STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

BFG Puyallup MC Propco LLC
Fieldstone Memory Care of Puyallup
2121 S Meridian
Puyallup, WA 98371

RE: Fieldstone Memory Care of Puyallup License # 2561

Dear Administrator:

This letter addresses Compliance Determination(s) 35210 (Completion Date 01/25/2024) and 26092 (Completion Date 10/05/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/25/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120-3-b

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Fieldstone Memory Care of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2561
Intake ID: 87776
Compliance Determination #: 26092
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 06/30/2023 through 10/05/2023
Complainant Contact Date(s):

Allegation(s):
1. Staff was holding down residents arms and forcing her to brush her teeth

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Resident representative X 3 failed attempts Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records Staff progress notes Incident log / reports, Facility P & P Abuse/Neglect

Investigation Summary:
1. Per record review, observations and interviews with collateral contacts and staff, the facility failed to monitor resident's well being after a staff member held her arms down during care. Failed facility practice identified. See Statement of Deficiency dated 10/05/2023.

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: Fieldstone Memory Care of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2561
Intake ID: 88029
Compliance Determination #: 26092
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 06/30/2023 through 10/05/2023
Complainant Contact Date(s):

Allegation(s):

1. Staff was holding down residents arms and forcing her to brush her teeth

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records Staff progress notes Incident log / reports, Facility P & P Abuse/Neglect

Investigation Summary:

1. Per record review, observations and interviews with collateral contacts and staff, the facility failed to monitor resident's well being after a staff member held her arms down during care. Failed facility practice identified. See Statement of Deficiency dated 10/05/2023.

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: Fieldstone Memory Care of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2561
Intake ID: 87996
Compliance Determination #: 26092
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 06/30/2023 through 10/05/2023
Complainant Contact Date(s):

Allegation(s):

1. Staff slapped resident on the face during care.

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Resident representative Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records Staff progress notes Incident log / reports, Facility P & P Abuse/Neglect

Investigation Summary:

1. Per record review, observations and interviews with collateral contacts and staff, the facility failed to monitor resident's well being after a staff member hit resident in the face. Failed facility practice identified. See Statement of Deficiency dated 10/05/2023.

Conclusion / Action:

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

STATE OF WASHINGTON
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PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2561	Compliance Determination # 26092
Plan of Correction	Fieldstone Memory Care of Puyallup	Completion Date
Page 1 of 4	Licensee: BFG Puyallup MC Propco LLC	10/05/2023

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 06/30/2023 and 09/25/2023 of:

Fieldstone Memory Care of Puyallup
2121 S Meridian
Puyallup, WA 98371

This document references the following complaint number(s): 87776, 88029, 87996

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

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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.

Residential Care Services

10/06/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Date

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:

(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.

This requirement was not met as evidenced by:

Based on record reviews, observations and interviews, the Assisted Living Facility (ALF) failed to monitor residents' psychosocial and mental wellbeing after incidents involving a staff member for 3 of 3 sampled residents (Residents 1, 2 & 3). This failure placed all 3 residents at risk for emotional distress and not receiving appropriate care in a timely manner.

Findings Included…

Record review of Resident 1's (R1) face sheet on 06/30/2023 showed that R1 was admitted to the ALF with diagnoses to include [redacted] Review of facility incident reports showed that on 06/30/2023 a staff member held down R1's wrist while assisting R1 with brushing her teeth. Further review of R1's progress notes showed no documentation that R1 was monitored for emotional harm or latent injuries.

Record review of Resident 2's (R2) face sheet on 06/30/2023 showed that R2 was admitted to the ALF with diagnoses to include [redacted] Review of facility incident reports showed that on 06/28/2023, a staff member grabbed R2's wrist tightly to where the resident responded with an expletive. Further review of R2's progress notes showed no documentation that R2 was monitored for emotional harm or for latent injuries.

