



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

Greenlake Management Ocean Shores, LLC
Ocean Shores Assisted Living
4441 W. Airport FWY Ste 160
Irving, TX 75062

RE: Ocean Shores Assisted Living License # 2615

Dear Administrator:

This letter addresses Compliance Determination(s) 25589 (Completion Date 06/21/2023) and 22436 (Completion Date 04/26/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/21/2023 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-2240, WAC 388-78A-2140, WAC 388-78A-2140-1, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-b, WAC 388-78A-2140-1-c, WAC 388-78A-2140-1-d, WAC 388-78A-2140-1-e, WAC 388-78A-2140-2, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2140-3, WAC 388-78A-2140-4, WAC 388-78A-2140-5, WAC 388-78A-2140-6, WAC 388-78A-2260, WAC 388-78A-2260-2, WAC 388-78A-2260-2-a, WAC 388-78A-2260-2-b, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2120, WAC 388-78A-2120-3, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2600, WAC 388-78A-2600-2, WAC 388-78A-2600-2-f, WAC 388-78A-2600-2-l, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210

The Department staff who did the on-site verification:

Paul Aube, ALF NCI

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

Sincerely,

Ocean Shores Assisted Living # 2615

06/21/2023

Page 2 of 2

Cory Cisneros

Cory Cisneros, Field Manager

Region 3, Unit E

Residential Care Services



Residential Care Services Investigation Summary Report

Provider/Facility: Ocean Shores Assisted Living

License/Cert.#: 2615

Compliance Determination #: 22436

Investigator: Paul Aube

Investigation Date(s): 04/12/2023 through 04/26/2023

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 77814

Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Resident/Patient/Client Neglect: Public allegation of facility not administering medications as per the resident's negotiated service agreement.
2. Administration/Personnel: Public allegation of facility failing to pay for medications, resulting in residents going without prescribed medications.

Investigation Methods:

Sample:	Total residents: 53 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Management Pharmacy Representatives
Record Reviews:	Medical records Facility policies Incident Logs Disclosure of Services Care Plans Progress Notes Medication Administration Records

Investigation Summary:

1. Resident/Patient/Client Neglect: Facility failed to follow policy and procedure of re-ordering medications, which resulted in resident's missing their scheduled medications. Failed practice identified.

2. Administration/Personnel: Facility helping to facilitate with residents and their physicians to provide alternative medications as able. Facility not required to pay for resident's medications. No failed practice.

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: Ocean Shores Assisted Living

License/Cert.#: 2615

Compliance Determination #: 22436

Investigator: Paul Aube

Investigation Date(s): 04/12/2023 through 04/26/2023

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 78567

Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Quality of Care/Treatment: Public report of medication errors occurring in the facility.
2. Dietary Services: Public report of facility serving left-overs for lunch, at the dinnertime hour.

Investigation Methods:

Sample:	Total residents: 53 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Management Pharmacy Representatives
Record Reviews:	Medical records Facility policies Incident Logs Disclosure of Services Care Plans Progress Notes Medication Administration Records Menus

Investigation Summary:

1. Quality of Care/Treatment: Facility staff observed to "pre-pour" medications, and deliver multiple resident medications at one time. Facility failed to investigate the med

error when became aware, failed to notify the physician, and failed to monitor the resident for adverse reactions to medications. Failed practice identified.

2. Dietary Services: Facility providing non-repeating main dishes, and offering alternate choices per resident wishes. No failed practice.

Conclusion / Action:

- ☒ 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
6639 Capitol Blvd SW, Floor 1 or 1, Tumwater, WA 98501

Statement of Deficiencies	License #: 2615	Compliance Determination #: 22438
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 25	Licensee: Greenlake Management Ocean Shores, LLC	04/26/2023

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 04/12/2023 and 04/12/2023 of:

Ocean Shores Assisted Living
1020 Catala Avenue SE
Ocean Shores, WA 98569

This document references the following complaint number(s): 77814, 78567

The following sample was selected for review during the unannounced on-site visit: 5 of 53 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Auba, ALF NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
6639 Capitol Blvd SW, Floor 1 or 1
Tumwater, WA 98501

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

05/09/2023
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.



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
6639 Capitol Blvd SW, Floor 1or 1, Tumwater, WA 98501

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Residential Care Services

Date

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Statement of Deficiencies

License #: 2815

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page 2 of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/25/2023

Administrator (or Representative)

Debbie Smathers

Date

5/23/23

WAC 388-78A-2240. Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to obtain medications in a timely manner for 3 of 5 sample residents (Resident 1 (R1), Resident 2 (R2), and Resident 3 (R3)) reviewed. This failure caused R1, R2, and R3 to not receive their medications in a timely manner, which resulted in missed doses of their prescribed medications and placed residents at risk for medical complications.

Findings included...

Review of the facility "Med Room Workflow" policy, last reviewed on 08/10/2021, under "Refills" stated, "It is the responsibility of every staff member involved with medications to ensure the medications are ordered appropriately. Medications are ordered at least 7 days before running out (more days may be needed when needed due to difficult or mail order pharmacies, upcoming holidays/weekends, and controlled substances)." "Each shift the Nurse/Med Tech is to follow through with refills pending (re-fax, call pharmacy, call family, etc.)."

<R1>

Review of R1's face sheet showed that the resident was admitted to the facility on [REDACTED]/2004.

Review of R1's Medication Administration Record (MAR) for March of 2023, and April of 2023, showed that the resident had the following missed medication doses:

•03/29/2023: Multivitamins Men's 50+ Tab (tablet): Under the "Exceptions" section it listed the reason for the missed dose as "Medication requires refill authorization PCP notified." Under the "Notes" for that missed dose, it stated, "Med not here."

•03/30/2023: Multivitamins Men's 50+ Tab Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "med not here."

•04/05/2023: Atorvastatin (medication for cholesterol) 80mg (milligrams) tab; Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "notes" for that missed dose, it stated, "Have not received medication from

Administrator (or Representative)

Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

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Based on record review and interview, the facility failed to obtain medications in a timely manner for 3 of 5 sample residents (Resident 1 (R1), Resident 2 (R2), and Resident 3 (R3)) reviewed. This failure caused R1, R2, and R3 to not receive their medications in a timely manner, which resulted in missed doses of their prescribed medications and placed residents at risk for medical complications.

