STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Marysville Senior Community LLC
Fieldstone Memory Care of Marysville
11015 State Ave
Marysville, WA 98271

RE: Fieldstone Memory Care of Marysville License # 2538

Dear Administrator:

This letter addresses Compliance Determination(s) 69854 (Completion Date 12/17/2025) and 63966 (Completion Date 09/15/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/17/2025 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-2660-4, RCW 70.129.005

The Department staff who did the on-site verification:
Cynthia Chenot-Potter, Nursing Consultant Institutional

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Fieldstone Memory Care of Marysville
Provider Type: Assisted Living Facility
License/Cert.#: 2538
Intake ID: 189560
Compliance Determination #: 63966
Region/Unit #: RCS Region 2 / Unit D
Investigator: Cynthia Chenot-Potter
Investigation Date(s): 08/11/2025 through 09/15/2025
Complainant Contact Date(s):

Allegation(s):

1. Named Resident (NR) was not allowed private visits in their room.
2. NR's spouse was alerted when NR had visitors.
3. NR appeared sedated.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records Facility policies Face sheets

Investigation Summary:

1. NR was not allowed to have private visits with visitors of their choice. Assisted Living Facility (ALF) staff required some of NR's visitors to only visit in common areas. There were no written visitor restrictions, and there weren't any no-contact orders. ALF staff confirmed they did not allow resident to have private visits with some of their chosen visitors. Reviewed visitation policy/resident rights. Failed practice identified. Citation for WAC 388-78a-2660 (1), (4), (RCW 70.129.005, RCW 70.129.050 (1),
2. ALF staff confirmed they notified NR's spouse/power of attorney (POA) when they had certain visitors, at the request of the spouse/POA. There were no protective orders in place for NR. When regulator asked NR if they wanted visits with those particular visitors, NR confirmed they did want visits with them. NR had the right to

privacy and to choose who they visited with. Failed practice identified and facility cited for WAC 388-78a-2660 (1),(4), (RCW 70.129.005, RCW 70.129.050 (1).
3. NR was sleeping when the regulator visited in late morning, but woke up quickly and was cognizant and able to participate in the conversation during the visit. Reviewed progress notes, medication administration record and medical provider notes. No new medications had been administered that NR had not been taking prior to admission to the Assisted Living Facility. Facility met regulatory requirements.

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: Fieldstone Memory Care of Marysville
Provider Type: Assisted Living Facility
License/Cert.#: 2538
Intake ID: 189444
Compliance Determination #: 63966
Region/Unit #: RCS Region 2 / Unit D
Investigator: Cynthia Chenot-Potter
Investigation Date(s): 08/11/2025 through 09/15/2025
Complainant Contact Date(s):

Allegation(s):

1. Named Resident (NR) appeared sedated.
2. NR was locked in their room and did not get lunch and dinner meals.
3. NR was not allowed visitors of their choice.
4. NR had multiple wounds on their arms, legs and a foot.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records Facility policies Face sheets

Investigation Summary:

1. NR was sleeping when the regulator visited in late morning, but woke up quickly and was cognizant and able to participate in the conversation during the visit. Reviewed progress notes and medication administration record. NR had not received any new medications while at the Assisted Living Facility. Medical provider notes reviewed. Facility met regulatory requirements.
2. NR denied not having access to meals and denied being locked in their room. Was able to show the regulator how to use their call bell, but stated they never use it. NR able to get up into their wheelchair independently, but requires assistance for safety. Observed NR having lunch meal. Reviewed care plan and assessment and resident weight record. Facility met regulatory requirement.

3. NR confirmed they were allowed to have visitors of their choice. Reviewed visitor policy and visitor log. Facility met regulatory requirement.
4. NR had healing skin tears on arms, legs and a foot that occurred during falls. Appeared to be healing at time of regulator's visit. NR denied any other skin issues or concerns. Reviewed skin monitor and pictures of wounds. Nurse provided wound care routinely. Facility met regulatory requirement.

