81 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator
Clinton Fridley, Community Nurse Field Manager

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 1111	Compliance Determination # 70904
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 2 of 7	Licensee: Olympia Special Care LLC	02/19/2026

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.

Clinton Fridley RN
Residential Care Services

02/25/2026
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)

2/26/26
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure staff were documenting safety checks in response to falls for 3 of 3 residents (Resident 1 (R1), Resident 2 (R2), Resident 3 (R3)) and failed to ensure staff completed a urine sample to check for infection for 1 of 4 residents (Resident 3). These failures resulted in the facility being unable to validate that interventions were implemented for R1, R2 and R2, resulted in R3's urine not be collected and tested until 10 days after initial order, and placed residents at risk for continued falls, injuries, untreated infections, decrease in quality of life and adverse health side effects.

Findings included...

<Safety Checks>

Record review of facility policy titled "Policy Point of Care Implementation and Use," undated, states that services that require staff accountability, such as activities of daily living (ADL's) and safety checks, must be scheduled by shift and include the time needed for each service. All care staff, including med techs, must have a logon for POC (a mobile application used for documenting ADLs) access to document/chart assigned services. All care staff will receive training on how to review service plans and confirm services.

On 01/22/2025 at 1:06 PM, Staff A, Executive Director, stated that all ADL's performed by care staff, during their shift, should be documented in POC. Staff A stated that by documenting the ADL's, per shift, the care staff are attesting that they completed the care planned tasks for their shift.

Resident 1

Record review of facility records show that R1 admitted on [redacted]/2025.

Record review of R1's service plan, dated 09/12/2025, showed that safety checks to be completed four times per shift.

Record review of progress notes for R1 dated 12/05/2025 showed that R1 returned from the hospital on the evening of 12/04/2025 after treatment for a head injury and left orbital fracture.

Record review of the facility document titled "Resident Incident Report," dated 12/04/2025, showed that R1 was found after unwitnessed fall, transferred to the emergency department where R1 was found to have suffered head trauma and a broken eye socket. R1 returned and placed on alert and a Temporary Service Plan (TSP) initiated for safety checks, does not indicated frequency of safety checks.

Review of a Temporary Service Plan (TSP) for R1 dated 12/04/2025 showed that care staff were to do safety checks. The plan did not say how often the checks should be completed.

Record review of progress notes for R1 dated [redacted]/2025 showed that R1 was found in the room lying in bed with a bleeding bump on the forehead and was sent to the hospital for evaluation.

Record review of the facility document titled "Resident Incident Report," dated [redacted]/2025, showed that R1 was found lying in bed with a large bleeding bump on the forehead. R1 was transported to the hospital, where a fractured vertebra and a forehead laceration requiring sutures were identified.

Record review of progress notes for R1 dated [redacted]/2025 showed that R1 returned from the hospital after treatment for a neck fracture, a bruise, and a cut on the forehead and was admitted to hospice services (care focused on comfort and not cure).

Record review of progress notes for R1 dated [redacted]/2025 showed that R1 passed away.

In an interview on 01/23/2026 at 4:00 PM, Staff A stated that R1 previously had safety checks care planned, and that if a TSP adds safety checks as an intervention, then safety checks should have been increased, by two additional safety checks, per shift.

In an interview on 01/23/2026 at 4:00 PM, Staff A stated that R1 was on safety checks four times per shift, or about once every two hours. Staff A stated the facility runs three shifts daily.

A review of facility document "Service Received" for R1, undated, showed that planned safety checks were not documented as completed for all shifts on the following dates:
• 12/04/2025: documentation was missing for two shifts.
• 12/05/2025: documentation was missing for all shifts.
• 12/06/2025: documentation was missing for two shifts.
• 12/07/2025 – 12/09/2025: documentation was missing for all shifts every day.
• 12/10/225: documentation was missing for one shift.
• 12/11/2025 – 12/18/2025: documentation was missing for all shifts each day.

In an interview on 01/05/2026 at 8:57 AM, Staff B, Resident Care Manager (RCM), stated staff are not required to document safety checks.

In an interview on 01/05/2026 at 1:08 PM, Staff C, caregiver, stated that they don't document that safety checks are completed.

In an interview on 01/05/2026 at 11:32 AM, Staff D, caregiver, stated that there is not a specific place to document that safety checks were completed.

In an interview on 01/05/2026 at 3:21 PM, Staff E, caregiver, stated they do not document safety checks anywhere and that documenting safety checks is not required.

In an interview on 01/23/2026 at 4:00 PM, Staff A stated there is no documentation showing safety checks were completed daily for R1. Staff A stated staff did not follow the process and did not check off the tasks they were supposed to. Staff A stated it is expected that staff mark off each task every shift, including safety checks, to show they were completed.

R2

Record review of facility records show that R2 admitted on [redacted]/2024.

Record review of R2's service plan, dated 03/14/2025, showed that safety checks to be completed four times per shift.

Record review of R2's progress notes documented the resident suffered falls on 11/13/2025, 11/14/2025, 11/15/2025, 11/30/2025 and 12/26/2025.