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- 04/05/2023: Atorvastatin (medication for cholesterol) 80mg (milligrams) tab: Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "notes" for that missed dose, it stated, "Have not received medication from

Statement of Deficiencies

License #: 2816

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page 3 of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

pharmacy."

•04/11/2023: Lantus (insulin medication to treat diabetes) 100U/1ml (milliliters) Vial: Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "Have not received medication from pharmacy."

•04/12/2023: Lantus 100U/1ml Vial. Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "Still waiting on pharmacy Delivery."

Review of R1's Medication Re-Order History in their medical record showed that the facility had the following re-orders:

- Multivitamins Men's 50+ Tab: Medication was re-ordered by the facility on 03/28/2023 at 4:28AM.
- Atorvastatin 80mg Tab: Medication was re-ordered by the facility on 04/04/2023 at 4:13AM.
- Lantus 100U/1ml Vial: Medication was re-ordered by the facility on 04/01/2023 at 4:19PM. The record showed the facility re-ordered the medication again on 4/11/2023 at 4:57PM, however no follow-up was completed to ensure the medication was on site after the initial ordering on 04/01/2023.

<R2>

Review of R2's face sheet showed that the resident was admitted to the facility on [REDACTED] /2020.

Review of R2's MAR for March of 2023, and April of 2023, showed that the resident had the following missed medication doses:

•04/06/2023: Buspirone (medication to treat anxiety) 10mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Waiting on Pharmacy."

•04/11/2023: Acetaminophen (pain relief medication) 500mg Caplet Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "No meds in overflow, reordered."

•04/12/2023: Allopurinol (acid reducing medication) 300mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Waiting on Pharmacy Delivery."

Review of R2's Medication Re-Order History in their medical record, showed that the facility had the following re-orders:

- Buspirone 10mg tab: Medication was re-ordered by the facility on 03/28/2023 at 8:08PM. The record showed the facility received a status code of "Rejected" on 04/06/2023 at 7:

pharmacy.”

•04/11/2023: Lantus (insulin medication to treat diabetes)100U/1ml (milliliters) Vial: Under the “Exceptions” section it listed the reason for the missed dose as “Physically unable to take.” Under the “Notes” for that missed dose, it stated, “Have not received medication from pharmacy.”

•04/12/2023: Lantus 100U/1ml Vial. Under the “Exceptions” section it listed the reason for the missed dose as “Physically unable to take.” Under the “Notes” for that missed dose, it stated, “Still waiting on pharmacy Delivery.”

Review of R1’s Medication Re-Order History in their medical record showed that the facility had the following re-orders:

- Multivitamins Men’s 50+ Tab: Medication was re-ordered by the facility on 03/29/2023 at 4:28AM.
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- Lantus 100U/1ml Vial: Medication was re-ordered by the facility on 04/01/2023 at 4:19PM. The record showed the facility re-ordered the medication again on 4/11/2023 at 4:57PM, however no follow-up was completed to ensure the medication was on site after the initial ordering on 04/01/2023.

<R2>

Review of R2’s face sheet showed that the resident was admitted to the facility on [REDACTED]/2020.

Review of R2’s MAR for March of 2023, and April of 2023, showed that the resident had the following missed medication doses:

- 04/06/2023: Buspirone (medication to treat anxiety) 10mg Tab. Under the “Exceptions” section it listed the reason for the missed dose as “Physically Unable to take.” Under the “Notes” for that missed dose, it stated, “Waiting on Pharmacy.”
- 04/11/2023: Acetaminophen (pain relief medication) 500mg Caplet Under the “Exceptions” section it listed the reason for the missed dose as “Physically Unable to take.” Under the “Notes” for that missed dose, it stated, “No meds in overflow, reordered.”
- 04/12/2023: Allopurinol (acid reducing medication) 300mg Tab. Under the “Exceptions” section it listed the reason for the missed dose as “Physically Unable to take.” Under the “Notes” for that missed dose, it stated, “Waiting on Pharmacy Delivery.”

Review of R2’s Medication Re-Order History in their medical record, showed that the facility had the following re-orders:

- Buspirone 10mg tab: Medication was re-ordered by the facility on 03/26/2023 at 8:08PM. The record showed the facility received a status code of “Rejected” on 04/06/2023 at 7:

Statement of Deficiencies

License #: 2616

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page 4 of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

3:30PM stating, "Failed! Pharmacy Rejected - Refill too soon."

- Allopurinol 300mg Tab: Medication was re-ordered by the facility on 04/12/2023 at 6:44AM.
- There was no Medication Re-Order History for Acetaminophen 500mg Caplet.

<R3>

Review of R3's face sheet showed that the resident was admitted to the facility on [REDACTED] 2022.

Review of R3's MAR for March of 2023, and April of 2023, showed that the resident had the following missed doses:

•03/08/2023: SulfaTrimeth (antibiotic to treat infections) DS 800-160mg Tab: Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not delivered."

•03/09/2023: SulfaTrimeth DS 800-160mg Tab: Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not here."

•03/09/2023: Vitamin D3 1000U (units). Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not here."

Review of R2's Medication Re-Order History in their medical record, showed that the facility had the following re-orders:

- Vitamin D3 1000U Cap: Medication was re-ordered by the pharmacy on 03/05/2023 at 1:10PM
- There was no Medication Order History provided for SulfaTrimeth DS 800-160mg Tab.

During an interview with the Staff A, the Health Services Director, on 04/12/2023 at 12:56PM, when asked what their expectation of staff is regarding medication re-ordering, they stated their expectation of staff is to re-order a medication when there is 7 days left of a medication. Staff A stated that this is currently a problem in the facility, and that they are working on re-educating staff to ensure this process is followed.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/10/23.

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

33PM stating, "Failed: Pharmacy Rejected – Refill too soon."

- Allopurinol 300mg Tab: Medication was re-ordered by the facility on 04/12/2023 at 6:44AM.
- There was no Medication Re-Order History for Acetaminophen 500mg Caplet.

