



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

NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC
Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

RE: Avamere at Port Townsend License # 2408

Dear Administrator:

This letter addresses Compliance Determination(s) 56344 (Completion Date 03/13/2025) and 52748 (Completion Date 01/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/13/2025 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-3152-1, WAC 388-78A-3152-5-a, WAC 388-78A-3152-5-b, WAC 388-78A-3152-5-c, WAC 388-78A-3152-5, WAC 388-78A-2600-2-I

The Department staff who did the on-site verification:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

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



Residential Care Services Investigation Summary Report

Provider/Facility: Avamere at Port Townsend **Provider Type:** Assisted Living Facility

License/Cert. #: 2408

Intake ID: 162167

Compliance Determination #: 52748

Region/Unit #: RCS Region 3 / Unit E

Investigator: Celeste Vashey

Investigation Date(s): 01/06/2025 through 01/08/2025

Complainant Contact Date(s):

Allegation(s):

1) The facility was not in agreeance with a citation they had been cited for and therefore did not attempt to get back in compliance with the citation.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms
Interviews:	Identified resident Residents Nursing staff
Record Reviews:	Medical records Facility policies

Investigation Summary:

1) Based on observation, interview, and record review the facility will be cited for WAC 388 78A 3152 15abc. The facility did not agree with being cited and therefore did not attempt to get back in compliance with infection control prevention citation.

Conclusion / Action:

- ☒ 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: Avamere at Port Townsend **Provider Type:** Assisted Living Facility

License/Cert. #: 2408

Intake ID: 162036

Compliance Determination #: 52748

Region/Unit #: RCS Region 3 / Unit E

Investigator: Celeste Vashey

Investigation Date(s): 01/06/2025 through 01/08/2025

Complainant Contact Date(s):

Allegation(s):

1) Concern residents who received medication administration services from the facility had unsecured medications inside of their rooms.

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Resident rooms
Interviews:	Identified resident Residents Nursing staff
Record Reviews:	Facility policies Medical records

Investigation Summary:

1) Based on observation, interview, and record review the facility will be cited for WAC 388 78A 2610 2I. While on site 3 residents had unsecured medications in their room that received medication administration from the facility. The facility did not have policies in place to ensure safe medication practices within the facility.

Conclusion / Action:

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



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Statement of Deficiencies	License #: 2408	Compliance Determination #52748
Plan of Correction	Avamere at Port Townsend	Completion Date
Page 1 of 14	Licensee: NorthWest HC Seaport Landing (WA) Operator NT-HCI LLC	01/08/2025

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 01/06/2025 and 01/06/2025 of:

Avamere at Port Townsend
1201 Hancock St
Port Townsend, WA 98368

This document references the following complaint number(s): 162036, 162167

The following sample was selected for review during the unannounced on-site visit: 6 of 58 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Celeste Vashey, ALF LTC Licenser
Anissa Bearden, Licenser

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

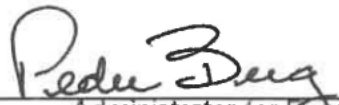
As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Cory Cisneros
Residential Care Services

01/22/2025
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.

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



Administrator (or Representative)

2/5/25

Date

WAC 388-78A-3152 Plan of correction Required.

(1) The assisted living facility must comply with all applicable licensing laws and regulations at all times.

(5) The home must be able to show to the department, upon request, that, for each deficiency cited, the home has:

- (a) A plan of correction and maintaining correction;
- (b) Corrected or is correcting each deficiency; and
- (c) Maintained or is maintaining compliance.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to maintain compliance and to implement a plan of correction for 1 of 1 facility's reviewed related to providing necessary handwashing supplies. This failure impacted all 58 of 58 residents, staff, and visitors at risk for spread of infectious disease or illness.

Findings included...