Record review of the facility document titled "Resident Incident Report," dated 11/13/2025, showed that R2 was found lying on the floor in their room. Care staff were instructed to perform safety checks when R2 was in their room to ensure their safety.

Review of a Temporary Service Plan (TSP) for R2 dated 11/13/2025 showed that care staff were to do safety checks. The plan did not say how often the checks should be completed.

In an interview on 01/28/2026 at 2:08 PM, Staff A stated R2's care plan required safety checks four times per shift and that the TSP started on 11/13/2025 should have specified increased safety checks.

A review of facility document "Service Received" for R2, undated, showed that planned safety checks were not documented as completed for all shifts on the following dates:
• 11/13/2025 – 11/18/2025: documentation was missing for all shifts each day.
• 11/19/2025 – 11/20/2025: documentation was missing for two shifts each day.
• 11/21/2025 – 11/27/2025: documentation was missing for all shifts each day.
• 11/28/2025: documentation was missing for two shifts.
• 11/29/2025-12/04/2025: documentation was missing for all shifts each day.
• 12/05/2025 – 12/06/2025: documentation was missing for two shifts each day.
• 12/07/2025 – 12/11/2025: documentation was missing for all shifts each day.
• 12/12/2025: documentation was missing for two shifts.
• 12/13/2025 – 12/15/2025: documentation was missing for all shifts each day.
• 12/16/2025: documentation was missing for two shifts.
• 12/17/2025 – 12/18/2025: documentation was missing for all shifts each day.
• 12/19/2025 – 12/20/2025: documentation was missing for two shifts each day.
• 12/21/2025: documentation was missing for all shifts.
• 12/22/2025: documentation was missing for two shifts.
• 12/23/2025 – 12/30/2025: documentation was missing for all shifts each day.
• 12/31/2025: documentation was missing for two shifts.

In an interview on 01/29/2026 at 3:16 PM, Staff A stated there is no documentation showing safety checks were completed four times daily for R2. Staff A Stated it is expected that staff mark off each task every shift, including safety checks, to show they were completed.

R3

Record review of facility records show that R3 admitted on [redacted]/2025.

Record review of R3's service plan, dated 12/09/2025, showed that safety checks to be completed four times per shift.

Record review of the facility document titled "Resident Incident Report," dated 12/30/2025, showed R3 was found lying on the floor next to their bed, covered in blood. R3 was taken to the hospital and arrived back to the facility after having stitches to their forehead.

Review of a Temporary Service Plan (TSP) for R3 dated 12/30/2025 showed that care staff were to do safety checks. The plan did not say how often the checks should be completed.

Record review of progress notes for R3 dated 12/30/2025 showed that the resident was found on the floor with a head injury and sent to the hospital. The resident returned to the facility after receiving stitches for a cut to the forehead.

Record review of progress notes for R3 dated 12/31/2025 showed that the resident was found on the floor next to their bed.

A review of facility document "Service Received" for R3, undated, showed that planned safety checks were not documented as completed for all shifts on the following dates:
• 12/30/2025 – 01/27/2026: documentation was missing for all shifts each day.

In an interview on 01/29/2026 at 3:16 PM, Staff A stated there is no documentation showing safety checks were completed four times daily for R3. Staff A Stated it is expected that staff mark off each task every shift, including safety checks, to show they were done. Staff A stated normally the RCM's normally audit to make sure staff document tasks but admitted there has been a lack of follow-through.

<Complete Provider Order>

Record review of facility policy titled "Receiving/Documenting Prescribed Orders," undated, stated that staff will follow up on provider orders to ensure they are followed.

Record review of fax notification from R3's primary care physician (PCP), dated 12/31/2025, showed an order to get a urinalysis (UA) with culture and sensitivity because of multiple falls.

Review of progress notes for R3 did not show documentation that the UA was completed.

In an interview on 01/21/2026 at 12:54 PM, Staff F, Licensed Practical Nurse, stated R1's PCP ordered a UA on 12/31/2026 due to R3's multiple falls and that the sample was obtained on 01/01/2026. The UA sample was left at the front desk, in the designated laboratory box that is supposed to be picked up by the laboratory courier. Staff F stated that the UA sample was not collected and that they did not receive notification of the missed pick up. Staff F stated another UA sample and delivered the sample to the hospital laboratory to be tested on 01/10/2026.

On 01/21/2026 at 12:54 PM Staff F stated there was a delay in treatment which could possibly have caused R3's falls on 01/09/2026 and 01/10/2026. Staff F stated R3's PCP was not aware of the mishap until yesterday 01/20/2026 and they should have been notified sooner. Staff F stated the process of ensuring orders are followed up on is broken and that this UA sample fell through the cracks which caused a delay in treatment for R3.

In an interview on 02/04/2026 at 12:05 PM, Staff A stated there should have been better communication and that the ball got dropped when the sample was left in the laboratory box to be picked up. Staff A stated the person that put the UA sample in the laboratory box should have made sure it was picked up. Staff A stated they were not sure exactly what happened but there was a part of the process that did not get followed through. Staff A stated R4 was having a decline in functioning and there was a delay in treatment due to the UA sample not being tested timely.

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) 3/31/26.

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

Administrator (or Representative) — Date: 2/24/24