STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

BFG Puyallup MC Propco LLC
Fieldstone Memory Care of Puyallup
2121 S Meridian
Puyallup, WA 98371

RE: Fieldstone Memory Care of Puyallup License # 2561

Dear Administrator:

This letter addresses Compliance Determination(s) 77965 (Completion Date 05/26/2026) and 73195 (Completion Date 03/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/26/2026 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-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2160, WAC 388-78A-2371-1, WAC 388-78A-2371-2

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

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

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit D
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Fieldstone Memory Care of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2561
Intake ID: 213867
Compliance Determination #: 73195
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 02/20/2026 through 03/26/2026
Complainant Contact Date(s):

Allegation(s):

1. Resident did not receive medications as ordered.

Investigation Methods:

Sample:	Total residents: Resident sample size: 7 Closed records sample size: 2
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents, including the named resident Staff Resident Representative
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff progress notes Incident log / reports, Facility P & P- Investigations

Investigation Summary:

1. Per record review and interviews with staff and resident representatives, the facility failed to ensure that residents received their medications as ordered. The Assisted Living Facility demonstrated failed provider practice as documented in a Statement of Deficiencies dated 03/26/2026.

Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: Fieldstone Memory Care of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2561
Intake ID: 209920
Compliance Determination #: 73195
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 02/20/2026 through 03/26/2026
Complainant Contact Date(s):

Allegation(s):
1. Injury of unknown source

Investigation Methods:

Sample:	Total residents: Resident sample size: 7 Closed records sample size: 2
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents, including the named resident Staff Resident Representative
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff progress notes Incident log / reports, Facility P & P- Investigations

Investigation Summary:
1. Per record review and interviews with staff and resident representative, the facility failed to investigate an injury of unknown source involving a resident who sustained a hip fracture. The Assisted Living Facility demonstrated failed provider practice as documented in a Statement of Deficiencies dated 03/26/2026.

Conclusion / Action:

- [x] 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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Residential Care Services
Investigation Summary Report

Provider/Facility: Fieldstone Memory Care of Puyallup
Provider Type: Assisted Living Facility
License/Cert.#: 2561
Intake ID: 213040
Compliance Determination #: 73195
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 02/20/2026 through 03/26/2026
Complainant Contact Date(s):

Allegation(s):

1. Resident did not receive medications as ordered.

Investigation Methods:

Sample:	Total residents: Resident sample size: 7 Closed records sample size: 2
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents, including the named resident Staff Resident Representative
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Medication administration records (MAR) Staff progress notes Incident log / reports, Facility P & P- Investigations

Investigation Summary:

1. Per record review and interviews with staff and resident representatives, the facility failed to ensure that residents received their medications as ordered. The Assisted Living Facility demonstrated failed provider practice as documented in a Statement of Deficiencies dated 03/26/2026.

Conclusion / Action:

- [x] 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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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2561	Compliance Determination # 73195
Plan of Correction	Fieldstone Memory Care of Puyallup	Completion Date
Page 1 of 13	Licensee: BFG Puyallup MC Propco LLC	03/26/2026

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 02/20/2026 of:

Fieldstone Memory Care of Puyallup
2121 S Meridian
Puyallup, WA 98371

This document references the following complaint number(s): 209920, 213040, 213925, 213867

The following sample was selected for review during the unannounced on-site visit: 7 of 0 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2561	Compliance Determination # 73195
Plan of Correction	Fieldstone Memory Care of Puyallup	Completion Date
Page 2 of 13	Licensee: BFG Puyallup MC Propco LLC	03/26/2026

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.

Laurie Anderson — Residential Care Services

04/06/2026 — 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.

Sandy Short — Administrator (or Representative)

4/15/26 — 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.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on record review and interviews, the Assisted Living Facility (ALF) failed to ensure 3 of 9 sample residents (Residents 1, Resident 2 and Resident 3) received their medications as ordered for. This failure resulted in all 3 residents not receiving their medications as ordered and placed them at risk for poor health outcomes and a decrease in quality of life.

Findings included...

Review of the facility's policy titled, "Med-08 Medication Ordering and Delivery", dated 04/08/2023, showed that the facility staff were "to have medications ordered and delivered in a timely manner... in order to promote a safe medication system."

Review of the facility's policy titled, "Med-09 Medications Availability", dated

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04/08/2023, showed that "medications will be available to the resident...that the community will re-order the medications with the community preferred pharmacy to ensure no disruption takes place."