<R3>

Review of R3's face sheet showed that the resident was admitted to the facility on [REDACTED]/2022.

Review of R3's MAR for March of 2023, and April of 2023, showed that the resident had the following missed doses:

•03/08/2023: SulfaTrimeth (antibiotic to treat infections) DS 800-160mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not delivered."

•03/09/2023: SulfaTrimeth DS 800-160mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med no here."

•03/09/2023: Vitamin D3 1000U (units). Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not here."

Review of R2's Medication Re-Order History in their medical record, showed that the facility had the following re-orders:

- Vitamin D3 1000U Cap: Medication was re-ordered by the pharmacy on 03/05/2023 at 1:10PM
- There was no Medication Order History provided for SulfaTrimeth DS 800-160mg Tab.

During an interview with the Staff A, the Health Services Director, on 04/12/2023 at 12:56PM, when asked what their expectation of staff is regarding medication re-ordering, they stated their expectation of staff is to re-order a medication when there is 7 days left of a medication. Staff A stated that this is currently a problem in the facility, and that they are working on re-educating staff to ensure this process is followed.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Statement of Deficiencies:

License #: 2816

Compliance Determination #: 22436

Plan of Correction

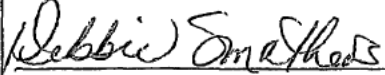
Ocean Shores Assisted Living

Completion Date

Page 6 of 26

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

 _____ Administrator (or Representative)	5/18/23 _____ Date
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WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

(e) The resident's preferences for how services will be provided, supported and accommodated by the assisted living facility.

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

(4) The resident's preferences for activities and how those preferences will be supported;

(5) Appropriate behavioral interventions, if needed;

(6) A communication plan, if special communication needs are present;

_____ Administrator (or Representative)	_____ Date
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WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (i) The resident's preadmission assessment;
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;
 - (b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;
 - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
 - (d) The plan to provide necessary health support services, if provided by the assisted living facility;
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- (2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:
 - (a) Exclusively for the individual resident; or
 - (b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.
- (3) The times services will be delivered, including frequency and approximate time of day, as appropriate;
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- (5) Appropriate behavioral interventions, if needed;
- (6) A communication plan, if special communication needs are present;

Statement of Deficiencies

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Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page 6 of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to develop and document necessary information in the resident negotiated service agreement to support each resident's assessed needs and preferences for 5 of 5 sample residents (Resident 1 (R1), Resident 2 (R2), Resident 3 (R3), Resident 4 (R4), and Resident 5 (R5)) reviewed. This failure places all 5 residents, and all other residents in the facility at risk of not receiving the negotiated care from the facility as per their agreement.

Findings Included:

<R1>

Review of R1's face sheet showed that the resident was admitted to the facility on [REDACTED] 2004.

Review of R1's Negotiated Service Agreement, last reviewed on 07/16/2022, showed the resident does not wear dentures, is independent with ambulation, does not wear glasses or hearing aids, and is on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "Independent." No other information was listed, and the resident's shower schedule was blank.
 - Under the "Grooming" category, it stated, "Reminders Only." There was no further information listed.
 - Under the "Dressing" category, it stated, "Independent." There was no further information listed.
 - Under the "Meals" category, it stated, "Preparation Only." "Resident gets room trays at all meals."
 - Under the "Toileting" category, it stated, "Independent." There was no further information listed.
 - Under the "Ambulation" category, it stated "Independent." There was no further information listed.
 - Under the "Transfers" category, it stated, "Independent." There was no further information listed.
 - Under the "Medication" category, it stated, "Independent." There was no further information listed.
 - Under the "Safety" category, it stated, "Can resident leave the premises unassisted? YES," "Falls: NO," and "Code Status: Full Code."
- Under the "Special Care Needs" category, it listed, "Wound/Skin - Diabetic" but no other information. It also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses.
- Under the "Goals" and "Interventions" section, there was no information listed.

<R2>

Review of R2's face sheet showed that the resident was admitted to the facility on [REDACTED] 2020.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to develop and document necessary information in the resident negotiated service agreement to support each resident's assessed needs and preferences for 5 of 5 sample residents (Resident 1 (R1), Resident 2 (R2), Resident 3 (R3), Resident 4 (R4), and Resident 5 (R5)) reviewed. This failure places all 5 residents, and all other residents in the facility at risk of not receiving the negotiated care from the facility as per their agreement.

Findings included...

<R1>

Review of R1's face sheet showed that the resident was admitted to the facility on [REDACTED]/2004.

Review of R1's Negotiated Service Agreement, last reviewed on 07/16/2022, showed the resident does not wear dentures, is independent with ambulation, does not wear glasses or hearing aids, and is on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "Independent." No other information was listed, and the resident's shower schedule was blank.
- Under the "Grooming" category, it stated, "Reminders Only." There was no further information listed.
- Under the "Dressing" category, it stated, "Independent." There was no further information listed.
- Under the "Meals" category, it stated, "Preparation Only." "Resident gets room trays at all meals."
- Under the "Toileting" category, it stated, "Independent." There was no further information listed.
- Under the "Ambulation" category, it stated "Independent." There was no further information listed.
- Under the "Transfers" category, it stated, "Independent." There was no further information listed.
- Under the "Medication" category, it stated, "Independent." There was no further information listed.
- Under the "Safety" category, it stated, "Can resident leave the premises unassisted? YES," "Falls: NO," and "Code Status: Full Code."

Under the "Special Care Needs" category, it listed, "Wound/Skin – Diabetic" but no other information. It also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses.

Under the "Goals" and "Interventions" section, there was no information listed.

<R2>

Review of R2's face sheet showed that the resident was admitted to the facility on [REDACTED]/2020.

