STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

OLYMPIC PLACE RETIREMENT AND ASSIST
OLYMPIC PLACE RETIREMENT AND ASSISTED LIVING COMMUNITY
3425 Boone Rd SE
SALEM, OR 97317

RE: OLYMPIC PLACE RETIREMENT AND ASSISTED LIVING COMMUNITY License # 1712

Dear Administrator:

This letter addresses Compliance Determination(s) 71662 (Completion Date 01/20/2026) and 66284 (Completion Date 10/30/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/20/2026 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-2120-1, WAC 388-78A-2120-2-b, WAC 388-78A-2120-4

The Department staff who did the on-site verification:
Teresa Pederson-Tuley, Nursing Consultant Institutional

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: OLYMPIC PLACE RETIREMENT AND ASSISTED LIVING COMMUNITY
License/Cert.#: 1712
Compliance Determination #: 66284
Investigator: Teresa Pederson-Tuley
Investigation Date(s): 09/29/2025 through 10/30/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 197079
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
The facility reported a medication error.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Staff to resident interactions Medication administration
Interviews:	Nursing staff Residents
Record Reviews:	Medical records Incident investigation Facility policies Personnel files Staff training records

Investigation Summary:
Review of the investigative records showed the Identified Resident (IR) was assessed and medical personnel were notified. Staff interviews and record review showed the IR became somnolent was unable to eat. Failed practice was identified and a citation was issued for noncompliance with WAC 388-78A-2210 on 09/26/2025 and ALF is in a plan of correction period. Collateral contact did not have care concerns related to care.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written

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☐ N/A

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 09/29/2025 of:

OLYMPIC PLACE RETIREMENT AND ASSISTED LIVING COMMUNITY
20909 Olympic Pl NE
Arlington, WA 98223

This document references the following complaint number(s): 196302, 195674, 197079

The following sample was selected for review during the unannounced on-site visit: 3 of 67 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Teresa Pederson-Tuley, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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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.

Jamie Singer
Residential Care Services

11/3/2025
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)

11/10/2025
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to monitor 1 of 3 resident's (Resident 1) daily weight as ordered by a physician and failed to observe or evaluate for changes with an identified disease process. This failure placed Resident 1 at risk of harm when weights were not taken to eliminate possible heart failure exacerbation.

Findings included...

NOTE: Washington Administrative Code 388-78A-2350 - Coordination of health care services. (1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

Record Review of the facility policy Medication Systems, dated 06/04/2025, stated in the section titled Physician Orders, showed staff shall follow requirements for community/physician communication about orders. In the section, Communication System Description, the policy stated that all

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new orders for medication or treatment needed to be carried out as prescribed; the staff member responsible for assisting with or administering a medication or treatment was required to notify the ordering health care professional when a resident did not receive the ordered medication or treatment (unavailable, refused etc.).

Record review showed the ALF admitted Resident 1 on [redacted]/2024 with a diagnosis of [redacted] and [redacted]. Review of the NSA, dated 04/29/2025, showed staff to monitor for swelling and edema (swelling) and that Resident 1 was alert and oriented.

Record Review of Hospital Discharge Orders, dated [redacted]/2024, showed Resident 1 had acute right-sided heart failure, heart Failure and physician orders to weigh daily, in the morning, and notify the physician if weight had increases by greater than three pounds in two days or five pounds in 1 week.

Record Review of the Medication Administration Record (MAR), dated August of 2025, showed from 08/10/2025 to 08/30/2025 staff attempted to take Resident 1's weight in the PM (afternoon/evening), instead of AM, and documented, "resident refused." The MAR, dated September of 2025, showed from 09/10/2025 to 09/31/2025 staff attempted to take Resident 1's weight in the PM, instead of AM, and documented, "resident refused."

Record review showed no documentation that the physician was notified Resident 1's weights were not being taken, no documentation the ALF observed, evaluated or monitored why weights were not being taken, or implement interventions to ensure physician's orders were being followed.

In an interview, on 09/29/2025 at 10:30 AM, Collateral Contact (CC – Resident 1's Representative) stated Resident 1 was not refusing to be weighed even though staff were documenting the weights as being refused. CC stated, while visiting Resident 1 she asked an unidentified Medication Technician (MT) to weigh Resident 1. The MT responded that they would have to talk with their supervisor before weighing the Resident 1 and left. The MT never returned to weigh Resident 1.

In an interview, on 09/29/2025 at 11:12 AM, Resident 1 stated they were concerned about their weight because they had heart issues. Resident 1 stated they had asked MTs to weigh her each morning and was told

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that they would have to ask the nurse about that.

In an interview, on 09/29/2025 at 11:30 AM, Staff C (MT) stated an ALF staff took residents' weights on the night shift only and she did not know of any residents that had a physician's order to be weighed in the morning. In a joint record review of Resident 1 August and September or 2025 MAR, Staff C agreed that Resident 1 had a physician's order to be weighed every morning.

In an interview, on 09/29/2025 at 12:25 PM, Staff B (Regional Nurse) confirmed ALF staff were documenting Resident 1 was refusing weights stating, "September is worse."

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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, OLYMPIC PLACE RETIREMENT AND ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 12/14/2025

SB confirmed amended POC date with Provider on 12/2/2025.

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

Administrator (or Representative) 11/10/2025
Date

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