RESIDENT 1
Review of Resident 1's records showed the ALF admitted Resident 1 on [redacted]/2025.

Review of Resident 1's negotiated service agreement, dated 01/16/2026, showed that facility staff administered Resident 1's medications.

Review of Resident 1's January 2026 Medication Administration Record (MAR) showed Resident 1 received Nystatin powder (for skin infections), applied twice a day, at 8:00 AM and 5:00 PM. The MAR showed Resident 1 did not receive the 8:00 AM application on 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/24/2026 and 01/28/2026. The MAR showed Resident 1 did not receive the 5:00 PM application on 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, and 01/10/2026.

The January 2026 MAR showed Resident 1 had an order for Diclofenac gel (cream used for pain), applied four times a day at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. The MAR showed Resident 1 did not receive the 9:00 AM application on 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/10/2026, 01/11/2026, 01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/17/2026, 01/18/2026, 01/19/2026, 01/20/2026, 01/21/2026, 01/22/2026, and 01/23/2026.

The January 2026 MAR showed Resident 1 did not receive the 12:00 PM application of Diclofenac on 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/10/2026, 01/11/2026, 01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/17/2026, 01/18/2026, 01/19/2026, and 01/22/2026.

The January 2026 MAR showed Resident 1 did not receive the 5:00 PM application of Diclofenac on 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/10/2026, 01/11/2026, 01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/17/2026, 01/18/2026, 01/19/2026, and 01/22/2026.

The January 2026 MAR showed Resident 1 did not receive the 9:00 PM application of Diclofenac on 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/10/2026, 01/11/2026, 01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/17/2026, 01/18/2026, 01/19/2026, 01/20/2026, 01/21/2026, and 01/22/2026.

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Review of Resident 1's February 2026 MAR showed Resident 1 received Gabapentin (medication used for nerve pain), administered at 9:00 AM, 2:00 PM and 9:00 PM. The MAR showed that Resident 1 did not receive the 9:00 AM dose on 02/14/2026 and on 02/16/2026.

The February 2026 MAR showed Resident 1 did not receive the 2:00 PM dose on 02/14/2026, 02/16/2026, and 02/17/2026.

The February 2026 MAR showed Resident 1 did not receive the 9:00 PM dose on 02/13/2026, 02/14/2026, 02/15/2026, 02/16/2026, and 02/17/2026.

The February 2026 MAR showed Resident 1 received Salonpas patches (used to treat right hip pain) every eight hours at midnight, 8:00 AM and 4:00 PM. The MAR showed that Resident 1 did not receive the midnight patch on 02/06/2026, 02/07/2026, 02/08/2026, 02/09/2026, 02/10/2026, 02/11/2026, 02/12/2026, 02/13/2026, 02/14/2026, 02/15/2026, and 02/16/2026.

The February 2026 MAR showed Resident 1 did not receive the 8:00 AM patch on 02/06/2026, 02/07/2026, 02/08/2026, 02/09/2026, 02/10/2026, 02/11/2026, 02/12/2026, 02/13/2026 and 02/14/2026.

The February 2026 MAR showed Resident 1 did not receive the 4:00 PM patch on 02/05/2026, 02/06/2026, 02/07/2026, 02/08/2026, 02/09/2026, 02/10/2026, 02/11/2026, 02/12/2026, 02/13/2026, 02/14/2026 and 02/15/2026.

RESIDENT 2
Review of Resident 2's records showed the ALF admitted Resident 2 on [redacted]2025.

Review of Resident 2's negotiated service agreement, dated 01/16/2026, showed that Resident 2 required medication assistance from facility staff.

Review of Resident 2's February 2026 MAR showed that Resident 2 received Escitalopram (medication used to manage depression), 20 milligrams (mg) every morning at 9:00 AM. The MAR showed Resident 2 did not receive the medication on 02/12/2026, 02/13/2026 and 02/14/2026.

The February 2026 MAR showed Resident 2 received Metoprolol 50 mg (medication used to treat high blood pressure) every morning at 9:00 AM. The MAR showed Resident 2 did not receive the medication on 02/12/2026, 02/13/2026, and 02/14/2026.

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The February 2026 MAR showed Resident 2 received Acetaminophen/Tylenol (for pain), 325 mg, two tablets three times a day at 8:00 AM, 2:00 PM, and 8:00 PM. The MAR showed Resident 2 did not receive the 8:00 AM dose on 02/12/206 and 02/13/2026. The MAR showed Resident 2 did not receive the 2:00 PM dose on 02/12/2026 and 02/14/2026.