Statement of Deficiencies

License #: 2615

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page 7 of 25

Licensee: Greenlake Management Ocean Shores, LLC

04/26/2023

Review of R2's Negotiated Service Agreement, last reviewed on 07/17/2022, showed the resident did not wear dentures, used a walker with ambulation, wore glasses but not hearing aids, and was on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "Reminders Only." The resident shower schedule was listed as twice a week, on Wednesday and Saturday evenings.
 - Under the "Grooming" category, it stated, "Independent." There was no further information listed.
 - Under the "Dressing" category, it stated, "Independent." There was no further information listed.
 - Under the "Meals" category, it stated, "Requires Reminders." There was no further information listed.
 - Under the "Toileting" category, it stated, "Independent." There was no further information listed.
 - Under the "Ambulation" category, it stated "Independent." There was no further information listed.
 - Under the "Transfers" category, it stated, "Independent." There was no further information listed.
 - Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - Under the "Safety" category, it stated, "Can resident leave the premises unassisted? YES," "Falls: YES," and "Code Status: Full Code."
- Under the "Special Care Needs" category, it listed, "Wound/Skin - Diabetic" but no other information. It also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses. Under the "Goals" and "Interventions" section, there was no information listed.

<R3>

Review of R3's face sheet showed that the resident was admitted to the facility on [REDACTED] 2022.

Review of R3's Negotiated Service Agreement, last reviewed on 03/22/2023, showed the resident did not wear dentures, used a wheelchair with ambulation, wore glasses but not hearing aids, and was on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "Reminders Only." The resident shower schedule was listed as twice a week, on Mondays and Thursdays, but did not designate in the evening or morning.
- Under the "Grooming" category, it stated, "Reminders Only." There was no further information listed.
- Under the "Dressing" category, it stated, "Total Assist." There was no further information listed.
- Under the "Meals" category, it stated, "Requires Reminders." There was no further information listed.
- Under the "Toileting" category, it stated, "Independent." There was no further information listed.
- Under the "Ambulation" category, it stated "Total Assist." There was no further information listed.

Review of R2's Negotiated Service Agreement, last reviewed on 07/17/2022, showed the resident did not wear dentures, used a walker with ambulation, wore glasses but not hearing aids, and was on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "Reminders Only." The resident shower schedule was listed as twice a week, on Wednesday and Saturday evenings.
 - Under the "Grooming" category, it stated, "Independent." There was no further information listed.
 - Under the "Dressing" category, it stated, "Independent." There was no further information listed.
 - Under the "Meals" category, it stated, "Requires Reminders." There was no further information listed.
 - Under the "Toileting" category, it stated, "Independent." There was no further information listed.
 - Under the "Ambulation" category, it stated "Independent." There was no further information listed.
 - Under the "Transfers" category, it stated, "Independent." There was no further information listed.
 - Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - Under the "Safety" category, it stated, "Can resident leave the premises unassisted? YES," "Falls: YES," and "Code Status: Full Code."
- Under the "Special Care Needs" category, it listed, "Wound/Skin – Diabetic" but no other information. It also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses. Under the "Goals" and "Interventions" section, there was no information listed.

<R3>

Review of R3's face sheet showed that the resident was admitted to the facility on [REDACTED]/2022.

Review of R3's Negotiated Service Agreement, last reviewed on 03/22/2023, showed the resident did not wear dentures, used a wheelchair with ambulation, wore glasses but not hearing aids, and was on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "Reminders Only." The resident shower schedule was listed as twice a week, on Mondays and Thursdays, but did not designate in the evening or morning.
- Under the "Grooming" category, it stated, "Reminders Only." There was no further information listed.
- Under the "Dressing" category, it stated, "Total Assist." There was no further information listed.
- Under the "Meals" category, it stated, "Requires Reminders." There was no further information listed.
- Under the "Toileting" category, it stated, "Independent." There was no further information listed.
- Under the "Ambulation" category, it stated "Total Assist." There was no further information listed.

Statement of Deficiencies

License #: 2816

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page 8 of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023

- * Under the "Transfers" category, it stated, "Total Assist." There was no further information listed.
 - * Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - * Under the "Safety" category, it stated, "Can resident leave the premises unassisted? NO," "Falls: YES," and "Code Status: DNR/Selective."
- Under the "Special Care Needs" category it also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses. Under the "Goals" and "Interventions" section, there was no information listed.

<R4>

Review of R4's face sheet showed that the resident was admitted to the facility on [REDACTED]/2022.

Review of R4's Negotiated Service Agreement, last reviewed on 08/15/2022, showed the resident did not wear dentures, used a walker or wheelchair with ambulation, wore glasses but not hearing aids, and was on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- * Under the "Bathing" category, it stated, "Independent." The resident shower schedule was listed as twice a week, on Mondays and Friday mornings.
 - * Under the "Grooming" category, it stated, "Independent." There was no further information listed.
 - * Under the "Dressing" category, it stated, "Total Assist." "Resident requests assistance with shoes, socks, and walking boot."
 - * Under the "Meals" category, it stated, "Requires Reminders." There was no further information listed.
 - * Under the "Toileting" category, it stated, "Independent." There was no further information listed.
 - * Under the "Ambulation" category, it stated "Occasional Assist." "Resident has a broken foot at this time and requires assistance at times."
 - * Under the "Transfers" category, it stated, "Independent." There was no further information listed.
 - * Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - * Under the "Safety" category, it stated, "Can resident leave the premises unassisted? YES," "Falls: YES," and "Code Status: DNR/Selective."
- Under the "Special Care Needs" category it also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses. Under the "Goals" and "Interventions" section, there was no information listed.

<R5>

Review of R5's face sheet showed that the resident was admitted to the facility on [REDACTED] 2018.

Review of R5's Negotiated Service Agreement, last reviewed on 07/18/2022, showed the resident did not wear dentures, used a wheelchair with ambulation, wore glasses and hearing aids, and was on a diabetic diet.

- Under the "Transfers" category, it stated, "Total Assist." There was no further information listed.
 - Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - Under the "Safety" category, it stated, "Can resident leave the premises unassisted? NO," "Falls: YES," and "Code Status: DNR/Selective."
- Under the "Special Care Needs" category it also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses. Under the "Goals" and "Interventions" section, there was no information listed.

<R4>

Review of R4's face sheet showed that the resident was admitted to the facility on [REDACTED]/2022.

Review of R4's Negotiated Service Agreement, last reviewed on 08/15/2022, showed the resident did not wear dentures, used a walker or wheelchair with ambulation, wore glasses but not hearing aids, and was on a regular diet.