Record review of the Center of Disease Control and Prevention (CDC) document, titled, "About Hand Hygiene for Patients in Healthcare Settings", dated 02/27/2024, showed, patients in healthcare setting were at risk of getting infections while receiving treatment for other conditions. Cleaning your hands could prevent the spread of germs, including those that were resistance to antibiotics, and protect healthcare personnel and patients. Under the section titled, "how to clean hands", showed they were to, wet their hands with warm water, apply a nickel or quarter sized amount of soap to the hand, rub hands together to form a lather, continue to rub for 15 seconds, rinse hands well under running water, and then dry hands using a paper towel and then turn off water with a paper towel. Under the section titled, "frequently asked questions", showed germs were everywhere. They were within and on a person's body and on every surface anyone touched. But not all germs were bad and that some germs were needed to help keep a person healthy and the immune system strong. Alcohol-based hand sanitizers kill the good and bad germs, but the good germs quickly come back on a person's hands. An alcohol-based hand sanitizer was the preferred method for cleaning your hands when they were not visibly dirty.

Record review of the CDC's website document titled, "clinical safety: Hand Hygiene for Healthcare Workers", dated 02/27/2024, showed hand hygiene protected both healthcare personnel and patients. A common challenge was to keep the skin on the healthcare personnel hands healthy and clean. Under the section titled, "when to use an

alcohol-based hand sanitizer (ABHS)", showed unless hands were visibly soiled, ABHS was preferred over soap and water in most clinical settings. Under the section titled, "when to wash with soap and water", showed when hands were visibly soiled, before eating, after using the restroom, and during care of patients with suspected or confirmed infection during outbreaks of *Clostridioides difficile* (a contagious virus that was easily transmitted through a person stool) and norovirus (an infectious virus that is easily transmitted that cause stomach upset, nausea, vomiting, and diarrhea). Under the section titled, "healthcare facilities" Make hand Hygiene a priority", showed they were to required healthcare personnel to perform hand hygiene based on CDC recommendations, ensure that healthcare providers perform hand hygiene with soap and water when hands were visibly soiled, and ensure supplies for adhering to hand hygiene were accessible when delivering patient care.

Record review of the CDC's website document titled, "Hand sanitizer Guidelines and Recommendations", dated 03/12/2024, showed hand sanitizers can quickly reduce the number of germs on hands in many situations. However sanitizers do not get rid of all types of germs, may not be effective when hands were visibly dirty or greasy, might not remove harmful chemicals, such as pesticides, and heavy metals like lead, and soap and water were more effective than hand sanitizer at removing certain kinds of germs like norovirus, cryptosporidium (an infection that causes a person to have loose stools), *clostridioides difficile*, as well as chemicals. Under the section titled, "tips", showed do not use hand sanitizers if a person's hands were visibly dirty or greasy.

Record review of CDC's fact sheet titled, "About Hand Hygiene at Work", dated 04/18/2024, showed hand hygiene was an easy, affordable, and effective way to prevent the spread of germs and keep employees healthy. Hand hygiene was one of the best ways to prevent employees from getting sick and spreading germs to others in the workplace. Good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It can also mean using alcohol-based hand sanitizer with at least 60 percent alcohol if soap and water were not readily available. Employees were to wash their hands use soap and water instead of hand sanitizer when their hands were visibly dirty. Under the section titled, "tips for protecting employee health", showed provide soap, water, and way to dry hands (for example paper towels or a hand dryer) so employees can wash and dry hands properly. An alcohol-based hand sanitizer was the preferred method for cleaning your hands when they were not visibly dirty.

Record review of the Washington State Department of Health's (DOH) document DOH 505-144 titled, "hand hygiene policy and procedure", dated "May 2018", showed effective hand hygiene reduces the incidence of healthcare-associated infections. All members of the healthcare team would comply with current CDC hand hygiene guidelines. Under the section titled, "indications for handwashing and hand rubbing", showed handwashing was to be conducted when hands were visibly dirty or contaminated with proteinaceous material or were visibly soiled with blood or other body fluids, wash hands with either non-antimicrobial soap and water or an antimicrobial soap and water. Handwashing may also be used routinely decontaminating hands (reduce bacterial count on hands by performing hand hygiene) in the clinical situations that included after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if hands were not

visibly soiled. Indications for use of hand rubbing included if hands were not visibly soiled. When gloves were used and removed the healthcare personnel were to decontaminate hands after removing gloves.