Conclusion / Action:

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

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20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 2538	Compliance Determination # 63966
Plan of Correction	Fieldstone Memory Care of Marysville	Completion Date
Page 1 of 4	Licensee: Marysville Senior Community LLC	09/15/2025

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 08/11/2025 of:

Fieldstone Memory Care of Marysville
11015 State Ave
Marysville, WA 98271

This document references the following complaint number(s): 188807, 189444, 189560

The following sample was selected for review during the unannounced on-site visit: 3 of 61 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Cynthia Chenot-Potter, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2538	Compliance Determination # 63966
Plan of Correction	Fieldstone Memory Care of Marysville	Completion Date
Page 2 of 4	Licensee: Marysville Senior Community LLC	09/15/2025

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.

James Sherman
Residential Care Services

09-24-2025
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)

10/3/25
Date

RCW 70.129.005 Intent -- Basic rights. * CHANGE IN 2012 *** (SEE 2056-S.SL) *** The legislature recognizes that long-term care facilities are a critical part of the state's long-term care services system. It is the intent of the legislature that individuals who reside in long-term care facilities receive appropriate services, be treated with courtesy, and continue to enjoy their basic civil and legal rights. It is also the intent of the legislature that long-term care facility residents have the opportunity to exercise reasonable control over life decisions. The legislature finds that choice, participation, privacy, and the opportunity to engage in religious, political, civic, recreational, and other social activities foster a sense of self-worth and enhance the quality of life for long-term care residents. The legislature finds that the public interest would be best served by providing the same basic resident rights in all long-term care settings. Residents in nursing facilities are guaranteed certain rights by federal law and regulation, 42 U.S.C. 1396r and 42 C.F.R. part 483. It is the intent of the legislature to extend those basic rights to residents in veterans' homes, boarding homes, and adult family homes. The legislature intends that a facility should care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. A resident should have a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. [1994 c 214 1.] NOTES: Zoning -- 1994 c 214: "Nothing in this act shall affect the classifying of an adult family home for the purposes of zoning." [1994 c 214 30.]**

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

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

WAC 388-78A-2660
Resident rights.

The assisted living facility must:
(4) Promote and protect the residents' exercise of all rights granted under chapter RCW 70.129.

RCW 70.129.050 (1).
Personal privacy includes accommodation, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room for each resident however, a resident cannot be prohibited by the facility from meeting with guests in his or her bedroom if no roommates object.

Based on interview and record review, the Assisted Living Facility (ALF) failed to allow private visitation for 1 of 3 sampled residents (Resident 1). This failure placed the resident at risk of psycho-social harm.

Record review of the ALF's Resident Handbook dated 05/27/2021 showed that resident's rights included "Each resident had the right to privacy and confidentiality" and "visitation with family, relatives, friends, and others subject to reasonable restrictions and consent of the resident."

On 08/08/2025 at 9:43 am, Collateral Contact (CC) stated that they had visited Resident 1 and were told by staff that they could only visit in one of the common areas . The CC said that they had brought in copies of paperwork Resident 1 had requested to review . While Resident 1 was reviewing requested documentation, they stated that the signatures did not appear to be their own. Resident 1 wrote their signature on a piece of paper for comparison. During that time, Staff B, medication technician, came into the common area and "lingered", not allowing for privacy.

On 08/11/2025 at 11:30 am, Resident 1 said that they did not want any restrictions on who could visit and wanted to be able to visit privately in their room.

On 08/11/2025 at 1:00 pm, Staff A, the Director of Nursing, said they had not spoken to Resident 1 regarding their wishes on who they wanted to be allowed to visit. Staff A indicated that ALF staff told certain visitors of Resident 1 that they could only visit in the common areas, not in Resident 1's room. Staff A stated the ALF's process was to allow visitors "unless there was an arrangement for them not to have certain visitors."

On 09/03/2025 at 3:20pm Staff A said Resident 1 did not have any legal protection orders in place and that Resident 1's Power-of-Attorney (POA) had requested that they be notified if certain people came to visit Resident 1.

On 09/03/2025 at 3:30pm, Staff B said that they had notified Resident 1's POA that Resident 1 had visitors and that Resident 1 was signing papers.

Statement of Deficiencies	License #: 2538	Compliance Determination # 63966
Plan of Correction	Fieldstone Memory Care of Marysville	Completion Date
Page 4 of 4	Licensee: Marysville Senior Community LLC	09/15/2025

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, Fieldstone Memory Care of Marysville is or will be in compliance with this law and / or regulation on (Date) 10/3/25.

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

Administrator (or Representative) — Date: 10/3/25