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "Independent." The resident shower schedule was listed as twice a week, on Mondays and Friday mornings.
 - Under the "Grooming" category, it stated, "Independent." There was no further information listed.
 - Under the "Dressing" category, it stated, "Total Assist." "Resident requests assistance with shoes, socks, and walking boot."
 - Under the "Meals" category, it stated, "Requires Reminders." There was no further information listed.
 - Under the "Toileting" category, it stated, "Independent." There was no further information listed.
 - Under the "Ambulation" category, it stated "Occasional Assist." "Resident has a broken foot at this time and requires assistance at times."
 - Under the "Transfers" category, it stated, "Independent." There was no further information listed.
 - Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - Under the "Safety" category, it stated, "Can resident leave the premises unassisted? YES," "Falls: YES," and "Code Status: DNR/Selective."
- Under the "Special Care Needs" category it also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses. Under the "Goals" and "Interventions" section, there was no information listed.

<R5>

Review of R5's face sheet showed that the resident was admitted to the facility on [REDACTED]/2016.

Review of R5's Negotiated Service Agreement, last reviewed on 07/18/2022, showed the resident did not wear dentures, used a wheelchair with ambulation, wore glasses and hearing aids, and was on a diabetic diet.

Statement of Deficiencies

License #: 2616

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page 9 of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "2 person assist." The resident shower schedule was listed as twice a week, on Tuesdays and Friday evenings. It also stated, "Resident now requires 2 person assistance because she refuses to stand or do things on her own."
 - Under the "Grooming" category, it stated, "Total Assist." There was no further information listed.
 - Under the "Dressing" category, it stated, "Total Assist." There was no further information listed.
 - Under the "Meals" category, it stated, "Preparation Only." There was no further information listed.
 - Under the "Toileting" category, it stated, "2 Person Assist and/or incontinent." There was no further information listed.
 - Under the "Ambulation" category, it stated, "Total Assist." "Resident needs to be pushed in wheelchair at this time."
 - Under the "Transfers" category, it stated, "2 Person Assist." There was no further information listed.
 - Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - Under the "Safety" category, it stated, "Can resident leave the premises unassisted? NO," "Falls: NO," and "Code Status: Full Code."
- Under the "Special Care Needs" category, it also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses.
- Under the "Goals" and "Interventions" section, there was no information listed.
- A Category of Behavioral/Mental was added for the resident on 03/27/2023, which stated resident was "Total Assist." However, no other information listed. Under the "Goals" and "Interventions" section, there was no information listed.

During an interview with the Staff A, the Health Services Director, on 04/12/2023 at 12:56PM, when asked why the Resident Service Plans had such minimal information on the resident, they stated they were unaware of the requirement to have more thorough information on each resident negotiated service agreement.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/10/23.

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

Administrator (or Representative)

Debbi Smother

Date 5/18/23

Under Activities of Daily Living (ADL's) it listed "Assistance provided by Caregivers," and listed the following categories:

- Under the "Bathing" category, it stated, "2 person assist." The resident shower schedule was listed as twice a week, on Tuesdays and Friday evenings. It also stated, "Resident now requires 2 person assistance because she refuses to stand or do things on her own."
 - Under the "Grooming" category, it stated, "Total Assist." There was no further information listed.
 - Under the "Dressing" category, it stated, "Total Assist." There was no further information listed.
 - Under the "Meals" category, it stated, "Preparation Only." There was no further information listed.
 - Under the "Toileting" category, it stated, "2 Person Assist and/or Incontinent." There was no further information listed.
 - Under the "Ambulation" category, it stated "Total Assist." "Resident needs to be pushed in wheelchair at this time."
 - Under the "Transfers" category, it stated, "2 Person Assist." There was no further information listed.
 - Under the "Medication" category, it stated, "Significant (Total) Assist by Med-Tech." There was no further information listed.
 - Under the "Safety" category, it stated, "Can resident leave the premises unassisted? NO," "Falls: NO," and "Code Status: Full Code."
- Under the "Special Care Needs" category, it also listed the resident's diagnosis but no other information on interventions for managing or monitoring of these diagnoses. Under the "Goals" and "Interventions" section, there was no information listed. A Category of Behavioral/Mental was added for the resident on 03/27/2023, which stated resident was "Total Assist." However, no other information listed. Under the "Goals" and "Interventions" section, there was no information listed.

During an interview with the Staff A, the Health Services Director, on 04/12/2023 at 12:56PM, when asked why the Resident Service Plans had such minimal information on the resident, they stated they were unaware of the requirement to have more thorough information on each resident negotiated service agreement.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

Statement of Deficiencies:

License #: 2816

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

- (a) In containers with pharmacist-prepared label or original manufacturer's label;
- (b) Together for each resident and physically separated from other residents' medications;

This requirement was not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure all resident medications were properly stored in containers with a pharmacist prepared label, and physically separated from other resident for 2 of 2 medication carts reviewed. This failure placed all residents receiving delegated medication services at risk for harm due to medication errors.

Findings Included...

Review of the The Institute for Safe Medical Practices article, "Guidelines for Timely Medication Administration," last reviewed on 01/13/2011, stated that professionals who dispense medications, due to the pressure of timeliness, will often take shortcuts in an attempt to accelerate the drug administration process. It defined one of these shortcuts as pre-pouring medications, which is the process of preparing medications in advance and then storing them until ready to administer to the resident at a later time. Pre-pouring medications is not a safe medication practice because the medications cannot be accurately compared to the Medication Administration Record (MAR) once they have been removed from their labeled packaging. Storing these opened, unlabeled resident medications together dramatically increases the probability of medication errors.

Review of the facility "Medication Storage of Centrally Stored Medications" policy, last reviewed 12/15/2021, stated, "Medications will be stored in a manner that ensures maintenance of both the integrity of the medication, and the safety of all residents residing in the community." Under numeral 3, it stated, "The Community must ensure all medications under the community's control are properly stored; in containers with pharmacist-prepared label or original manufacturer's label, together for each resident, and physically separated from other resident's medications."