Record review of the facility's document titled, "infection control manual", dated 07/18/2021, showed people who live or work together, such as in an assisted living facility, were more likely to share germs. Many infections could be prevented with basic infection prevention and control steps, such as hand hygiene. Under the section titled, "specific standard precautions", showed hand hygiene referred to the practice of removing or killing germs that were on the hands so that germs do not spread to other people or surfaces. To practice hand hygiene, keep your hands clean by either washing with soap and water or using an alcohol-based hand sanitizer. Change gloves frequently and perform hand hygiene each time gloves were changed as dirty gloves can spread germs too. Keeping your hands clean was the most important thing that could be done to prevent infections. Staff were to wash their hand with soap and water for at least 20 seconds if their hands were visibly soiled, if hands had contact with blood or body fluids, before and after assisting residents with toileting or perineal care, after use of the toilet, and before handling food. Hands were to be dried thoroughly with paper towels and the water was to be turned off with a paper towel. "Hand sanitizer may be used in all other hand hygiene situations not mentioned above", that was listed above. Under the section titled, "engaging everyone in infection prevent and control" for area "survey readiness", showed survey teams monitored compliance with state and federal health care regulations. The community was required to have safeguards in place to prevent health care workers from being hurt or injured on the job, including from infections and infectious diseases. Under the section titled, "how do infections spread?", showed germs could be shared on the hands or gloves of health care workers, on surfaces in the facility, and on medical equipment. If these were not properly cleaned and disinfected, the germs may spread to other people and the environment. Older people, due to declining ability of their immune systems to resist germs, were more susceptible to infection and can become infected more easily.

Record review of the "Department of Social And Health Services" document, Completion date 10/24/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2610] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 11/20/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 12/08/2024."

R1

Record review of the facility's, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R1 moved into the facility on [REDACTED]/2016 and received [REDACTED] services.

In an interview and observation on 01/06/2025 at 1:02 PM, R1 said they supplied their own soap and paper towels for their room. R1's bathroom had been observed to have lavender chamomile hand soap and Yardley London bar soap. R1's bathroom had not been supplied with facility provided soap, paper towels or disposable hand towels for the staff to use.

In an interview and observation on 01/06/2025 at 1:10 PM, Staff G, Caregiver and Staff D, Agency Certified Medical Assistant, entered R1's room. Staff G said R1 did not need current assistance in the restroom. Staff G said if R1 had asked the facility staff to help them in the restroom then they would. When the Department inquired if the facility provided residents hand soap and paper towels in their rooms for facility staff to wash their hands, Staff D said the residents shopped for their own supplies when they went out into the community.

R2

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R2 moved into the facility on [REDACTED]/2024 and was a private pay resident.

In an interview and observation on 01/06/2025 at 12:03 PM, R2 said they could not remember if the facility provided them hand soap and paper towels for the staff to use in their room. R2's kitchenette had a bottle of dawn dish soap and a roll of paper towels. R2's bathroom had a bar of hand soap next to the sink and two blue cloth hand towels. There was no facility provided soap or paper towels in the bathroom or at the kitchenette sink available for the staff to wash their hands.

R3

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R3 moved into the facility on [REDACTED]/2023 and was a private pay resident.

In an observation and interview on 01/06/2025 at 3:43 PM, R3 stated they bought the paper towels that were hung up under the cabinet in the kitchenette area by the sink. There was no observed soap or soap dispenser available at that kitchenette sink for staff to use to wash their hands if needed. At 3:51 PM inside of R3's bathroom, there was a bottle of 7.5 fluid ounces of soft soap fresh breeze hand soap. There were no paper towels or disposable hand towels in R3's bathroom available for staff to use. Above R3's bathroom there had been briefs stocked on an organizational shelf.

