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

FFII Olympia Tennant LLC
Fieldstone Memory Care of Olympia
710 Fieldstone Dr SW
Olympia, WA 98502

RE: Fieldstone Memory Care of Olympia License # 2687

Dear Administrator:

This letter addresses Compliance Determination(s) 61275 (Completion Date 06/18/2025) and 58609 (Completion Date 05/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/18/2025 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-2160, WAC 388-78A-2640-1-a

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

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

Sincerely,

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Fieldstone Memory Care of Olympia
Provider Type: Assisted Living Facility
License/Cert.#: 2687
Intake ID: 173483
Compliance Determination #: 58609
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 04/25/2025 through 05/01/2025
Complainant Contact Date(s): 05/01/2025

Allegation(s):
Quality of care - Staff did not report a fall with injuries to management staff.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An on-site investigation was conducted, and the concerns related to fall with injury, quality of care and treatments were reviewed. Named resident fell and sustained injuries to her knee and hip. The staff did not report the incident to management in a timely manner. The facility also failed to ensure staff members followed the resident negotiated service agreement to prevent fall for one sampled resident.

Conclusion / Action:

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

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AGING AND LONG-TERM SUPPORT 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 04/25/2025 of:

Fieldstone Memory Care of Olympia
710 Fieldstone Dr SW
Olympia, WA 98502

This document references the following complaint number(s): 173483

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

05/07/2025
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)

Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members implemented the negotiated service agreement to prevent injuries for 1 of 4 sampled residents (Resident 1) reviewed. This failure caused substantial injuries to Resident 1 and placed ambulatory dependent residents at risk for harm.

Findings included...

Review of Resident 1's (R1) face sheet, dated 04/25/2025, showed R1 admitted to the facility on [redacted]/2019 with diagnosis including [redacted].

Review of R1's negotiated service plan, revision dated 09/15/2024, showed R1 had inappropriate judgement related to safety, memory impairment and required staff assistance with his activities of daily living. R1 was at risk for falls and interventions to prevent falls included direct R1 to keep his hands out of his pant pockets when ambulating, keep R1 in common area and in line of sight and assist the resident with ambulation at all times.

On 04/25/2025 at 9:37 AM, R1 was observed sitting in a wheelchair in the dining room.

The resident's right arm was in a sling, his left eye was swollen, had blueish/green skin discoloration around both eyes, redness to forehead, and quarter sized redness to right upper lip. R1 was not able to provide information related to the injuries.

Review of an incident investigation for R1, dated 04/21/2025 at 12:00PM, showed staff documented staff discovered R1 lying face down on the courtyard pathway and the fall was unwitnessed. R1 was bleeding from the wounds on his nose and upper lip. R1 had abrasions on his forehead and the bridge of his nose. R1 showed he was in significant pain and was unable to move his right arm. R1 was transported to the hospital for further evaluation.

Review of R1's progress notes, dated 04/21/2025 at 4:52 PM, showed staff documented R1 returned from the hospital and had diagnoses including [redacted] and [redacted]. R1 had multiple abrasions to his face including his forehead, right cheek, right upper lip and chin.

Review of R1's hospital record, dated 04/21/2025, documented that R1 had severe cognitive impairment, had a ground level fall and sustained abrasions to his face. R1 fractured his right arm, his nose and the cartilage that divided the nose into two separate air passages.

In an interview on 04/25/2025 at 11:22 AM, Staff C, Caregiver, said R1 was not to be left alone and should be in the line of sight of staff when the resident was in the common areas. Staff C stated each resident had an individualized care plan and the care plan had information related to the care and services each resident needed. Staff C said he had been trained to review the residents' care plans daily for changes. Staff C stated staff members were responsible for following the residents' care plans and ensuring the residents were safe and care were being met.

