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

09/09/2025

Caring Places Management, LLC
Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

RE: Artesian Place # 2542

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 65136 (Completion Date 09/09/2025) and 61809 (Completion Date 07/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/09/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

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

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

The Department staff who did the On Site verification:
Anissa Bearden, Licensor

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

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse 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 #: 2542	Compliance Determination #:61809
Plan of Correction	Artesian Place	Completion Date
Page 1 of 5	Licensee: Caring Places Management, LLC	07/01/2025

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 06/26/2025 of:
Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

This document references the following SOD dated: 07/01/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 60 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor

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

Statement of Deficiencies	License #: 2542	Compliance Determination # 61809
Plan of Correction	Artesian Place	Completion Date
Page 2 of 5	Licensee: Caring Places Management, LLC	07/01/2025

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.

Clinton Fridley
Residential Care Services

07/14/2025
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.

Administrator (or Representative)

7.16.25
Date

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

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to secure medications for 1 of 3 sampled residents (Resident 1 [R1]). This failure placed R1 at risk for improper medication administration and possible incorrect record keeping due to unsecured medications not controlled by the facility.

Findings included...

Record review of the facility's policy titled, "Medication Administration," undated, under the section titled, "Procedure for Medication Service-A-Self Administration with Assistance," showed staff were responsible for supervision of medication and must always sign the medication log which indicated the medication was taken appropriately. Staff were to inform the resident that they were entering, unlocking medication cupboard, take out the medication, hand the container to the resident, instruct and observed the resident to ensure the prescribed amount was taken, provide water, and observe the resident swallow the medication or apply the medication and then return the medication in the cupboard, lock up and document.

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," dated 06/26/2025, showed 20 of 60 residents were noted to have dementia (a condition that effects thinking, remembering, reasoning, and effects daily life)/Alzheimer's (condition causing memory loss and reduced functional abilities)/Cognitive Impairment (condition affecting thinking, memory, and decision-making).

Record review of the facility's "Plan of Correction," undated, showed it was a plan of correction for complaint investigation dated 04/18/2025 for WAC 388-78A-2260 for storing, securing, and accounting for medications. The actions the facility took were that they sent out letters to the families and residents as reminder of the facility's medication policy. Staff were to monitor medications in the resident's rooms that receive assistance with medications from staff and report to the resident care coordinator and administrator.

Record review of the "Department of Social and Health Services" document, completion date 04/18/2025, showed, "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2260] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Administrator, signed the document on 04/30/2025. Staff A signed the "Plan/Attestation Statement" for all citations cited that read, "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, [the facility] is or will be in compliance with this law and/or regulation on 06/02/2025."

Record review of R1's "Resident Info Sheet," undated, showed R1 moved into the facility on [redacted]/2023 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R1's, "Medication Evaluation," dated 06/13/2025, showed the reason for the evaluation was for routine check. The evaluation showed R1 did not feel comfortable administering their own medications. R1 was determined to have the staff assist R1 with administering their medications that included oral, topical, inhalers, and drops. This evaluation was completed by Staff B, Resident Care Coordinator.

Record review of R1's, "Medication Self-Administration Evaluation", dated 06/13/2025, showed R1 was unable to correctly read medication labels and/or identify each medications, R1 was unable to correctly state what each medication was for, unable to state what time a medication was to be taken, unable to correctly measure the appropriate amount of medication from the container, unable to demonstrate secure storage of medications kept in the room, unable to correctly document the administration of as needed medications, and was unable to identified the time to refill prescriptions. Under the section titled, "evaluation results", showed R1 was deemed unable to safely self-administer medications. The evaluation was completed by Staff C,

Registered Nurse.

Record review of R1's, "Service Agreement Quarterly Update," dated 06/13/2025, under the section titled, "medical care management," showed staff were to assist R1 with their medications. Staff were to store, order, and reorder medications from the house pharmacy. Staff were to assist R1 with as needed medications. On 04/02/2025 R1 was experiencing occasional pain in their knees. Staff were to offer as needed pain medications. Under the section titled, "transfers," showed on 03/31/2025 that R1 was experiencing pain in their right knee and was sent to the local hospital emergency room for further evaluation.

