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

SH1 Olympics West LLC
Olympics West Senior Living
929 Trosper Rd SW
Tumwater, WA 98512

RE: Olympics West Senior Living License # 2494

Dear Administrator:

This letter addresses Compliance Determination(s) 41200 (Completion Date 05/13/2024) and 37616 (Completion Date 03/15/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/13/2024 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-2210-2-b, WAC 388-78A-2660-1

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

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Olympics West Senior Living **Provider Type:** Assisted Living Facility

**License/Cert.#:** 2494
**Compliance Determination #:** 37616
**Investigator:** Phan Pham
**Intake ID:** 119029
**Region/Unit #:** RCS Region 3 / Unit E
**Investigation Date(s):** 03/14/2024 through 03/15/2024
**Complainant Contact Date(s):** 02/27/2024, 03/15/2024

**Allegation(s):**

1) False billing - The assisted living withdrew Named resident's funds after the resident had been discharged.
2) Quality of life, resident rights - The assisted living facility did not refund Named resident's money.
3) Quality of care - Named resident did not receive a medication for her skin infection.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 50<br>Resident sample size: 4<br>Closed records sample size: 1 |
| **Observations:** | Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures. |
| **Interviews:** | Named resident, residents, staff members, administrative and member not associated with the facility. |
| **Record Reviews:** | Sampled residents and incident reports. |

**Investigation Summary:**

An investigation was conducted, and allegation identified in the intake related to 1) False billing, 2) Quality of life and 3) Quality of care and services were reviewed.
The Assisted Living Facility failed to ensure prompt efforts were provided by management staff to resolve grievances. The assisted living facility also failed to ensure physician ordered medication was available in a timely manner. Additional residents reviewed for care, services and safety had no concerns.

**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 #: 2494 | Compliance Determination # 37616 |
| Plan of Correction | Olympics West Senior Living | Completion Date |
| Page 1 of 5 | Licensee: SH1 Olympics West LLC | 03/15/2024 |

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 03/14/2024, 03/14/2024 and 03/15/2024 of:

Olympics West Senior Living
929 Trosper Rd SW
Tumwater, WA 98512

This document references the following complaint number(s): 119029, 122181

The following sample was selected for review during the unannounced on-site visit: 4 of 50 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

03/20/2024
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.

STATE OF WASHINGTON

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

***800 NE 136th Ave Ste 200, Vancouver, WA 98684***



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Cory Cisneros
Residential Care Services

03/20/2024
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.

Matt Cuskett

Administrator (or Representative)

3/21/24

Date

**WAC 388-78A-2210 Medication services.**

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the assisted living facility failed to ensure physician ordered medication was available in a timely manner for 1 of 4 sampled residents (Resident 1) reviewed for medication services. This failure resulted in Resident 1 not receiving prescribed skin treatment timely and placed the resident at risk of worsening of the skin condition.

Findings included...

Review of Resident 1's (R1) face sheet showed the resident admitted to the facility on [redacted]/2021 with diagnoses including [redacted] and had a history of skin irritation. R1 required assistance with her activities of daily living and medication administration.

Review of R1's record revealed on 01/10/2024 at 1:18 PM, a staff member sent a fax to the resident's physician. The staff documented R1 had redness and foul-smelling rash under her breasts and abdominal fold. On 01/12/2024 at 11:04 AM the resident physician's office sent a fax to the assisted living facility. The resident's physician ordered for R1 to have Nystatin (antifungal) cream 100,000 units/gram to be applied to the affected areas twice daily. A staff member documented "noted" and initialed the fax from on 01/16/2024.

Review of R1's medication administration record, dated 01/01/2024-01/31/2024, showed staff documented the medication was not available on the evening of 01/16/2024, twice on 01/17/2024 and the morning of 01/18/2024. The resident did not receive the medication treatment prior to her discharge to another facility on [redacted]/2024.

On 03/11/2024 at 11:44 AM, R1 was observed ambulating in the hallway at her new home. In an interview the resident was not able to provide any information related to the care and treatment she had received at the assisted living facility.

Administrator (or Representative) Date

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Findings included...

Review of Resident 1's (R1) face sheet showed the resident admitted to the facility on [redacted]/2021 with diagnoses including [redacted] and had a history of skin irritation. R1 required assistance with her activities of daily living and medication administration.

Review of R1's record revealed on 01/10/2024 at 1:18 PM, a staff member sent a fax to the resident's physician. The staff documented R1 had redness and foul-smelling rash under her breasts and abdominal fold. On 01/12/2024 at 11:04 AM the resident physician's office sent a fax to the assisted living facility. The resident's physician ordered for R1 to have Nystatin (antifungal) cream 100,000 units/gram to be applied to the affected areas twice daily. A staff member documented "noted" and initialed the fax from on 01/16/2024.

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On 03/11/2024 at 11:44 AM, R1 was observed ambulating in the hallway at her new home. In an interview the resident was not able to provide any information related to the care and treatment she had received at the assisted living facility.

Review of R1's record revealed on [redacted]/2024 staff documented R1 admitted to a new facility on [redacted]/2024. The resident was observed with redness under R1's breasts and belly fold.

Review of R1's physician visit note, dated 01/19/2024, showed R1 was seen for skin infection and was diagnosed with [redacted].