R4

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R4 moved into the facility on [REDACTED]/2021 and received [REDACTED] services. The document showed that R4 experienced urinary incontinence and required moderate assistance from staff with activities of daily living needs.

In an observation on 01/06/2025 at 12:03 PM, inside R4's kitchenette sink area it was observed that R4 had a bottle of dawn dish soap. There was no other soap or soap dispenser and disposable paper towels in the area of the kitchenette sink available for the staff to use to wash their hands. Inside R4's bathroom at the sink there was a bottle of peri cleanser. There were no other soap, soap dispenser, or disposable paper towels available for staff to use to wash their hands available.

R5

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R5 moved into the facility on [REDACTED]/2022 and was a private pay resident. The document showed that R5 experienced urinary incontinence.

In an observation and interview on 01/06/2025 at 1:11 PM, inside R5's room the kitchenette sink had a bottle of green dawn dish soap. There was no other soap or soap dispenser and disposable paper towels in the area of the kitchenette sink available for staff to use if they needed to wash their hands. At 1:18 PM, inside R5's bathroom at the sink was a pink bar of soap that had "camay". There was no other soap or soap dispenser and disposable paper towels available in the bathroom for staff to use to wash their hands. R5 was unable to say if the facility provided soap and paper towels in their room for the staff to use. R5 was noted to have a difficult time expressing their words. R5 had green and white incontinent cloth pad in their room, on their bed, and one that was on the seat cushion of their fabric chair that was in the corner of the living area of their room.

R6

Record review of the facility, "Assisted Living Facility Resident Characteristic Roster and Sample Selection", undated, showed R6 moved into the facility on [REDACTED]/2024 and was a private pay resident.

In an interview and observation on 01/06/2025 at 12:06 PM, R6 stated the facility did not provide their room with soap or disposable paper towels at either the kitchenette or bathroom sink for the staff to use. R6 stated that the caregivers assisted them with their showers two times a week and with their laundry services. At 12:14 PM inside R6's bathroom at the sink, it was observed there was a bottle of soap with a label that showed "the unscented company". There was no other soap or soap dispenser and disposable paper towels available for the staff to use to wash their hands. There was a cloth rag that hung on the towel bar that R6 stated was their own. R6's kitchenette sink

was observed and noted that there was a bottle of Meyer's hand soap. There was no disposable paper towels, soap, or soap dispenser available for staff to wash their hand with.

In an interview on 01/06/2025 at 3:13 PM, Staff H, Caregiver, stated if their hands were soiled or dirty the facility's expectation was for the caregiver to put a glove over their soiled hand, exit the residents room to walk down the hallway to the resident accessible laundry room if they were on the second or third floor and wash their hands with soap and water in the laundry room sink. Staff H stated if their glove broke during resident care and their hand got soiled, they would use the residents sink with whatever soap was available in the resident's room to get their hands clean. Staff H stated they have had their gloves break in the past during resident care. Staff H stated the facility provided only [REDACTED] resident's soap in soap dispensers for the staff to wash their hands within the residents' room. Staff H stated the staff hand washing procedure consisted of staff putting on gloves, performing the resident task in the resident room, then exiting the resident room and go down the hallway to the sink in the laundry room on the second or third floor of the facility to wash their hands with soap, water, and dry with paper towels. Staff E, Caregiver, Staff H, Caregiver and Staff D said the facility provided hand soap only to [REDACTED] paid residents, and that would be a liquid soap stored in soap dispensers in the resident's rooms.