In an observation and interview on 06/26/2025 at 12:42 PM, upon entering R1's apartment, on the right side of the room was a wooden rolling top desk dresser. The desk was open and on top was a foil package that was undated when it was open with purple labeled ipratropium bromide and albuterol sulfate nebulizer solution , a bottle that stood upright with the labeled Flonase, one oval inhaler that had a label of Trelegy that showed it had three doses left, and another inhaler albuterol sulfate inhaler that showed it had 120 doses left. R1 stated they took all their inhalers by themselves. R1 stated they gave themself the Flonase nasal spray daily they thought. R1 stated they took the inhalers four times a day. R1 stated there was one inhaler that you had to click that they took only daily. R1 stated the facility staff provided them their medication that they took with applesauce. R1 stated that the medications technicians are the ones that put the nebulizer solution medication into the nebulizer machine canister for them to take they think four times daily as needed. On the bedside table next to the nebulizer machine and R1's bed was a white pill bottle with no lid that had a label of "Tylenol extra strength 500 milligram tablets," inside the bottle it was noted that only ten percent of the bottle remained. The tablets were white with red lettering "Tylenol" was printed on them. R1 stated that they took the two tablets of the Tylenol to help with the pain in their hips and knees. R1 thought they could take Tylenol two times a day and that the facility also brings her some Tylenol to take as well. R1 was unable to state when they last took the Tylenol or how many times a day they took the Tylenol. R1 stated they did not write down when they took the Tylenol.

In an interview on 06/26/2025 at 1:49 PM, Staff D, Medication Aide, stated R1's medications were administered by the facility. Staff D stated R1 has their Trelegy inhaler in their room. Staff D stated R1 was not cleared to have any medications in their room. Staff D stated if the facility staff observed a resident to have medications in their room, they were trained to let management know to address the medications. Staff D stated it was a concern for any residents to have medications in their room especially if the facility provides the medication.

In an interview on 06/26/2025 at 2:00 PM, Staff B stated the facility provided R1 their medications. Staff B stated R1 had not been cleared to do any medication administration themselves or store medication in their room. Staff C stated it was concerning that R1 was administering Tylenol themselves, and that the facility had been providing it to them.

Statement of Deficiencies	License #: 2542	Compliance Determination # 61809
Plan of Correction	Artesian Place	Completion Date
Page 5 of 5	Licensee: Caring Places Management, LLC	07/01/2025

This is an uncorrected deficiency previously cited on 04/18/2025.

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, Artesian Place is or will be in compliance with this law and / or regulation on (Date) 8.13.25 .

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

Angela Pitts 7.16.25

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Artesian Place
Provider Type: Assisted Living Facility
License/Cert.#: 2542
Compliance Determination #: 57635
Intake ID: 171339
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 04/08/2025 through 04/18/2025
Complainant Contact Date(s):

Allegation(s):
Nursing Services: Report of concern related to medication administration and storage practices.

Investigation Methods:

Sample:
Total residents: 50
Resident sample size: 4
Closed records sample size: 0

Observations:
Identified resident
Residents
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Identified resident
Nursing staff
Residents
Social services staff

Record Reviews:
State reporting log
Facility policies
MAR
Care Plan

Investigation Summary:
Based on observation, interview and record review, the facility failed to ensure safe medication practices after it was discovered residents were keeping medications in their room when they weren't care planned to do so. Failed practice identified.

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

Statement of Deficiencies	License #: 2542	Compliance Determination # 57635
Plan of Correction	Artesian Place	Completion Date
Page 1 of 6	Licensee: Caring Places Management, LLC	04/18/2025

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 complaint investigation on 04/08/2025 and 04/18/2025 of:

Artesian Place
828 McPhee Rd SW
Olympia, WA 98502

This document references the following complaint number(s): 171339

The following sample was selected for review during the unannounced on-site visit: 4 of 50 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

Statement of Deficiencies	License #: 2542	Compliance Determination # 57635
Plan of Correction	Artesian Place	Completion Date
Page 2 of 6	Licensee: Caring Places Management, LLC	04/18/2025

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

04/24/2025
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.