In an interview on 03/14/2024 at 12:44 PM, Staff B, Health Services Director, said R1 physician's office sent a fax to the ALF on 01/12/2024 for an anti-fungal cream and the order was not reviewed until 01/16/2024. Staff B said the Licensed Nurse was responsible for reviewing the orders, approving and forwarding to pharmacy. Staff B stated the goal was to have all orders reviewed within 24 hours.

In an interview on 03/15/2024 at 10:40 AM, Staff C, Medication Aide, said the Licensed Nurses and Medication Aides were responsible for reviewing physician orders and forwarding to pharmacy to have the medication filled. Staff C stated she would consult with Staff B when she had questions about an order and/or medication. Staff C said she tried to review the physicians' orders within 24 hours.

**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, Olympics West Senior Living is or will be in compliance with this law and / or regulation on (Date) 5-1-2024 4/29/24

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

Matt Crockett — 3/21/24

Administrator (or Representative) — Date

**WAC 388-78A-2660 Resident rights. The assisted living facility must:**

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility failed to ensure prompt efforts were provided by management staff to resolve grievances in a timely manner for one of one sampled resident (Resident 1) reviewed for resident rights. This failure placed residents at risk for unresolved concerns, and decreased quality of life.

Findings included...

Review of R1's record revealed on [redacted]/2024 staff documented R1 admitted to a new facility on [redacted]/2024. The resident was observed with redness under R1's breasts and belly fold.

Review of R1's physician visit note, dated 01/19/2024, showed R1 was seen for skin infection and was diagnosed with [redacted].

In an interview on 03/14/2024 at 12:44 PM, Staff B, Health Services Director, said R1 physician's office sent a fax to the ALF on 01/12/2024 for an anti-fungal cream and the order was not reviewed until 01/16/2024. Staff B said the Licensed Nurse was responsible for reviewing the orders, approving and forwarding to pharmacy. Staff B stated the goal was to have all orders reviewed within 24 hours.

In an interview on 03/15/2024 at 10:40 AM, Staff C, Medication Aide, said the Licensed Nurses and Medication Aides were responsible for reviewing physician orders and forwarding to pharmacy to have the medication filled. Staff C stated she would consult with Staff B when she had questions about an order and/or medication. Staff C said she tried to review the physicians' orders within 24 hours.

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Findings included...

"RCW 70.129.060 Grievances.
A resident has the right to:
(1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and
(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents."

Review of Resident 1's (R1) face sheet showed the resident admitted to the facility on [redacted]/2021 with diagnoses including [redacted] and had a history of agitation. R1 required assistance with her activities of daily living and managing her finance. The resident was independent with transfers and ambulation.

Reviewed of R1's progress notes showed on 01/07/2024 at 9:37 PM, staff documented it was cold and dark outside and R1 was in the parking lot. The resident did not want to come back in the building. On 01/14/2024 at 4:15 PM, staff documented the resident went outside the building. The resident became aggressive, balled up her fists and made threats when staff attempted to assist R1 back in the building. Local law enforcement had to be called. On [redacted]/2024 at 12:44 PM, staff documented the resident was discharged from the Assisted Living Facility (ALF).

Review of an email, dated 01/14/2024 at 4:27 PM, showed Staff B, Health Services Director, sent an email to Collateral Contact 1 (CC1), representative for R1. Staff B documented R1 was far too confused and unsafe to reside at the ALF per the disclosure of services signed upon move in. The ALF would be sending an official letter to vacate at the next business day.

In an interview on 02/27/2024 at 10:25 AM, CC1 said R1 was discharged from the ALF on [redacted]/2024. CC1 stated on 02/05/2024 the ALF withdrew $6005.00 from R1's account. CC1 said he had emailed Staff A, Administrator, and Staff B in February 2024 inquiring about the money withdrawn from R1's bank account and when to expect the money to be refunded to R1. CC1 stated the ALF staff had not contacted CC1 regarding his inquiry.

Review of R1's bank record showed on 02/05/2024 the ALF affiliation withdrew $6005.00 from R1's bank account.

Review of the Department's record revealed on 02/06/2024 at 8:52 PM, CC1 sent an email to Staff A and Staff B. CC1 documented $6005.00 was withdrawn from R1's bank account on 02/05/2024 by the ALF's vendor. CC1 asked how long it would take for the ALF to return R1's money.

In an interview on 03/14/2024 at 12:27 PM, Staff B, said R1 had an emergency discharge on [redacted]/2024. Staff B stated R1 needed higher level of care, the resident was unsafe, and the ALF was not able to meet R1's care needs.

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In an interview on 03/14/2024 at 12:45 PM, Staff A said he noticed $6005.00 was withdrawn from R1's bank account on 02/02/2024 and that should not have occurred. Staff A stated it was his responsibility to ensure residents were not overcharged and their concerns were timely addressed. Staff A said he did not recall any communication with R1's representative regarding the money withdrawn from the resident's bank account. Staff A said the resident will be credited a prorated amount of $2342.00 for the January 2024 and the $6005.00 withdrew for February 2024 which totaled $8347.00.

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Matt Cruchett
Administrator (or Representative)

3/21/24
Date

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