In an interview on 01/06/2025 at 3:52 PM, when Staff B, Director of Health Services Registered Nurse, stated they were not going to answer the question if the facility provided soap and paper towels in the residents' rooms for the staff to wash their hands with if they were visibly soiled. Staff B stated Staff A, executive director, would discuss the topic. Staff B stated R5 had expressive aphasia (a condition when it is difficult to express thoughts and ideas through speech). Staff B stated R5 could get "ripe" at times. When the Department clarified "ripe", Staff B stated R5 was incontinent of urine and had a history of soiling their cloths and bed linens with urine. Staff B stated when R5 was out of their room and downstairs in the dining room or attending activities, the caregivers would go into R5's room to remove the soiled incontinent pads, linens, and any clothing to get rid of the urine. Staff B stated if the caregivers hands became soiled or had gotten urine on their hands, the expectation would be for the caregiver to put a glove on their soiled hand, exit the room, walk down the hallway to the nearest laundry room sink, remove the glove and then wash their hands with soap and water. Staff B stated if the caregiver's glove broke and their hand became soiled, they were expected to take the rest of the glove off turn it inside out, open the resident's door with the inside of the glove, exit the resident's room and go to the nearest laundry room sink to wash their hands with soap and water. Staff B stated if the caregiver's hands were really soiled the caregiver could always ask permission from the resident to rinse their hands in the residents sink in their room. Staff B stated the staff were trained per the CDC's guidance of hand washing and the reason why they exit the residents' room to go to the nears laundry room sink to wash their hands with soap, water, and dry with paper towels. Staff B stated the assisted living facility was "light care" and the residents that reside at the facility did not require a lot of personal care.

In an interview on 01/06/2025 at 5:09 PM, Staff A, Executive Director, stated all caregivers were required to wear gloves with personal resident care. Staff A stated soap and disposable paper towels were provided and accessible by all caregivers for only the [REDACTED] residents that resided in the facility. Staff A stated that each staff member

went through training on handwashing and infection control policy and procedures when they were asked what the facility did to ensure all private pay residents had soap and paper towels in their rooms for staff to wash their hands with. Staff A stated staff were expected to use hand sanitizer to wash their hands in the resident's room, exit the resident's room, and go to the nearest laundry room sink to wash their hands with soap, water, and paper towels. Staff A stated, "we have not done that as we disagree with your [the Departments] decision", when they were asked if they had supplied the private pay resident rooms with soap and disposable paper towels for the staff to wash their hands with.

In an interview on 01/08/2025 at 1:11 PM, Staff A stated they were not in agreement with the Department on the citations. Staff A stated a plan of correction (POC) was told it was not required. The Department reviewed that a written POC was not required but the facility must take action to correct and fix the citation to be in compliance with the regulation.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 2/22/25.

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



Administrator (or Representative)

2/5/25

Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290, sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to develop policies and procedures and train facility staff on safe medication practices for 3 of 3 sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). These failures placed all 58 of 58 residents at risk of potential ingestion of potentially harmful substances, presented risk for misuse of medications by residents, staff, or visitors, lack of resident assessment of capability to take medication independently and untrained staff on safe medication procedures placed all residents at risk for medical complications.

Findings included...

Washington Administrative Code (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."

WAC 388-78A-2260 Storing, securing, and accounting for medications "(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications."

WAC 388-78A-2270 Resident controlled medications "(1) The assisted living facility must ensure all medications are stored in a manner that prevents each resident from gaining access to another resident's medications."

Record review of the United States Food and Drug Administration (FDA) website document titled, "Drugs @ FDA Glossary of Terms", undated, showed a drug was defined as a substance recognized by an official pharmacopoeia or formulary, intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease, a substance (other than food) intended to affect the structure of any function of the body, a substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device, and biological products included within this defining that were generally covered by the same laws and regulations, but differences existing regarding their manufacturing process (chemical process versus biological process). Under the section titled, "marketing status", showed marketing status indicated how a drug product was sold in the United States. Drug products in "Drugs @FDA" were identified as prescription, over-the-counter, discontinued, and non-drug products that have been tentatively approved.