The February 2026 MAR showed Resident 2 received Boost (a nutritional supplement) three times a day, at 9:00 AM, 2:00 PM and 9:00 PM. The MAR showed Resident 2 did not receive the 8:00 AM supplement on 02/22/2026, 02/23/2026, 02/24/2026, 02/25/2026, 02/26/2026, 02/27/2026, and 02/28/2026.

The MAR showed Resident 2 did not receive the 2:00 PM supplement on 02/22/2026, 02/23/2026, 02/24/2026, 02/25/2026, 02/26/2026, 02/27/2026 and 02/28/2026.

The MAR showed Resident 2 did not receive the 9:00 PM supplement on 02/21/2026, 02/23/2026, 02/27/2026, and 02/28/2026.

RESIDENT 3
Review of Resident 3's records showed the ALF admitted Resident 3 on [redacted]/2024.

Review of Resident 3's negotiated service agreement, dated 01/21/2026, showed that Resident 3 required medication assistance from facility staff.

Review of Resident 3's January 2026 MAR showed that Resident 3 received Benazepril (medication for high blood pressure), 40 mg every morning at 8:00 AM. The MAR showed Resident 3 did not receive the medication on 01/11/2026 and 01/30/2026.

Review of Resident 3's January 2026 MAR showed that Resident 3 received Donepezil (medication used for memory loss), 10 mg at 9:00 PM. The MAR showed Resident 3 did not receive medication on 01/27/2026.

Review of Resident 3's January 2026 MAR showed that Resident 3 received Mirtazapine (medication used for sleep/appetite) 7.5 mg at 9:00 PM. The MAR showed Resident 3 did not receive medication on 01/09/2026 and 01/27/2026.

Review of Resident 3's January 2026 MAR showed Resident 3 received Rosuvastatin (medication used to lower cholesterol), 20 mg every day at 8:00 AM. The MAR showed Resident 3 did not receive medication on 01/10/2026, 01/16/2026, and 01/30/2026.

Review of Resident 3's January 2026 MAR showed Resident 3 received Carvedilol (medication used for high blood pressure) 12.5 mg twice a day at 8:00 AM and 5:00 PM.

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Resident 3 did not receive the 8:00 AM dose on 01/16/2026. The MAR showed Resident 3 did not receive the 5:00 PM dose on 01/16/2026 and 01/17/2026.

During an interview on 02/20/2026 at 9:07 AM, Collateral Contact 1 (CC1, Anonymous staff) stated that residents were not receiving their medications as ordered. CC1 stated that when medications were not received on time from their representatives or alternate pharmacies, staff were required to order from the facility's preferred pharmacy to avoid missed medications. CC1 stated that Resident 1 did not receive medications when staff did not follow through. CC1 stated that there were several other residents that did not receive their medications as ordered.

During an interview on 02/20/2026 at 12:00 PM, Collateral Contact 2 (CC2, Anonymous staff) stated that Resident 1 went several days without pain medications. CC2 stated that Resident 1 missed other medications besides the pain medications.

During an interview on 02/20/2026 at 12:10 PM, Staff B, Director of Nursing, stated that Resident 1 was "without meds (medications) for two days". Staff B stated that staff needed to order emergency refills from the ALF's preferred pharmacy to ensure residents received their medications on time.

During an interview on 03/26/2026 at 1:45 PM, Staff B, Director of Nursing stated that there were problems getting medications delivered from Resident 1's preferred pharmacy. Staff B stated that staff did not follow policy to order emergency refills from the ALF's preferred pharmacy. Staff B stated that they needed to look at Resident 2 and Resident 3's MARs to figure out why they did not receive their medications.

During an interview on 02/20/2026 at 1:10 PM, Staff A, Administrator, stated that they were aware Resident 1 missed their medications. Staff A stated that it had 'been handled'. Staff A stated that staff "should have STAT (immediately/urgent) ordered it". Staff A stated that there was "no reason this happened... no reason to miss meds (medications)".

During an interview on 03/05/2026 at 11:27 AM, Collateral Contact 3 (CC3, Resident 1's representative) stated that Resident 1 missed their medications and that the facility "figured it out". CC3 stated that they were not aware of any delivery or reordering problems with Resident 1's preferred pharmacy.

