STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

02/03/2026

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

RE: Olympics West Senior Living # 2494

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 72337 (Completion Date 02/03/2026) and 69428 (Completion Date 12/04/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/03/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

The Department staff who did the On Site verification:
Pamela Horlick, NCI RN Complaint Investigator

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

Sincerely,

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E

Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

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 follow-up on 12/02/2025 of:

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

This document references the following SOD dated: 12/04/2025

The following sample was selected for review during the unannounced on-site visit: 0 of 65 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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.

Residential Care Services | 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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, staff failed to implement systems that support and promote safe medication services for 2 of 2 medication carts (medication cart 1, medication cart 2) reviewed. This failure placed all residents at risk for improper/inconsistent medication management.

Findings included…

Record review of the facility policy titled, “Narcotics, Controlled Substances, and Preventing Drug Diversion,” dated 12/01/2021, showed at the end of each shift, the staff member responsible for medications completing their shift, and the staff member responsible for medications who was starting their shift, will count all narcotic medications and confirm that the amount on hand matches what was listed on the Narcotic count sheet for each medication. Both staff members are to sign a Shift count verification form to confirm the accurate count of narcotics on hand and any discrepancies are immediately reported to the administrator and/or health services director.

Record review of facility provided documents titled, “Shift count verification”, dated November 2025 for medication cart 1 showed:

- On 11/30/2025 for the shift starting at 11:00 PM and ending at 7:00 AM; signature 2 (the staff coming on shift) was blank.

Record review of facility provided document titled, “Shift count verification”, dated December 2025 for medication cart 1 showed:

- On 12/01/2025 for the shift starting at 11:00 PM and ending 7:00 AM; signature 1 (the staff member coming off shift) and signature 2 were blank and had an “X” near the bottom left corner.
- On 12/02/2025 for the shift starting at 7:00 AM and ending 3:00 PM; signature 1 was blank and had an “X” near the bottom left corner.

Record review of facility provided document titled, “Shift count verification”, dated November 2025 for medication cart 2 showed:

- On 11/18/2025 for the shift at 11:00 PM and ending 7:00 AM; signature 2 was blank and had an “X” near the bottom left corner.
- On 11/19/2025 for the shift starting at 7:00 AM and ending 3:00 PM; signature 1 was blank and had an “X” near the bottom left corner.
- On 11/29/2025 for the shift starting at 7:00 AM and ending 3:00 PM; signature 2 was blank and had an “X” near the bottom left corner.
- On 11/29/2025 for the shift starting at 3:00 PM and ending 11:00 PM; signature 1 was blank and had an “X” near the upper left corner.

Record review of facility provided document titled, “Shift count verification”, dated December 2025 for Cart 2 showed:

- On 12/01/2025 for the shift at 11:00 PM and ending 7:00 AM; signature 2 was blank.
- On 12/02/2025 for the shift starting at 7:00 AM and ending 3:00 PM; signature 1 was blank.

In an interview on 12/02/2025 at 10:23 AM, Staff A, Executive Director, stated staff were trained on the policy regarding counting narcotics at the end/beginning of each shift and signing the narcotic Shift count verification form and that the issue was fixed.

In an interview on 12/02/2025 at 10:25 AM, Staff B, Health Services Director/Nurse,

stated staff are to sign the narcotic Shift count verification form every single shift and there needs to be two signatures verifying the count was correct. Staff B stated they are monitoring the narcotic Shift count verification form for signatures along with Staff C, charge nurse, weekly. Staff B stated staff were to notify them if staff see someone hadn't signed the narcotic Shift count verification form. Staff B said, "we are in constant vigilance."

In an interview on 12/02/2025 at 11:06 AM, Staff E, medication technician, stated, when asked if they signed the narcotic Shift count verification form today, they stated they did not because they were frazzled and got in late that morning. Staff E stated they should have signed the Shift count verification form and was able to describe the correct process.

In an interview on 12/02/2025 at 11:29 AM, Staff D, medication technician, stated they counted narcotic medications with Staff F, medication technician, today. Staff D was shown the narcotic Shift count verification form, from 12/02/2025, and asked if Staff D signed the form this morning at shift change after counting the narcotics, they stated Staff F did not sign the book. Staff D stated they counted them but without the signature, they couldn't prove that. Staff D stated it doesn't look good and looked like it wasn't done. Staff D stated Staff F should have signed the Shift count verification form yesterday on 12/01/2025 also. Staff D stated that they did not notify their supervisors that the Shift count verification form wasn't signed.

In an interview on 12/02/2025 at 11:39 AM, Staff B stated there shouldn't be any blank spaces in the narcotic Shift count verification form. Staff B stated there were missing signatures on 12/01/2025 and that it looked like night shift didn't sign the narcotic shift count verification form and it looked like it wasn't done. Staff B stated signatures for today weren't done either. Staff B was observed to mark an "X", in the narcotic Shift count verification form, on 12/02/2025 for the shift that started at 7:00 AM and ended at 3:00 PM, signature line 1 and signature line 2 in the bottom left corner. Staff B was asked if they mark an "X" on the narcotic shift count verification form when they see a missing signature, they stated yes it means they need staff to sign the book. Staff B stated that was the only time they have ever done that. Staff B was asked if anyone else marks an "X" in the narcotic book, Staff B stated no, only they do and they only did it that one time.