Revised Code of Washington (RCW) 18.64.011 Definitions- Washington "the definitions in this section apply throughout this chapter unless the context clearly requires otherwise... (15) "Drugs" means: (a) Articles recognized in the official United States pharmacopoeia or the official homeopathic pharmacopoeia of the United States; (b) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings or other animals; (c) Substances (other than food) intended to affect the structure or any function of the body of human beings or other animals; or (d) Substances intended for use as a component of any substances specified in (a), (b), or (c) of this subsection, but not including devices or their component parts or accessories... (23) "Long-term care facility" means a nursing home licensed under chapter 18.51 RCW, an assisted living facility licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

RCW 18.20.280 General responsibility for each resident. "(1) The assisted living facility must assume general responsibility for each resident and must promote each resident's health, safety, and wellbeing consistent with the resident negotiated care plan. (2) The assisted living facility is not required to supervise the activities of a person providing care or services to a resident when the resident, or legal representative, has independently arranged for or contracted with the person and the person is not directly or indirectly controlled or paid by the assisted living facility. However, the assisted living facility is required to coordinate services with such person to the extent allowed by the

resident, or legal representative, and consistent with the resident's negotiated care plan. Further, the assisted living facility is required to observe the resident and respond appropriately to any changes in the resident's overall functioning consistent with chapter 70.129 RCW, this chapter, and rules adopted under this chapter."

RCW 18.20.360 Full reassessment of resident. "(1) The assisted living facility licensee shall within fourteen days of the resident's date of move-in, unless extended by the department for good cause, and thereafter at least annually, complete a full reassessment addressing the following: (i) Any prescribed medications and over-the-counter medications that are commonly taken by the individual, and that the individual is able to independently self-administer or safely and accurately direct others to administer to him or her; (ii) Any prescribed medications and over-the-counter medications that are commonly taken by the individual and that the individual is able to self-administer when he or she has the assistance of a resident-care staff person; and (iii) Any prescribed medications and over-the-counter medications that are commonly taken by the individual and that the individual is not able to self-administer... (h) The individual's level of personal care needs, including: Ability to perform activities of daily living; medication management ability, including the individual's ability to obtain and appropriately use over-the-counter medications; and how the individual will obtain prescribed medications for use in the assisted living facility."

Record review of the Center of Disease Control website document titled, "Low Blood Sugar (Hypoglycemia)", dated 05/16/2024, showed blood sugar below 70 mg/dL (milligrams per deciliter) was considered low. Low blood sugar was common in people with type 1 diabetes (a condition that affected the bodies' ability to regulate high and low blood sugar levels). Symptoms of low blood sugar levels included feeling weak, acting strange, and feeling confused.

Record review of the FDA (Food and Drug Administration) website document titled, "Don't overuse Acetaminophen", dated 02/01/2024, showed both prescription and nonprescription medications contained acetaminophen to help relieve pain, reduce fever, relieve pain from headaches, muscles aches, sore throats, toothaches, and backaches. Too much acetaminophen can lead to overdose and severe liver damage. Symptoms of an overdose included nausea, vomiting, abdominal pain, confusion, and jaundice (yellow skin and eyes). The FDA recommended not to take a prescription and an over-the-counter medicine that contained acetaminophen unless advised by a health care professional.

Record review of the facility's policy, titled, "Medication Management", dated "3/2022", showed the executive director would ensure a safe and accurate system for dispensing of medications by staff or by the resident if they self-administered medication. The Director of Health would collaborate with the physician to see if each resident had the ability to self-administer their own medication. Residents who self-administered medications must have written authorization from their physician. Residents could keep over the counter medications in their apartment without a physician order. If a resident had been determined they could not safely administer their own medications, then facility staff should administer medications as ordered by the physician. Residents who received assistance with administration of medications would have their medications stored in a designated locked community storage area that was not accessible to other people other than facility staff. If the facility managed resident's medications that resident's medication should be bubble packed or in the original container.

R1

Record review of R1's, "Department of Social and Health Services Assessment Details", dated 11/18/2024, showed R1 required daily assistance with self-administration of their medication. R1's limitation included that their ability to take their medication fluctuated and they forgot to take their medications. The memory section indicated R1 had short term memory problems.