During an interview with Staff C, a Medication Technician (Med Tech), on 04/21/2023, at 09:58AM, when asked if they ever pre-poured their medications to speed up their medication administration process, Staff C stated, "No, we do not pre-pour medications." When asked if they ever carry two or more resident medication cups at one time while administering medications, Staff C stated they would only carry and administer medications to one resident at a time. After the interview, Staff C was asked to open their medication cart for inspection. Observation showed six, pre-poured medication cups, all stacked on top of one other. Each medication cup had open, unlabeled medications ready for administration to residents.

WAC 388-78A-2260 Storing, securing, and accounting for medications.

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- (a) In containers with pharmacist-prepared label or original manufacturer's label;
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This requirement was not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure all resident medications were properly stored in containers with a pharmacist prepared label, and physically separated from other resident for 2 of 2 medication carts reviewed. This failure placed all residents receiving delegated medication services at risk for harm due to medication errors.

Findings included...

Review of the The Institute for Safe Medical Practices article, "Guidelines for Timely Medication Administration," last reviewed on 01/13/2011, stated that professionals who dispense medications, due to the pressure of timeliness, will often take shortcuts in an attempt to accelerate the drug administration process. It defined one of these shortcuts as pre-pouring medications, which is the process of preparing medications in advance and then storing them until ready to administer to the resident at a later time. Pre-pouring medications is not a safe medication practice because the medications cannot be accurately compared to the Medication Administration Record (MAR) once they have been removed from their labeled packaging. Storing these opened, unlabeled resident medications together dramatically increases the probability of medication errors.

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During an interview with Staff C, a Medication Technician (Med Tech), on 04/21/2023, at 09:58AM, when asked if they ever pre-poured their medications to speed up their medication administration process, Staff C stated, "No, we do not pre-pour medications." When asked if they ever carry two or more resident medication cups at one time while administering medications, Staff C stated they would only carry and administer medications to one resident at a time. After the interview, Staff C was asked to open their medication cart for inspection. Observation showed six, pre-poured medication cups, all stacked on top of one other. Each medication cup had open, unlabeled medications ready for administration to residents.

Statement of Deficiencies

License #: 2816

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 10:10AM, when asked if they ever pre-pour medications, Staff D stated that they never pre-pour their medications. When asked if they ever carry multiple resident medication cups at one time while administering medications, Staff D stated they would only carry and administer medications to one resident at a time. After the interview, Staff D was asked to open their medication cart for inspection. Staff D stated, "I never usually do this, but I do have one here." Observation showed one medication cup with open, unlabeled medications, pre-poured for another resident.

During an interview with Resident 6 (R6) on 04/21/2023 at 10:42AM, when asked if they had ever witnessed the Med Techs carrying other resident medications when they were receiving their medications, R6 eyes grew wide stating, "Oh yea. That is a big problem here." When asked to elaborate on what they had witnessed, R6 stated, "I have seen them carry other people's medications, you know, in the medication cups, all stacked up on top of each other. When they come in, they put all of the cups on my counter, and then go through them to get mine. They give me my pills, and then scoop them all up and walk out."

During an interview with Resident 7 (R7) on 04/21/2023 at 10:50AM, when asked if they had noticed staff carrying multiple resident medication cups while administering their medication, R7 stated, "Yes, the [Med Tech] came in here to give me my medicine. [They are] excellent at everything [they do], but this night [they] carried two medications cups of pills into my room and [they] handed me the wrong one, I put them in my mouth, and [they] looked in the other container and [they] saw my purplish pill in the other container, and then [they] yelled at me to stop! Then [they] told me to spit them out back in the cup, I hadn't swallowed them at that point, so I did."

During an interview with Staff B, the Health Services Director on 04/21/2023 at 1:53PM, when asked if it was acceptable for staff to pre-pour medications, Staff B stated, "Absolutely not." After notifying Staff B of what was observed in the medication carts, Staff B stated that they had provided education to staff on proper medication storage and administration. Staff B stated, "They should know that pre-pouring their medications is not acceptable."

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/10/23.

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

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 10:10AM, when asked if they ever pre-pour medications, Staff D stated that they never pre-pour their medications. When asked if they ever carry multiple resident medication cups at one time while administering medications, Staff D stated they would only carry and administer medications to one resident at a time. After the interview, Staff D was asked to open their medication cart for inspection. Staff D stated, "I never usually do this, but I do have one here." Observation showed one medication cup with open, unlabeled medications, pre-poured for another resident.

During an interview with Resident 6 (R6) on 04/21/2023 at 10:42AM, when asked if they had ever witnessed the Med Techs carrying other resident medications when they were receiving their medications, R6 eyes grew wide stating, "Oh yea. That is a big problem here." When asked to elaborate on what they had witnessed, R6 stated, "I have seen them carry other people's medications, you know, in the medication cups, all stacked up on top of each other. When they come in, they put all of the cups on my counter, and then go through them to get mine. They give me my pills, and then scoop them all up and walk out."

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

Statement of Deficiencies

License #: 2616

Compliance Determination #: 22436

Plan of Correction

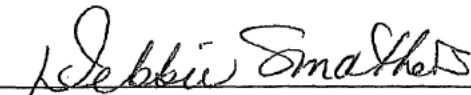
Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023



 Administrator (or Representative)

 5/18/23
 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;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and
- (4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to investigate and document investigative actions and findings after they became aware of a medication error for one of one resident reviewed (Resident B, R8) for medication services. This failure resulted in harm to R8 when they experienced pain and caused the resident to live in fear of potential adverse reactions from receiving the incorrect medications.

Findings Included...

Review of the facility "Med Room Workflow" policy, last reviewed on 08/10/2021, under the "Medication Handling" category it stated, "No resident shall be allowed to take another's medication, nor shall staff be allowed to give one resident's medication to another resident."

Review of the facility "Internal Incident Report and State Incident Report" policy, last reviewed on 08/10/2021, under the "Procedure" category stated, "An Internal Incident Report is completed by staff for all unusual occurrences, injury, and incidents." Under numeral "8" it stated, "The assisted living facility must: 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 of life."

