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

Highland Court Operating Company LLC
Highland Court Memory Care
1704 Melody Ln
Port Angeles, WA 98362

RE: Highland Court Memory Care License # 2378

Dear Administrator:

This letter addresses Compliance Determination(s) 69040 (Completion Date 11/19/2025) and 65605 (Completion Date 09/30/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/19/2025 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-2210-1-b, WAC 388-78A-2210-1

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, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Highland Court Memory Care
License/Cert.#: 2378
Compliance Determination #: 65605
Investigator: Pamela Horlick
Investigation Date(s): 09/15/2025 through 09/30/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 192977
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Resident/Patient/Client Abuse: Report of a staff member using medication to sedate residents to allow respite from their needs.
2. Restraints/Seclusion General: Report of a staff member using medication to sedate residents to allow respite from their needs.
3. Quality of Care/Treatment: Report of staff hiding in closets to avoid assisting residents.
4. Unqualified Personnel: Report of staff not being qualified to conduct medication technician duties.

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Executive Director Registered Nurse
Record Reviews:	State reporting log Facility policies Personnel files Staff training records Medication Administration Records (MAR) Staff actual worked schedule Staff List Medication reconciliation record

Investigation Summary:

1. Resident/Patient/Client Abuse: Sample of resident MAR's reviewed did not show pattern of antipsychotic medication administration consistent with any certain staff member. Unable to substantiate failed practice.
2. Restraints/Seclusion General: Sample of resident MAR's reviewed did not show pattern of antipsychotic medication administration consistent with any certain staff member. Unable to substantiate failed practice.
3. Quality of Care/Treatment: staff interviewed deny seeing or hearing of anyone hiding from residents to avoid providing care. Unable to substantiate failed practice.
4. Unqualified Personnel: Facility failed to ensure med tech had received proper training prior to being allowed to work on the medication cart alone. Failed practice identified.

Conclusion / Action:

- [x] 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

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 09/15/2025 of:

Highland Court Memory Care
1704 Melody Ln
Port Angeles, WA 98362

This document references the following complaint number(s): 192977

The following sample was selected for review during the unannounced on-site visit: 3 of 35 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, the facility failed to implement their medication technician training and validation of skills to ensure staff were safe to pass medications unattended for 1 of 3 staff (Staff C). This failure placed all residents at risk for receiving care and services from untrained staff.

Findings included…

Record review of facility policy titled, “Medication Administration Policy,” undated, documented staff responsible for assisting with or administering medications will receive a minimum of five days of orientation and will have their competency validated by the Registered Nurse (RN) or Licensed Practical Nurse (LPN) prior to the assistance of administration of medications.

In an interview on 09/15/2025 at 12:09PM, Staff B, RN, stated staff would take extra training if they wanted to be a medication technician (Med tech). Staff B stated there was a checkoff list with medication technician tasks that are done with Staff C, Resident Care Coordinator (RCC), to become a med tech.

During a records request on 09/15/2025 at 12:09, Staff E’s Med tech training was

requested and not provided.

In an interview on 09/15/2025 at 1:20PM, Staff B stated they can only find Staff E's checklist for being a caregiver and not a checkoff list for completing med tech training.

Record review of facility provided staff list shows Staff E was hired on 05/28/2025.

Record review of facility provided work schedule, for actual hours worked, showed Staff E was the only Med tech scheduled to work from 6:00PM through 6:00 AM on 08/08/2025 through 08/10/2025 and 08/15/2025 through 08/17/2025.

In an interview on 09/15/2025 at 4:35PM, Staff A, Executive Director, stated during the training process the checklist is checked off. The checkoff sheet would be reviewed and filed appropriately before the med tech is allowed to be alone on the cart. Staff A stated the checklist is done to make sure the med tech in training has gone over everything required to do their job. Staff A stated Staff D, Resident Care Manager, schedules the Med techs and would review the check-off list to make sure someone is trained to work on the medication cart. Staff A stated the Med techs need to have physical training to be on the medication cart and the checklist shows that physical training took place. Staff A stated that without the check list we can't validate that the physical training took place. Staff A stated Staff B would validate that the training was completed prior to a Med tech working on the cart alone. Staff A stated there is no documentation to prove Staff E got the medication technician training and that they don't know why it happened.

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, Highland Court Memory Care 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