In an interview on 12/02/2025 at 12:54 PM, Staff A stated that they expect the medication technician to count the narcotic medications together at the beginning of their shift and at the end and sign the narcotic Shift count verification form confirming that all narcotics are accounted for. By staff not signing the Shift count verification form, it looked like the counting of the narcotics was not completed.

This is an uncorrected deficiency previously cited on 10/09/2025.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2494
Intake ID: 191722
Compliance Determination #: 65741
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 09/17/2025 through 10/09/2025
Complainant Contact Date(s):

Allegation(s):
Pharmaceutical Services: Facility report of a medication discrepancy.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 4 Closed records sample size: 1
Observations:	Identified resident Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Nursing staff Residents Health Services Director/Nurse Resident Care Coordinator Executive Director
Record Reviews:	State reporting log Incident investigation Facility policies Narcotic Book Medication Administration Record (MAR) Physician Orders Face sheets Incident report Progress notes

Investigation Summary:

Pharmaceutical Services: Facility failed to follow policy and procedure when staff did not conduct a narcotic medication count at shift change. Failed practice identified.

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 09/17/2025 of:

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

This document references the following complaint number(s): 191722, 193675

The following sample was selected for review during the unannounced on-site visit: 4 of 67 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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.

Residential Care Services | 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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, staff failed to implement systems that support and promote safe medication services for 1 of 1 facility reviewed. This failure resulted in a medication being misplaced and placed all residents at risk for improper/inconsistent medication management.

Findings included…

Record review of the facility policy titled, “Narcotics, Controlled Substances, and Preventing Drug Diversion,” dated 12/01/2021, showed at the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications who is starting his/her shift, count all narcotic medications and confirm that the amount on hand matches what was listed on the Narcotic count sheet for each medication. Both staff members are to sign a Narcotic Reconciliation Sheet to confirm the accurate count of narcotics on hand and any discrepancies are immediately reported to the administrator and/or health services director.

In an interview on 09/30/2025 at 12:09PM, Staff C, Resident Care Coordinator, stated that a medication discrepancy occurred, where a single pill of a narcotic pain medication was missing, between evening shift and night shift on 08/17/2025. Staff C stated Staff F skipped doing the count with the evening shift med aid. Staff C stated Staff F signed the narcotic book taking responsibility for the medication cart but

admitted that they did not count the narcotic medications. Staff C stated it was not acceptable for Staff F to sign the book taking responsibility of the cart when they didn't conduct a narcotic count and was verbally counseled.

Record review of facility provided document, "Shift Count Verification," one dated August 2025 and the other September 2025, showed no signatures that documented the narcotic medication count was done from the medication aide completing their shift or from the medication aide starting their shift for the following days and times:

- 08/03/2025 – night shift (11:00 PM to 7:00 AM) on 08/03/2025 to morning shift (7:00 AM to 3: 00 PM) on 08/04/2025
- 08/06/2025 – from morning shift to evening shift (3:00 PM to 11:00 PM)
- 08/07/2025 – from morning shift to evening shift
- 08/10/2025 – from morning shift to evening shift
- 08/12/2025 – from morning shift to evening shift
- 08/13/2025 – from morning shift to evening shift
- 08/23/2025 – from morning shift to evening shift
- 08/28/2025 – from morning shift to evening shift
- 09/02/2025 – from morning shift to evening shift
- 09/04/2025 – from morning shift to evening shift
- 09/12/2025 – from morning shift to evening shift
- 09/14/2025 – from morning shift to evening shift
- 09/16/2025 – from evening shift to night shift

In an interview on 09/18/2025 at 4:09PM, Staff C stated there isn't a routine to review the book, they stated they look at it once a month. Staff C stated that they were not notified on, or after, 09/16/2025 when medication aides did not sign the book from midday shift to night shift. Staff C stated they were not notified of the missing signatures on 09/14/2025 and 09/12/2025. Staff C stated the medication aides on the following shift should have called Staff B when they saw that someone didn't sign the narcotic book and that they were never made aware of the missing signatures.

In an interview on 10/02/2025 at 3:04PM, Staff B stated they were not notified on 09/12/2025, 09/16/2025, or 09/16/2025 of missing signatures in the narcotic book. Staff B stated staff should have texted them and they would have done an investigation into why it wasn't signed.

In an interview on 09/17/2025 at 4:43PM, Staff A, Executive Director, stated it was Staff B and Staff C's responsibility to review the narcotic book to ensure staff are conducting the shift counts at shift change. Staff A stated, Staff B and Staff C should be reviewing the narcotic book for accuracy every couple of days.

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)_____ .

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

_____ _____

Administrator (or Representative) Date