Record review of Resident 3's (R3) face sheet on 06/30/2023 showed that R3 was admitted to the ALF with diagnoses to include [redacted] Review of facility incident reports showed that on 06/03/2023, a staff member struck R3 on her face. Further review of R3's progress notes showed no documentation that R3 was monitored for emotional harm or latent injuries.

An observation on 06/30/2023 at 9:40am noted bruises to R1's bilateral arms.

During an interview on 06/30/2023 at 9:45am, Staff C, Caregiver was asked if any resident

was being monitored for emotional harm or latent injuries. Staff C stated he was not aware of anyone on alert. When asked how R1 had sustained bruises to her arms, Staff C stated he did not know what happened. Staff C was asked if they received any report about staff being aggressive with or hitting residents, or any incident that occurred involving residents and staff. Staff C stated he was not aware of any incident involving staff and residents.

During an interview on 06/30/2023 at 9:50am, Staff D, Caregiver stated that she was not aware of how R1 sustained bruises. When asked if any residents were on alert, Staff D stated she was not aware of anyone being on alert. Staff D was asked if staff received a report on residents that were in a staff related incident or those who had any incidents. Staff D stated that nothing was mentioned in report. Staff D stated she was not aware of any incidents involving a staff member and residents.

During an interview on 06/30/2023 at 10:30am, Staff E, Medication Technician stated that they were not aware of staff incidents with R2 or R3. Staff E stated that they heard about R1's incident from another staff member. When asked if all three residents should had been placed on alert, Staff E stated that they should and did not know why they were not. When asked if there was a temporary care plan to address potential harm or latent injuries, Staff E stated there was not.

During an interview on 06/30/2023 at 10:30am, Staff B, Assistant Director for Nursing stated that when there was a resident incident, it would be investigated, and resident would be placed on alert. Staff B stated that it would be documented in progress notes. When asked how R1 sustained bruises to arms, Staff B stated, “I don’t have anything, she scratches herself.” When reminded that skin issues were not scratches but bruises, Staff B did not provide an answer. Staff B was asked if all three residents were placed on alert for emotional harm and latent injuries. Staff B stated they were not. Staff B stated she should have placed them on alert and had no reason why she didn’t.

During an interview on 06/30/2023 at 10:50am, Staff A, Administrator stated that an investigation should be conducted whenever there was a resident incident. Staff A stated that residents would be placed on alert, and it would be documented. When asked if R1, R2, and R3 should have been placed on alert after a staff member held down R1’s and R2's hands, and one staff member hitting R3 on her face, Staff A stated that they “probably should.” When asked why residents were not monitored after those incidents for emotional harm, Staff A stated nursing should have placed them on alert. Staff A stated she did not know why residents were not being monitored for emotional and physical harm.

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, Fieldstone Memory Care of Puyallup is or will be in compliance with this law and / or regulation on (Date) 11/20/23 .

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

Sandra Short — Administrator (or Representative)

10/12/23 — Date

PLAN OF CORRECTIONS

Community Name: Fieldstone Memory Care **Survey/Investigation Date:** 10/6/23

Plan of Correction

Regulation #	Deficient System or Standard	Action Plan	Team Member's Name	Estimated date of completion	Signature/Date
WAC 388-78A-2120	Monitoring Residents' Well - Being	**Review Policy on Alert Charting/Monitoring**	ED/DNS/ADNS/ RCC/caregiver/ Med tech or designee	10/18/2023 & Ongoing	Sandra Stuart 10/12/23

FIELDSTONE COMMUNITIES

PLAN OF CORRECTIONS

		Education done with staff on documentation/monitoring	ED/DNS/ADNS/ RCC Or designee	11/24/2023 & Ongoing	Sandra Scott 10/12/23
		Audit Weekly	ED/DNS/ADNS	11/24/2023	Sandra Scott 10/12/23

FIELDSTONE COMMUNITIES

PLAN OF CORRECTIONS

FIELDSTONE COMMUNITIES