Record review of R1's, "AL (Assisted Living) Level of Care and Service Plan – WA (Washington)", dated 12/01/2024, showed R1 had multiple medication diagnoses that included [REDACTED]

[REDACTED] and [REDACTED]. The medications and treatments management section showed that R1 received full assistance with their medication three times a day. The facility staff would order all of R1's medications as they had a complex medication regimen that needed to be reviewed by the licensed nurse quarterly.

Record review of R1's service plan, dated 04/29/2024, showed under medication management, R1 had a complex medication regimen and that polypharmacy (simultaneous use of multiple drugs to treat a condition) or psychoactive medications (mind altering drug that changed the brains' function) placed R1 at risk for complications. The facility staff were to provide R1 with medication assistance and would document medications in the MAR (Medication Administration Record). R1 could put the medication in their mouth but needed assistance to prepare medication and having it handed to them to take.

Record review of R1's MAR, dated 01/01/2025 through 01/31/2025, showed R1 had a blood sugar check on 01/03/2025 at 7:00 AM that was 48.

In an interview and observation on 01/06/2025 at 1:02 PM, R1 said the facility staff provided them their medications. In R1's closet outside of their bathroom R1 had a wooden hutch that contained over 20 different medications. Some of the medications included three 16 fluid ounces of Pepto Bismol bottles (a medication used to treat heartburn, acid reflux, indigestion, diarrhea, and nausea), 12 fluid ounces of antacid (a medication used to neutralize stomach acid and relieves heartburn, indigestion, and upset stomach), a package of 30 cherry cough drops, a package of Ricola original cough drops, a bottle of 200 milligram 50 coated Advil (a medication used to treat pain, fever, swelling, and redness), and a container of the brand major cold and flu daytime relief (a medication that temporarily alleviates headaches, fever, body aches, nasal congestion, and cough).

In an interview and observation on 01/06/2025 at 1:10 PM, Staff D, Agency Certified Medical Assistant, entered R1's room. Staff D confirmed the facility staff provided R1 their medications. Staff D stated the facility provided medications were stored inside of

the medication cart. The Department inquired if Staff D had been aware R1 stored a variety of medications inside of their room. Staff D's eyes got very wide but before they could respond R1 interjected and said they had a lot of over-the-counter medications.

In an interview on 01/06/2024 at 3:14 PM, Staff D said their hands were tied in regard to R1 having medication stored in their room and there was nothing they could do about it. Staff D said they had not yet reported that R1 had medication in their room to Staff B, Director of Health Services. Staff D said they saw R1's medications today because R1 had a fall earlier in the day and they had more access to R1's bedroom.

R2

Record review of R2's, "AL Level of Care and Service Plan – WA", dated 12/17/2024, showed R2 had a diagnosis of [REDACTED] and [REDACTED]. The medications and treatment management section showed R2 received full assistance with medication four times a day. The facility staff would provide R2 with medication assistance and would document all medications in the MAR.

Record review of R2's service plan, dated 12/18/2024, under the section titled, medication management showed the facility staff would provide R2 medication assistance and would document all medications on the MAR. R2 could put the medication in their mouth but needed help preparing medication and having it handed to them to take.

In an interview and observation on 01/06/2024 at 12:03 PM, R2 said the facility provided them their medications for them to take. In R2's closet outside of their bathroom showed a wooden hutch that contained over 10 medications. Some of which included two bottles of 12 fluid ounces of Nyquil severe cold and flu (medication that treats cold and flu symptoms), Kirkland 500 milligram extra strength acetaminophen (a medication that relieves headaches, muscle aches, colds, sore throats, tooth aches, backaches, and reduces fever), 34 ounces of MiraLAX (medication to treat constipation), and a bottle of Afrin original (a nasal decongestant spray).