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, "Yeah, they gave me the wrong medication." R8 stated that they were pressuring the Medication Technician (Med Tech) to give them their medications quickly because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally did. R8 stated that they had no reason to

Administrator (or Representative)

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;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and
- (4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to investigate and document investigative actions and findings after they became aware of a medication error for one of one resident reviewed (Resident 8, R8) for medication services. This failure resulted in harm to R8 when they experienced pain and caused the resident to live in fear of potential adverse reactions from receiving the incorrect medications.

Findings included...

Review of the facility "Med Room Workflow" policy, last reviewed on 08/10/2021, under the "Medication Handling" category it stated, "No resident shall be allowed to take another's medication, nor shall staff be allowed to give one resident's medication to another resident."

Review of the facility "Internal Incident Report and State Incident Report" policy, last reviewed on 08/10/2021, under the "Procedure" category stated, "An internal Incident Report is completed by staff for all unusual occurrences, injury, and incidents." Under numeral "8" it stated, "The assisted living facility must: 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 of life."

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, "Yeah, they gave me the wrong medication." R8 stated that they were pressuring the Medication Technician (Med Tech) to give them their medications quickly because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally did. R8 stated that they had no reason to

Statement of Deficiencies

License #: 2815

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management Ocean Shores, LLC

04/28/2023

believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident's medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, "No, I was in pain all day!" When asked how this incident made the resident feel, they stated, "That made me feel like shit, really bad. That could kill me." R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. "One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn't take, things that I don't need. Things that I am afraid of."

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:50PM, Staff D stated, "[Staff A] told me that [R8] was asking, well, really demanding [their] meds." Staff D stated that while getting the medications ready, they accidentally prepared another resident's medications, and administered them to R8. "[Staff A] came back and asked about R8's [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get. I was not told to do anything else at that point. I did not do an incident report which I should have."

During an interview with Staff A, the Executive Director on 04/21/2023 at 1:53PM, when asked if it was facility process to do an Incident Report and investigation for unusual occurrences, Staff A confirmed that it was. When asked if they would categorize a medication error as an unusual occurrence, Staff A stated, "Yes."

During an interview with Staff B, the Health Services Director on 04/21/2023 at 1:53PM, when asked to discuss the facility process when it was determined a medication error had occurred, Staff B stated that staff were instructed to notify them, ensure the resident was safe and call Emergency Medical Services (EMS) if needed. Staff B stated that staff were to document the incident in a progress note. Staff B stated that they would do an incident report, do an online report to the state, and notify the resident's physician of the error, and resident family if necessary. Staff B stated that the resident would be placed on alert and staff would be responsible for monitoring the resident for any adverse reactions, and document these in the resident progress notes for 3 days minimum and extended if necessary. When asked if they were aware of a reported medication error regarding R8, Staff B confirmed that the medication error occurred. When asked what date this error occurred, Staff B had difficulty determining the date of the medication error due to the lack of documentation, but after conferring with Staff A and Staff D, they eventually determined the incident to have occurred on 03/29/2023. When asked what was done after becoming aware of the error, Staff B stated they called R8's doctor to notify them of the error, to which they were instructed to hold all of R8's medications for the remainder of that day. When asked to provide documentation of that physician notification, Staff B was unable to provide it. Staff B stated that they do not remember if they wrote a progress note on the incident or not, and stated they remembered doing an incident report.

believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident's medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, "No, I was in pain all day!" When asked how this incident made the resident feel they stated, "That made me feel like shit, really bad. That could kill me." R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. "One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn't take, things that I don't need. Things that I am afraid of."

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:59PM, Staff D stated, "[Staff A] told me that [R8] was asking, well really demanding [their] meds." Staff D stated that while getting the medications ready, they accidentally prepared another resident's medications, and administered them to R8. "[Staff A] came back and asked about R8's [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get. I was not told to do anything else at that point. I did not do an incident report which I should have."

During an interview with Staff A, the Executive Director on 04/21/2023 at 1:53PM, when asked if it was facility process to do an Incident Report and investigation for unusual occurrences, Staff A confirmed that it was. When asked if they would categorize a medication error as an unusual occurrence, Staff A stated, "Yes."

During an interview with Staff B, the Health Services Director on 04/21/2023 at 1:53PM, when asked to discuss the facility process when it was determined a medication error had occurred, Staff B stated that staff were instructed to notify them, ensure the resident was safe and call Emergency Medical Services (EMS) if needed. Staff B stated that staff were to document the incident in a progress note. Staff B stated that they would do an incident report, do an online report to the state, and notify the resident's physician of the error, and resident family if necessary. Staff B stated that the resident would be placed on alert and staff would be responsible for monitoring the resident for any adverse reactions, and document these in the resident progress notes for 3 days minimum and extended if necessary. When asked if they were aware of a reported medication error regarding R8, Staff B confirmed that the medication error occurred. When asked what date this error occurred, Staff B had difficulty determining the date of the medication error due to the lack of documentation, but after conferring with Staff A and Staff D, they eventually determined the incident to have occurred on 03/29/2023. When asked what was done after becoming aware of the error, Staff B stated they called R8's doctor to notify them of the error, to which they were instructed to hold all of R8's medications for the remainder of that day. When asked to provide documentation of that physician notification, Staff B was unable to provide it. Staff B stated that they do not remember if they wrote a progress note on the incident or not, and stated they remembered doing an incident report.

Statement of Deficiencies

License #: 2816

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

Review of the facility Incident Log on 04/21/2023 showed no Incident Report created for any medication errors. Review of R8's progress notes showed no progress note of the medication error, and no monitoring of the resident for adverse reactions for the minimum period of 3 days. Review of R8's Medication Administration Record, showed no mention of a medication error in the notes.

During an interview on 04/21/2023 at 1:53PM, Staff B was asked why there was no Incident Report, progress note, and alert charting documented in the resident record for R8. Staff B shook their head and stated, "There should have been."

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/10/23.

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

Rebecca Smathers
Administrator (or Representative)

5/18-23
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident, or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to monitor a resident for adverse reactions from a medication error after a staff administered a resident the wrong medications, for one of one resident reviewed (Resident 8, R8). This failure resulted in R8 experiencing pain, and placed the resident at risk for potential unidentified adverse reactions related to ingesting the incorrect medications, and decreased quality of life.