In an interview on 04/25/2025 at 11:35 AM, Staff B, Medication Technician, said on 04/21/2025 she had left R1 in the recliner chair in the dining room and went to assist another resident. Staff B stated R1 was not in the recliner when she returned to the dining room. Staff B said she asked the staff members that were in the dining room, and they said R1 had gotten up and walked away. Staff B said staff members should have assisted R1 back in the recliner or walked with the resident. Staff B stated she had informed staff members more than once that R1 needed assistance with walking and was to be in line of sight at all times. Staff B said R1's care plan had information related to the assistance the resident required, and staff members were to review at the start of their shift and follow the care plan.

In an interview on 04/25/2025 at 11:49 AM, Staff A, Assistant Nursing Director, said the memory care unit's standards of care were to keep the residents in line of sight when they were in the common areas. Staff A stated staff members were responsible for reviewing and providing the care and services documented in the residents' care plans. Staff A said R1 was a fall risk and was not to be left alone. Staff A stated it was her

responsibility to ensure services were provided and residents were safe.

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

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to ensure they reported a fall with injuries to the management staff members, the resident's representative and physician in a timely manner for 1 of 4 sampled residents (Resident 2) reviewed. This failure resulted in delay in receiving care, services, and pain relief for Resident 2 and placed residents at risk for not receiving the necessary care and treatment timely.

Findings included...

Review of Resident 2's (R2) face sheet, dated 04/01/2025, showed R2 admitted to the facility on [redacted]/2023 with diagnosis including [redacted].

Review of R2's negotiated service plan, revision dated 03/21/2025, showed R2 had memory, cognition and physical decline that placed R2 at risk for falls. R2 was dependent on staff members for assistance with her activities of daily living. Staff members were to monitor R2 for changes and immediately notify management staff members for further evaluation.

Review of an incident investigation for R2, dated 03/29/2025 at 09:00PM, showed staff

documented on 03/28/2025 at 9:00 PM, Staff E, Caregiver, and Staff F, Caregiver, discovered R2 on the floor between her bed and closet. The caregivers summoned Staff D, Medication Tech, to assess R2 and they assisted the resident to bed. On the morning of 03/29/2025 staff members observed R2 was having pain and had difficulty bearing weight when they attempted to assist the resident with care. The staff members reported R2's pain to Staff D and Staff D administered pain medications for R2 but was not effective. On the morning of 03/30/2025 staff members reported to Staff G, Licensed Nurse, that R2's pain level had increased and possibly had fallen on 03/28/2025. Staff G assessed R2 and noticed bluish skin discoloration on the back of her hip and her right knee was swollen. Staff members were instructed to administer Morphine (pain medication) as needed for pain control. On the evening of [redacted]/2025 R2 continued to experience pain that was not being managed by the Morphine and was transported to the hospital for treatment. R2 returned to the assisted living facility on the early morning of [redacted]/2025 and passed away at [redacted]. The staff members did not immediately report the fall to management staff members.

Review of R2's hospital record, dated [redacted]/2025, documented that R2 was seen for leg pain and received Morphine treatments.

In an interview on 04/25/2025 at 11:17 AM, Staff C, Caregiver, said his responsibility was to summon the medication technician to assess the resident when discovered a resident had fallen. Staff C stated the medication technician complete an incident report and notified management staff members, the resident's representative and physician.

In an interview on 04/25/2025 at 11:31 AM, Staff B, Medication Technician, said care staff report residents' incidents to her and it was her responsibility was to assess the resident, call 911 if needed, complete an incident report, and notify management staff members, the resident's representative and physician. Staff B stated she would notify the management staff members as soon as the resident was stable.

In an interview on 04/25/2025 at 11:49 AM, Staff A, Assistant Nursing Director, said care staff members had been in-serviced to report suspected fall to the medication technicians for assessment. Staff A stated part of the medication techs training was to immediately notify the management staff members, the residents' representatives and physicians when a fall was suspected. Staff A said management staff members were available to provide guidance for the medication technicians at all times.

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

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

Administrator (or Representative) Date