During an interview on 03/06/2026 at 3:14 PM, Collateral Contact 4 (CC4, Anonymous staff) stated that there was no reason for residents to miss their medications. CC4 stated that when residents' medications were not delivered by family or not delivered from a different pharmacy, staff were required to "call pharmacy and place a STAT order".

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During an interview on 03/20/2026 at 1:27 PM, Collateral Contact 5 (CC5, Anonymous staff), stated that if a resident's medications were not delivered on time, staff were supposed to call and order the medications "STAT". CC5 stated that Resident 1 went without medications for several days. CC5 stated that Resident 2, Resident 3 and many others did not always receive their medications.

During an interview on 03/20/2026 at 1:48 PM, Collateral Contact 6 (CC6, Resident representative) stated that they did not think Resident 2 received their medications as ordered. CC6 stated that Resident 2 was combative and that may have contributed to staff not wanting to deal with them.

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 Puyallup is or will be in compliance with this law and / or regulation on (Date) 5/10/26.

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

Sandy Short — Administrator (or Representative)

4/15/26 — 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 record reviews and interviews, the Assisted Living Facility (ALF) failed to ensure that 4 of 7 sample residents (Resident 1, Resident 2, Resident 3, and Resident 4) received showers as agreed upon. This failure placed all four residents at risk for skin infections and poor quality of life.

Findings included...

Review of ALF's undated shower schedule showed that residents were to receive two showers a week.

RESIDENT 1

This document was prepared by Residential Care Services for the Locator website.

Review of Resident 1's records showed the ALF admitted Resident 1 on [redacted]/2025.

Review of Resident 1's negotiated service agreement, dated 01/16/2026, showed that Resident 1 needed staff assistance with showers.

Review of the ALFs shower schedule showed that Resident 1 was scheduled to receive showers on Monday and Thursday mornings. Review of the facility's shower logs showed that in December 2025, Resident 1 did not receive showers on 12/15/2025, 12/22/2025, and 12/25/2026. The log showed that in January 2026, Resident 1 did not receive showers on 01/05/2026, 01/08/2026, 01/12/2026, and 01/15/202. The log showed that in February 2026, Resident 1 did not receive showers on 02/05/2026, 02/09/2026, and 02/23/2026.

RESIDENT 2
Review of Resident 2's records showed the ALF admitted Resident 2 on [redacted]/2022.

Review of Resident 2's negotiated service agreement, dated 02/19/2026, showed that Resident 2 needed staff assistance for showers.

Review of the ALF's shower schedule showed that Resident 2 was scheduled to receive two showers on Monday and Thursday evening. Review of the facility's shower logs showed that in February 2026, Resident 2 did not receive showers on 02/05/2026, 02/16/2026, 02/19/2026, 02/23/2026 and 02/26/2026.

RESIDENT 3
Review of Resident 3's records showed the ALF admitted Resident 3 on [redacted]/2024.

Review of Resident 3's negotiated service agreement, dated 01/21/2026, showed that Resident 3 needed staff assistance with bathing.

Review of the ALFs shower logs showed that Resident 3 was scheduled to receive showers on Tuesday and Friday evening. Review of the ALF's shower logs showed that in December 2025, Resident 3 did not receive showers on 12/02/2025, 12/05/2025, 12/16/2025, 12/23/2025 and 12/25/2026. The log showed that in January 2026, Resident 3 did not receive showers on 01/02/2026, 01/06/2026, 01/09/2026, and 01/26/2026. The log showed that in February 2026, Resident 3 did not receive showers on 02/03/2026, 02/06/2026, 02/13/2026, 02/17/2026, 02/20/2026, and 02/27/2026.

RESIDENT 4
Review of Resident 4's records showed the ALF admitted Resident 4 on [redacted]/2024.

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Review of Resident 4's negotiated service agreement, dated 01/27/2026, showed that Resident 4 needed staff assistance with bathing.

Review of the ALFs shower schedule showed that Resident 4 was scheduled to receive showers on Tuesday and Friday morning. Review of the ALF's shower logs showed that in December 2025, Resident 4 did not receive showers on 12/16/2025, 12/23/2025, and 12/26/2025. The log showed that in January 2026, Resident 4 did not receive showers on 01/06/2026, 01/09/2026, 01/13/2026, and 01/16/2026. The log showed that in February 2026, Resident 4 did not receive showers on 02/10/2026 and 02/17/2026.

During an interview on 02/20/2026 at 9:07 AM, Collateral Contact 1 (CC1, Anonymous staff) stated that residents did not receive showers as scheduled. CC1 stated that residents were to receive at least two showers per week, following the shower schedule.