Administrator (or Representative)

4.30.2025
Date

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

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to secure medications for 3 of 3 sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). This failure placed all 50 of 50 residents at risk of potential ingestion of potentially harmful substances, presented risk for misuse of medications by residents, staff, or visitors, and placed all residents at risk for medical complications.

Findings included...

Record review of the facility's policy titled, "Medication Administration", undated, under section titled, "Procedure for Medication Service-A-Self Administration with Assistance," showed, "Staff will assist residents who are on Medication Service A to obtain medication via reminding, coaching or, help to prepare a medication for administration.
Assistance may include:
1) Opening a container
2) Using an enabler or placing the medication in the Resident's hand.
3) Assistance with applying or instilling skin, nose, eye and ear preparation.
4) Steady or guide a Resident's hand to assist with medications,..
Staff responsible for supervision of medication service under category A must always

sign medication log indicating medication was taken appropriately. If medication is refused, the medication log must show the refusal.
Procedure:
1) Inform the Resident of the reason that you're coming.
2) Take out medication (mediset, blister pack, etc.) from the medication cart and, open if needed.
3) Hand container to Resident.
4) Instruct/observe Resident. Check to assure prescribed amount was taken.
5) Provide water and observe client swallow pills/apply medication.
6) Return medication and document."

Record review of the Resident Characteristic Roster, dated 04/08/2025 showed next to R1, R2 and R3's name, in the column labeled "Medication: Ind (I), Assist (A), Adm. (Ad), Fam (F)" showed, "A". The roster showed R1, R2, and R3 received medication assistance.

<R1>

Review of R1's face sheet, undated, showed R1 was admitted to the facility on [redacted]/2021. Under, "Medication administration," showed "A-Self with Assistance."

Record review of R1's Service Agreement, dated 02/22/2025, under "Medical Care Management," showed "A-Self with Assistance." Under "Assistance required," showed: "Staff to administer all medications per MD (Doctor of Medicine) order."

Record review of R1's Medication Administration Record (MAR), dated 04/08/2025 showed R1 was received Systane Balance Eyedrops and Acetaminophen (pain relief medication).

In an interview and observation on 04/08/2025 at 10:56 AM, R1 was asked if the facility helped them with their medications, they stated yes. R1 stated the Medication Technician just gave them their medications. On a table to the left of the recliner that R1 was sitting in, were 2 bottles of Tylenol (pain relief medication). On the table behind the recliner was a box of Systane eye drops. On a dresser, up against a wall was a full bottle of Dayquil cold and flu medicine.

<R2>

Review of R2's face sheet, undated, showed R2 was admitted to the facility on [redacted]/2023. Under, "Medication administration," showed "A-Self with Assistance."

Record review of R2's Service Agreement, dated 02/22/2025, under "Medical Care

Management," showed "A-Self with Assistance." Under "Assistance required," showed: "Store, order, and re-order all medications for Resident, Assist with medication as ordered, hand whole medications to Resident, observe swallow, do not leave meds unattended with resident."

In an interview on 04/08/2025 at 10:40 AM, R2 was asked if the facility helps them with their medications, they stated yes. R2 stated the facility maintained the medication schedule and brought them their medications. R2 was asked if they store any medications in their room, they stated Tylenol.

In an observation and interview on 04/08/2025 at 12:18 PM, R2 had a bottle of Tylenol (Acetaminophen) in a drawer in their room. R2 stated they had vitamins in their bathroom medicine cabinet. In the medicine cabinet were numerous bottles of vitamins, supplements and medication to include Potassium, magnesium, glucosamine, vitamin B, Vitamin E, Vitamin D, Dayquil capsule gels(used for cold and flu symptoms), melatonin (sleep aid), and turmeric (anti-inflammatory).

