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) 63066 (Completion Date 07/25/2025) and 60577 (Completion Date 06/09/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/25/2025 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-2630-1-a

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

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

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse 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
Intake ID: 180629
Compliance Determination #: 60577
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 06/03/2025 through 06/09/2025
Complainant Contact Date(s):

Allegation(s):

Quality of care - Residents had long toenails and not assisted with showers.
Physical environment - The ALF had bed bugs, cockroaches, and flees.
Misappropriation of property - Residents had money missing.
Unqualified personnel - Staff did not have license to pass medications.
Nursing services - Residents were not receiving medications.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 5 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) Physical environment, 2) Misappropriation of property, 3) Unqualified personnel, 4) Nursing services and 5) Quality of care and services were reviewed. The facility failed to ensure staff members implemented the negotiated service agreement and trim the residents' toenails. There were insufficient information to support failed facility practice related to allegation of missing money. Additional residents reviewed for unqualified personnel, care, services, physical environment, 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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2494
Intake ID: 181516
Compliance Determination #: 60577
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 06/03/2025 through 06/09/2025
Complainant Contact Date(s):

Allegation(s):
Quality of care - Named resident fell and sustained ribs fractured.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 5 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 on-site investigation was conducted, and the concerns related to fall with fracture quality of care and treatments were reviewed. The resident's care plan had interventions to ensure necessary care and services were being met and kept the resident safe and were being implemented. A deficiency not related to original complaint was cited.

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

License/Cert.#: 2494
Intake ID: 181358
Compliance Determination #: 60577
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 06/03/2025 through 06/09/2025
Complainant Contact Date(s):

Allegation(s):
Quality of care - Named resident's granddaughter allegedly wiped the resident's personal area.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 5 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 quality of care and services were reviewed. The facility failed to ensure a staff member report allegations of care provided in sexual nature to the Complaint Resolution Unit in a timely manner. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2494	Compliance Determination # 60577
Plan of Correction	Olympics West Senior Living	Completion Date
Page 1 of 6	Licensee: SH1 Olympics West LLC	06/09/2025

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 06/03/2025 and 06/06/2025 of:

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

This document references the following complaint number(s): 179298, 180629, 181516, 181358

The following sample was selected for review during the unannounced on-site visit: 5 of 67 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

Statement of Deficiencies	License #: 2494	Compliance Determination # 60577
Plan of Correction	Olympics West Senior Living	Completion Date
Page 2 of 6	Licensee: SH1 Olympics West LLC	06/09/2025

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.

Clinton Fridley — Residential Care Services

06/10/2025 — 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.

Annette Johnson RN HSD — Administrator (or Representative)

6/17/25 — 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 and trim the residents' toenails to prevent discomfort and injuries for 2 of 4 sampled residents (Resident 1 and Resident 2) reviewed. This failure resulted in the residents' toenails were long and experienced discomfort.

Findings included...

Resident 1 (R1)

Review of Resident 1's face sheet, dated 06/02/2025, showed R1 admitted to the facility on [redacted]/2022 with diagnosis including [redacted] and [redacted].

Review of R1's negotiated service plan, dated 03/12/2025, showed R1 was effectively able to verbally communicate her needs known. The resident required assistance with nail care and staff members were responsible for monitoring and ensuring R1 received nail care.

On 06/02/2025 at 9:48 AM, R1 was observed sitting in a chair in her room and neatly groomed. The resident stated her toenails were terrible and felt ashamed of them. The resident said her toenails were long, they put pressure on her toes and would like to have them trimmed. R1 said she her toenails were trimmed once since she was admitted to the assisted living facility.

At 9:48 AM, R1's great toenails were observed to be approximately one quarter inch thick, one quarter inch beyond the toes, growing laterally, dried, and yellow embedment under the toenails. The rest of the resident's toenails were approximately one-half inch beyond the toes, growing medially, and jagged.

On 06/02/2025 at 11:15 AM, Staff C, Medication Tech, was asked to observe R1's toenails. Staff C stated R1's toenails were very long and have not been trimmed for a long time. Staff C said R1's great toenails were approximately one quarter inch thick, dried, long, and yellow in color. Staff C stated the rest of the toenails were about half an inch beyond the resident's toes, growing sideway, curved, and jagged. Staff C said caregivers were responsible for checking the resident's toenails and report concerns to management staff.

On 06/02/2025 at 11:27 AM, Staff B, Resident Care Coordinator, was asked to observe R1's toenails. Staff B observed R1's toenails and said the resident had extensive nail care issues. Staff B stated R1's toenails were very long, growing sideway, curved, dried, jagged, and one-half inch beyond the toes. Staff B said the resident's great toes had fungal, growing sideway, a quarter of an inch thick, and yellow in color. Staff B stated staff members were to check the residents' toenails when assisting residents with dressing and shower. Staff B said staff members were able to assist trimming non-diabetic residents' toenails and notify the licensed nurse when diabetic residents had long toenails.