During an interview on 03/04/2026 at 11:43 AM, Collateral Contact 7 (CC7, Resident representative) stated that Resident 4 was supposed to have showers twice a week. CC7 stated that Resident 4 did not receive any showers from staff. CC7 stated that Resident 4's companions were with Resident 4 all day and reported that staff did not give Resident 4 a shower. CC7 stated that the companions gave Resident 4 a shower because they smelled bad.

During an interview on 03/06/2026 at 2:07 PM, CC1 stated that Resident 1 did not receive their showers. CC1 stated that they were supposed to document and notify the medication technician if a resident refused or was not given their shower. CC1 stated that Resident 4 was "supposed to be a hospice shower...I never see a hospice shower aide". CC1 stated that if hospice did not show up, facility staff were to give Resident 4 their shower.

During an interview on 03/06/2026 at 3:14 PM, Collateral Contact 4 (CC4, Anonymous staff) stated that residents were supposed to receive two showers a week. CC4 stated that facility staff were supposed to give showers to hospice residents if the hospice aide did not show up.

During an interview on 03/06/2026 at 3:31 PM, Collateral Contact 8 (CC8, Anonymous staff) stated that residents were supposed to receive a shower twice a week. CC8 stated that some residents went for two weeks without a shower. CC8 stated that staff were to document on the computer when care and showers were given or when refused and notify the Medication technician if residents refused.

During an interview on 03/20/2026 at 1:27 PM, Collateral Contact 5 (CC5, Anonymous staff) stated that residents went for a couple of weeks without a shower. CC5 stated that if a shower was not given, staff were to re-attempt, try a different staff, a different shift, or another day. CC5 stated that staff never go back and offer a shower...the

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residents just do not get a shower. CC5 stated that the facility staff were unaware when someone had a shower or not. CC5 stated that they just do not get one.

During an interview on 03/20/2026 at 1:48 PM, Collateral Contact 6 (CC6, Resident representative) stated that Resident 2 did not always receive their showers. CC6 stated that Resident 2 sometimes had feces on their hands and clothing. CC6 stated that the showers were not as frequent as they were supposed to be, maybe once a week they would get a shower.

During an interview on 03/20/2026 at 4:21 PM Staff B, Director of Nursing, stated that residents were supposed to receive two showers a week. Staff B stated that there was a shower schedule that staff were supposed to follow. Staff B stated that staff were to document when showers were given or refused.

During an interview on 03/25/2025 at 12:00 PM, Collateral Contact 9 (CC9, Resident representative), stated that Resident 4 was supposed to receive at least one shower a week. CC9 stated that Resident 4 went for over two weeks without a shower. CC9 stated that Resident 4's companions informed them that Resident 4 was not receiving showers.

During an interview on 03/26/2026 at 1:06 PM, Staff A, Administrator, stated that the facility's standard was to give all residents two showers a week. Staff A stated that the shower frequency was not included in the service plan unless there was an exception and residents were getting more than the standard. Staff A stated that staff were to re-attempt missed showers and notify us (management) if they were unsuccessful. Staff A stated that showers were to be given and then documented on the shower logs.

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 Puyallup is or will be in compliance with this law and / or regulation on (Date) 5/10/26.

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

Sandy Short — Administrator (or Representative)

4/15/26 — Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

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(2) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to investigate the incidents of medication errors for 3 of 3 sample residents (Residents 1, Resident 2, and Resident 3) and injury of unknown origin for I of 1 resident (Resident 5) to determine the circumstances and implement interventions to prevent recurrence. This failure placed Resident 1 and Resident 2 at a risk for a decline in their health related to missed medications and caused Resident 5 to experience pain for several days related to a delay in care and caused a decrease in their quality of life.

Findings included...

Review of the facility records showed no documentation of any investigation related to Resident missed medications to rule out abuse, neglect, or exploitation. There was no documentation that showed the facility investigated the cause of Resident 5's hip injury to rule out abuse or neglect. There was no documentation that showed the facility implemented any plan to prevent any recurrence of medication errors or developed any additional plan to reduce the potential for resident falls.

RESIDENT 1
Review of Resident 1's records showed the ALF admitted Resident 1 on [redacted]/2025.

Review of Resident 1's negotiated service agreement, dated 01/16/2026, showed that facility staff assisted Resident 1 with medications.