In an interview on 01/06/2024 at 3:14 PM, Staff D confirmed the facility provided and stored R2 their medications. Staff D said the facility staff discouraged residents to have medications in their room because they could overdose (a toxic drug amount or combination of drugs overwhelm the body). Staff D said if R2 had a headache and took medication then they also gave them medication it could cause an overdose. Staff D said they saw R2's medication in their room today because R2 asked for help getting something in the bathroom and when they passed R2's closet they saw the medications.

R3

Record review of R3's service plan, dated 11/08/2024, showed under the medication

management section that the facility staff would provide R3 with medication assistance and would document all medications on the MAR. R3 could put the medication in their mouth but needed help preparing medication and having it handed to them to take.

Record review of R3's MAR, dated 01/01/2025 through 01/31/2025, showed R3 had an order to take two tablets of 500 milligrams of acetaminophen three times a day for pain. R3 received 18 of 18 dosages for the six days they received their medication.

In an observation on 01/06/2024 at 3:51 PM, R3's bathroom sink had a bottle of 225 capsules of 500 milligram extra strength acetaminophen.

Record review of an email sent to the Department on 01/06/2025 at 11:57 AM, Staff A, executive director, said the facility provided R1 and R2's their prescription medications. Staff A said the facility did not complete a self-medication assessment on R1 and R2 to provide. Staff A said their policy stated residents who self-administered their prescription medications must have written authorization from their physician. Residents could keep over-the-counter medications in their apartment without a physician's order.

In an interview on 01/06/2025 at 3:52 PM, Staff B, Director of Health Services, stated the facility administered and stored R1 and R2's prescription medications to them. Staff A stated R1 and R1 were allowed to have over-the-counter medication stored in their rooms. Staff A stated they had not completed a self-medication assessment for R1 and R2 as they did not administer their own prescription medications. Staff A stated the facility, and the resident did not need a physician order to take over-the-counter medication themselves and store in their room. When Staff A was asked how the facility knew that the resident was safe to self-administer their medications, Staff A stated they would have a physician order. Staff A stated the residents had a right to have over-the-counter medication in their room since they resided at an assisted living facility. Staff A stated when R2 came into the facility the family had brought all R2's medication to the facility to check with the physician orders. Staff A stated they had reviewed the medication with R2's family and told them to take the rest of the medication back home. Staff A again said that R2's medications were given to them by the facility and reason why a self-medication assessment was not completed. Staff A stated the facility's policy stated the residents were allowed to store and keep over-the-counter medication in their room and did not need a physician order for the over-the-counter medications or self-administer. Staff A stated if R1 could drive and order off the internet shopping then they were allowed to keep and administer their own over-the-counter medications. Staff A stated the facility provided R3's prescription medications to them. Staff A stated they did not have a self-medication assessment completed on R3. Staff A stated R3 was allowed to have acetaminophen in their room as it was an over-the-counter medication and did not require a physician order. Staff A stated they would only store and administer over-the-counter medications to a resident if they did have a physician order for them.

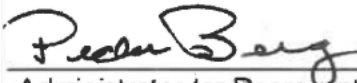
In an interview on 01/06/2025 at 5:09 PM, Staff A was informed that R1, R2, and R3's rooms were observed to have unsecured medications. Staff A stated the facility's policy was over-the-counter medications were not required to be assessed, residents were

allowed to have them in their room, and residents were able to self-administer the over-the-counter medications. Staff A stated the guidance was the corporation's policy. Staff A stated there was not a self-medication assessment completed for R1, R2, or R3, as the facility administers their medications. The Department expressed great concern that the facility was managing and administering R1, R2, and R3 prescription medication, but no self-medication assessment was completed, and there were multiple staff in the resident's rooms that had observed the medication without informing the management. Staff A acknowledged that there were residents that resided in the facility that stored over-the-counter medication in their rooms, but the facility and corporations' policy stated the residents could have over-the-counter medications in their possession without a physician's order.

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, Avamere at Port Townsend is or will be in compliance with this law and / or regulation on (Date) 2/22/25.

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



Administrator (or Representative)

2/5/25

Date