Record review of R2's MAR, dated 04/08/2025 showed R2 had Acetaminophen tablet ordered to take 2 tablets by mouth every 6 hours as needed for mild discomfort or a temperature above 99.5. There were no orders for R2 to take Potassium, magnesium, glucosamine, Vitamin B, Vitamin E, Vitamin D, Dayquil capsule gels, melatonin or turmeric.

<R3>

Review of R3's face sheet, undated, showed R3 was admitted to the facility on [redacted]/2024. Under, "Medication administration," showed "A-Self with Assistance."

Record review of R3's Service Agreement, dated 02/22/2025, under "Medical Care Management," showed "A-Self with Assistance."

In an interview and observation on 04/08/2025 at 10:48 AM, L-Lysine bottle of 250 tablets and a bottle of melatonin (sleep aid) 90 tablets were on the counter next to the microwave in R3's room. On a table next to the resident was a bottle of Emergen C (supplement), a bottle of Daily energy CoQ10 with Goji berry (supplement), and a bottle of centrum silver 50+ (multivitamin). R3 was asked if the facility helps them with their medications, they stated, yes.

Record review of R3's MAR, dated 04/08/2025, showed R3 did not have an order for L-lysine tablets , Melatonin, Emergen C, Daily Energy Coq10 with Goji berry, or centrum silver men 50+.

In an interview on 04/08/2025 at 11:02 AM, Staff C, Medication Technician, was asked if there were residents who were able to store medications in their rooms, they stated there were a few that can but most of them were not supposed to. Staff C was asked if residents could have Tylenol in their rooms, they stated usually not. Staff C stated they knew R1 had Tylenol in their room again. Staff C was asked if R1 was care planned to have Tylenol (acetaminophen) in their room, they stated, that was a good question, I believe they were. Staff C was asked to look at R1's MAR. Staff C was asked if it stated on the MAR if R1 could have Tylenol in their room, they stated it didn't say. Staff C stated that R1's daughter could have brought it in but did not give it to staff. Staff C was asked if residents could have a bottle of Dayquil, they stated, usually not. Staff C stated there was family who would bring stuff in. Staff C was asked if R1 could have their Systane eyedrops in their room, they stated R1 self administered their eyedrops, they always had.

In an interview on 04/08/2025 at 11:29 AM, Staff B, Medication Technician, was asked to explain what the "A" meant on the characteristic roster in the column labeled "Medication: Ind (I), Assist (A), Adm. (Ad), Fam (F)." Staff B stated it means assist. Staff B was asked if they were an "assist", would the residents have medications in their room, they stated they didn't think so. Staff B was asked if it would be on the care plan if they could have medications in their room, they stated yes.

In a joint interview on 04/08/2025 at 12:38 PM, Staff A, Executive Director, was asked what the "A" meant on the roster in the medication column, they stated, they assist the resident by administering the medication. Staff A was asked if R1 would have medications or vitamins in their room, they stated they should not. Staff A stated R1's family was notorious for bringing in things per their request. Staff A was asked if Tylenol and Dayquil would be stored in the medication cart for a resident, they stated, yes it should be, unless the order stated that they could self-medicate. Staff A was asked if there was an order for R1 to self-administer Tylenol, they stated, no. Staff A was asked if R1 could self-administer Dayquil, they stated no, R1 didn't even have an order for Dayquil. Staff A was asked if R2 could have Tylenol or vitamins in their room to self-administer, they stated no they should not. Staff A was asked if R3 self-administers any medications to themselves, they stated, no, nothing we have on file or on record.

In an interview on 04/08/2025 at 1:35PM, Staff A was asked if R1 could have eyedrops in their room, they stated no they should not be in their room.

Statement of Deficiencies	License #: 2542	Compliance Determination # 57635
Plan of Correction	Artesian Place	Completion Date
Page 6 of 6	Licensee: Caring Places Management, LLC	04/18/2025

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, Artesian Place is or will be in compliance with this law and / or regulation on (Date) ~~June 8th, 2025~~ LP June 2nd, 2025

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

Administrator (or Representative) [signature] Date 4.30.25