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

BFG Silverdale Propco V LLC
Fieldstone Memory Care of Silverdale
11313 Clear Creek Rd NW
Silverdale, WA 98383

RE: Fieldstone Memory Care of Silverdale License # 2583

Dear Administrator:

This letter addresses Compliance Determination(s) 32402 (Completion Date 11/08/2023) and 29357 (Completion Date 09/25/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/08/2023 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-2260-2, WAC 388-78A-2260-2-d

The Department staff who did the on-site verification:
Cathleen Davis, ALF Licensor

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 Silverdale
Provider Type: Assisted Living Facility
License/Cert.#: 2583
Intake ID: 91909
Compliance Determination #: 29357
Region/Unit #: RCS Region 3 / Unit D
Investigator: Cathleen Davis
Investigation Date(s): 09/11/2023 through 09/25/2023
Complainant Contact Date(s):

Allegation(s):
On 7-28-2023 methadone was left in resident room for another resident.

Investigation Methods:

Sample:	Total residents: 140 Resident sample size: 3 Closed records sample size: 3
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Business office manager
Record Reviews:	Medical records State reporting log Facility policies Incident investigation

Investigation Summary:
Interview and record review determined the facility did not secure the scheduled II medication, methadone. This medication was delivered to the wrong resident. Record Review of the incident report showed the unsecured medication was found in the wrong resident's room. Record review of the facility policy showed the scheduled II medication was left in the Assisted Living Facility resident room. This was a failed facility practice cited under WAC 388-78A-2260.

Conclusion / Action:

- [x] 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 #: 2583	Compliance Determination # 29357
Plan of Correction	Fieldstone Memory Care of Silverdale	Completion Date
Page 1 of 3	Licensee: BFG Silverdale Propco V LLC	09/25/2023

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 09/11/2023 and 09/25/2023 of:

Fieldstone Memory Care of Silverdale
11313 Clear Creek Rd NW
Silverdale, WA 98383

This document references the following complaint number(s): 91909

The following sample was selected for review during the unannounced on-site visit: 3 of 140 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Cathleen Davis, ALF Licensor

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

09/26/2023
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.

Statement of Deficiencies	License #: 2583	Compliance Determination # 29357
Plan of Correction	Fieldstone Memory Care of Silverdale	Completion Date
Page 2 of 3	Licensee: BFG Silverdale Propco V LLC	09/25/2023

Stephanie Perry
Administrator (or Representative)

10.4.2023
Date

WAC 388-78A-2260 Storing, securing, and accounting for 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 interviews, and record reviews the Assisted Living Facility (ALF) failed to develop and implement a safe medication system to ensure medication was secured for 1 of 2 sampled residents (Resident 1, R1). This failure placed R1 at risk for potential medical decline.

Findings included...

On 09/12/2023 a record review of the facility policy, SECTION "N" Nursing Services Policies & Procedures revised July 7, 2017, provided by Staff A (Executive Director), stated on page 12 under Control and Accountability of Narcotics, "It is the policy of the facility to maintain accountability for all schedule II and schedule III narcotics that are prescribed and provided to residents."

On 09/12/2023 a record review of a facility incident report, provided by Staff A, showed a medication technician found methadone in the wrong resident's room and removed it. The result of the investigation was a sign off sheet for the front desk staff, admin staff, life enrichment and transportation staff to be mindful of packages delivered to correct residents and stating if there is question of the packages containing medications to deliver it to the nursing department.

On 09/11/2023 at 1:09 PM, in an interview with Collateral Contact 1 (CC1), R1's Adult Daughter, said a call was received from R1 asking CC1 what methadone was. CC1 said R1 informed a bag was left in the room and the contents in the bag were labeled methadone, a medication used for pain management.

On 09/11/2023 at 4:24 PM in an interview with R1, R1 stated a bag was found in her room. R1 was uncertain of the contents and called CC1 to ask what this medication was. R1 said the exterior of the bag was labeled methadone. R1 said Staff C (Medication Technician) came into the room and removed the bag, while saying, "This doesn't belong in here."

On 09/14/2023 at 3:15 PM in an interview with Staff B (Medication Technician) said "to my knowledge there are no medications distributed by mail." Staff B said there was currently one resident, placed on hospice and prescribed methadone. Staff B said this would be Resident 2 (R2).

On 09/14/2023 at 3:46 PM in an interview with Staff C said the process of ordering medications is done through the pharmacy. Staff C said the pharmacies deliver medications directly to the facility. Staff C said the medications should then be secured in each cart by the medication technician.

On 09/15/2023 at 4:27 PM in an interview with Collateral Contact 2 (CC2), Hospice RN, said R2 was prescribed methadone since July 2023.

On 09/20/2023 at 4:17 PM in an interview with Collateral Contact 5 (CC 5), Lincoln Pharmacy packing supervisor, said the methadone was delivered to the facility. CC 5 said Staff D (HCA Trainee Nursing Department) signed for the methadone on 07/27/2023 at 09:17 PM.

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 Silverdale is or will be in compliance with this law and / or regulation on (Date) 10.4.2023 .

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

Stephanie Perry
Administrator (or Representative)

10.4.2023
Date