Review of Resident 1's January 2026 and February 2026 Medication Administration Record (MAR) showed multiple days where Resident 1 did not receive the following medications: Gabapentin (used to treat nerve pain) 900 milligrams (mg) three times a day; Salonpas patch (used to treat right hip pain) three times a day; Nystatin powder (used to treat skin infections) twice a day; and Diclofenac get (cream used to treat pain) four times per day.

RESIDENT 2
Review of Resident 2's records showed the ALF admitted Resident 2 on [redacted]/2025.

Review of Resident 2's negotiated service agreement, dated 01/16/2026, showed that Resident 2 required medication assistance from facility staff.

Review of Resident 2's February 2026 MAR showed multiple days where Resident 2 did not receive the following medications: Escitalopram (medication used to treat

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depression) 20 mg every morning at 9:00 AM; Metoprolol (medication used to treat high blood pressure) 50 mg every morning at 9:00 AM; Acetaminophen/Tylenol (for pain) 650 mg three times a day at 8:00 AM, 2:00 PM and 8:00 PM; and Boost (nutritional supplement) three times a day at 9:00 AM, 2:00 PM and 9:00 PM.

RESIDENT 3
Review of Resident 3's records showed the ALF admitted Resident 3 on [redacted]/2024.

Review of Resident 3's January 2026 MAR showed multiple days where Resident 3 did not receive the following medications: Benazepril (medication for high blood pressure) once per day, Donepezil (medication used for memory loss) once per day, Mirtazapine (medication used for sleep/appetite) once per day, Rosuvastatin (medication used to lower cholesterol) once per day, and Carvedilol (medication used for high blood pressure) twice per day.

RESIDENT 5
Review of Resident 5's records showed the ALF admitted Resident 5 on [redacted]/2022.

Review of the ALF incident report, dated 01/18/2025, showed that Resident 5 was sent to the hospital for evaluation of hip and leg pain.

Review of Resident 5's progress notes showed multiple dates where staff documented a change in Resident 5's condition. On 01/16/2025, staff documented that Resident 5 complained of knee and leg pain. On 01/17/2026, at three different times, staff documented that Resident 5 complained of leg pain and difficulty walking. On 01/18/2026, at four different times, staff documented that Resident 5 complained of leg pain. One progress note entry documented that Resident 5 was offered pain medication. Resident 5 continued to complain of pain. On 01/18/2026 at 1:39 PM, Resident 5's representative was notified that Resident 5 was unable to walk and complained of leg pain.

During an interview on 02/20/2026 at 12:10 PM, Staff B, Director of Nursing, stated that they did not know what happened to Resident 5 to cause their leg pain. Staff B stated that they were unsure of the last day Resident 5 was at their baseline to walk without pain. Staff B stated that they were unsure when Resident 5 started to complain of pain. Staff B stated that they were unaware of any reports by staff for a change in Resident 5's condition. Staff B stated that they were unaware of any falls that Resident 5 had. Staff B stated that they determined there was no abuse or neglect. Staff B stated that they did not have any documentation of the investigation they completed to rule out abuse or neglect.

During an interview on 02/20/2026 at 1:10 PM, Staff A, Administrator, stated that Resident 5 was very impulsive. Staff A stated that they understood that Resident 5 sustained a fall. Staff A stated that staff were unable to find anything that explained

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what happened. Staff A stated that they were unaware of the findings from Staff B's investigation.

During an interview on 03/05/2026 at 11:33 AM, Collateral Contact 10 (CC10, Resident representative) stated that staff called and asked them to come to the facility. CC10 stated that when they arrived at the facility, Resident 5 was in pain. CC10 stated that they asked staff to call emergency services to transport Resident 5 to the hospital. CC10 stated that Resident 5 was diagnosed with [redacted] which required surgery. CC10 stated that none of the facility staff were able to explain what happened. CC10 stated that they were informed Resident 5 had complained of pain for the last three days. CC10 stated that the reached out to the "higher ups" and never received a response about what may have caused the hip fracture.

During an interview on 03/06/2026 at 2:07 PM, Collateral Contact 1 (CC1, Anonymous staff), stated that they did not know what happened to cause Resident 5's hip fracture. CC1 stated that Resident 5 was now bedbound and none of the facility staff knew what happened. CC1 stated that prior to this incident, Resident 5 walked independently and now their quality of life and care was poor.

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 Puyallup is or will be in compliance with this law and / or regulation on (Date) 5|10|26.

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

Sandy Short — Administrator (or Representative)

4|15|26 — Date

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