R2

Review of Resident 2's face sheet, dated 06/02/2025, showed R1 admitted to the facility on [redacted]/2021 with diagnosis including [redacted].

Review of R1's negotiated service plan, dated 02/02/2025, showed R2 was effectively able to verbally communicate her needs known. The resident required assistance with nail care and staff members were responsible for monitoring and ensuring R2 received nail care.

On 06/02/2025 at 10:40 AM, R2 was observed in bed and covered with blankets. The resident stated her toenails were long and needed to be trimmed. R2 said she was not able to recall the last time her toenails were trimmed.

On 06/02/2025 at 11:10 AM, Staff C was asked to observe the resident's toenails. Staff C said R2's toenails were long approximately one-third of an inch beyond the resident's toes and were not growing straight. Staff C stated R2's great toenails were thick and were yellow in color.

At 11:10 AM, R2's toenails were observed to be approximately one-third of an inch beyond the resident's toes, yellow in color, jagged and growing medially.

In an interview on 06/06/2025 at 9:40 AM, Staff A, Health Services Director, said staff members were instructed to check the residents' toenails on shower days and report concerns to management staff members. Staff A stated care staff members were able to perform nail care for non-diabetic residents. Staff A said all care staff members had been counselled regarding nail care and to consult with management staff when staff had questions and/or concerns.

In an interview on 06/06/2025 at 9:51 AM, Staff D, Caregiver, said she had been instructed to check the residents' toenails on shower day and assist non-diabetic residents as needed. Staff D stated she would notify management staff when there were questions regarding residents' nail care.

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) 6/17/25 .

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

Jennifer Johnson RN HSD — Administrator (or Representative)

6/12/25 — Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where

the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a staff member report allegations of care provided in sexual nature by a member not associated with the facility to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34.035(3) RCW as required by mandatory reporters in a timely manner for 1 of 3 sampled residents (Resident 3) reviewed. This failure placed residents at risk for services not being met.

Findings included...

Review of Resident 3's (R3) face sheet showed the resident was admitted to the facility on [redacted]/2024 with diagnoses including [redacted].

Review of R3's negotiated service plan, dated 06/03/2025, showed R3 was effectively able to verbally communicate her needs known. The resident required assistance with incontinent care.

On 06/06/2025 at 9:25 AM, R3 was observed in bed and covered with blankets. The resident stated her incontinent cares were provided by staff members.

Review of the Department's reporting record dated 06/02/2025, showed a caregiver witnessed R3's four years old granddaughter wiped the resident's vaginal area in two separate incidents while the resident was on the toilet. The alleged incidents occurred during the week between March 25 and April 4, 2025, and the staff member did not report the incidents.

Review of R3's progress notes revealed on 06/02/2025 at 11:43 AM, Staff A, Health Services Director, was advised a staff member had witnessed in two separate incidents the resident's granddaughter wiped R3's vaginal area while the resident was on the toilet.

In an interview on 06/06/2025 at 9:40 AM, Staff A, stated staff members have been in-serviced on resident abuse and reporting requirements. Staff A said the staff member witnessed the incidents between March 25, 2025, and April 4, 2025, and did not report to the management staff until 06/02/2025. Staff

A stated staff members have been instructed to immediately report allegations of resident abuse immediately.

In an interview on 06/06/2025 at 9:51 AM, Staff D, Medication Tech, said she have been in-serviced on resident abuse, neglect and reporting requirements. Staff D stated she would report to management staff and the State immediately.

In an interview on 06/06/2025 at 9:57 AM, Staff E, Caregiver, said she had been trained on abuse, neglect and reporting requirements. Staff E stated she would immediately report allegations of abuse and resident mistreatment to management staff and the State.

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) 6/17/25 .

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

Annette Johnson PW HSD 6/17/25

Administrator (or Representative) Date

6/19/2025

Olympics West Senior Living

License number 2494

Visit date 06/02/2025

Plan of correction re potential abuse by resident room [redacted], [redacted]

Inservice for all employees of Olympics West re mandatory reporting and all classifications of abuse was given 6/6/25 1400.

Temporary service plan instituted for resident initials [redacted] room [redacted]
Time limits instituted re any minor visitations. 2-to-3-hour limit per day for visitations of minors. Resident informed of the fact that any behavior related to potential abuse will be immediately reported.

Plan of correction related to proper foot and toenail care:

Complete education related to process of proper nail trimming and foot care was done with knowledge testing done with clinical staff 6/18/25 1330 to 1400.

Olympics West has a contract for podiatry as of 6/25 for in house podiatry care.

Olympics West has several kits for foot care/ nail trimming including antiseptics, emery boards. Nail clippers and personal foot basins for residents.