Findings included...

Review of the facility "Medication Errors" policy, last reviewed on 08/10/2021, under the "Procedure" category, numeral "1" it stated, "The individual identifying the medication error

Review of the facility Incident Log on 04/21/2023 showed no Incident Report created for any medication errors. Review of R8's progress notes showed no progress note of the medication error, and no monitoring of the resident for adverse reactions for the minimum period of 3 days. Review of R8's Medication Administration Record, showed no mention of a medication error in the notes.

During an interview on 04/21/2023 at 1:53PM, Staff B was asked why there was no Incident Report, progress note, and alert charting documented in the resident record for R8, Staff B shook their head and stated, "There should have been."

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
_____ Administrator (or Representative)	_____ Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (3) Evaluate, in order to determine if there is a need for further action:
- (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to monitor a resident for adverse reactions from a medication error after a staff administered a resident the wrong medications, for one of one resident reviewed (Resident 8, R8). This failure resulted in R8 experiencing pain, and placed the resident at risk for potential unidentified adverse reactions related to ingesting the incorrect medications, and decreased quality of life.

Findings included...

Review of the facility "Medication Errors" policy, last reviewed on 08/10/2021, under the "Procedure" category, numeral "1" it stated, "The individual identifying the medication error

Statement of Deficiencies

License #: 2615

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023

immediately reports it to the Wellness Director. If the Wellness Director is not available, the report is made to the nurse or Executive Director." Under numeral "4" it stated, "Monitor the resident for signs and symptoms of a serious adverse reaction (e.g., shortness of breath, allergic reaction, change in condition, pale skin color, rash, nausea, vomiting, diarrhea, etc.) Numeral "5" stated if signs and symptoms of adverse reaction are noted, immediately contact Emergency Medical Services." Numeral "6" stated "enter a narrative note on resident status during every shift for 48 hours after a medication error occurs."

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, "Yeah, they gave me the wrong medication." R8 stated that they were pressuring the Medication Technician (Med Tech) to give them their medications quickly, because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally do. R8 stated that they had no reason to believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident's medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, "No, I was in pain all day!" When asked how this incident made the resident feel they stated, "That made me feel like shit, really bad. That could kill me." R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. "One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn't take, things that I don't need. Things that I am afraid of."

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:59PM, Staff D stated, "[Staff A] told me that [R8] was asking, well really demanding [their] meds." Staff D stated that while getting the medications ready, they accidentally prepared another resident's medications, and administered them to R8. "[Staff A] came back and asked about R8's [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get. I was not told to do anything else at that point. I did not do an incident report which I should have."

During an interview with Staff B, the Health Services Director on 04/21/2023 at 1:53PM, when asked to discuss the facility process when it was determined a medication error had occurred, Staff B stated that staff were instructed to notify them, ensure the resident was safe and call Emergency Medical Services (EMS) if needed. Staff B stated that staff were to document the incident in a progress note. Staff B stated that they would do an incident report, do an online report to the state, and notify the resident's physician of the error, and resident family if necessary. Staff B stated that the resident would be placed on alert and staff would be responsible for monitoring the resident for any adverse reactions, and document these in the resident progress notes for 3 days minimum and extended if necessary. When asked if they were aware of a reported medication error regarding R8,

immediately reports it to the Wellness Director. If the Wellness Director is not available, the report is made to the nurse or Executive Director.” Under numeral “4” it stated, “Monitor the resident for signs and symptoms of a serious adverse reaction (e.g., shortness of breath, allergic reaction, change in condition, pale skin color, rash, nausea, vomiting, diarrhea, etc.) Numeral “5” stated if signs and symptoms of adverse reaction are noted, immediately contact Emergency Medical Services.” Numeral “6” stated “enter a narrative note on resident status during every shift for 48 hours after a medication error occurs.”

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, “Yeah, they gave me the wrong medication.” R8 stated that they were pressuring the Medication Technician (Med Tech) to give them their medications quickly, because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally do. R8 stated that they had no reason to believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident’s medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, “No, I was in pain all day!” When asked how this incident made the resident feel they stated, “That made me feel like shit, really bad. That could kill me.” R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. “One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn’t take, things that I don’t need. Things that I am afraid of.”

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:59PM, Staff D stated, “[Staff A] told me that [R8] was asking, well really demanding [their] meds.” Staff D stated that while getting the medications ready, they accidentally prepared another resident’s medications, and administered them to R8. “[Staff A] came back and asked about R8’s [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get. I was not told to do anything else at that point. I did not do an incident report which I should have.”

During an interview with Staff B, the Health Services Director on 04/21/2023 at 1:53PM, when asked to discuss the facility process when it was determined a medication error had occurred, Staff B stated that staff were instructed to notify them, ensure the resident was safe and call Emergency Medical Services (EMS) if needed. Staff B stated that staff were to document the incident in a progress note. Staff B stated that they would do an incident report, do an online report to the state, and notify the resident’s physician of the error, and resident family if necessary. Staff B stated that the resident would be placed on alert and staff would be responsible for monitoring the resident for any adverse reactions, and document these in the resident progress notes for 3 days minimum and extended if necessary. When asked if they were aware of a reported medication error regarding R8,

Statement of Deficiencies:

License #: 2616

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

Staff B confirmed that the medication error occurred. When asked what date this error occurred, Staff B stated they had difficulty determining the date of the medication error due to the lack of documentation, but after conferring with Staff A and Staff D, they eventually determined the incident had occurred on 03/29/2023. When asked what was done after becoming aware of the error, Staff B stated they called R8's doctor to notify them of the error, to which they were instructed to hold all of R8's medications for the remainder of that day. When asked to provide documentation of that physician notification, Staff B was unable to provide it. Staff B stated that they do not remember if they wrote a progress note on the incident or not, and stated they remembered completing an incident report.

Review of the facility Incident Log on 04/21/2023 showed no progress note of the medication error, and no monitoring of R8 for adverse reactions for the minimum period of 48 hours. Review of R8's Medication Administration Record, showed no mention of a medication error in the notes.

During an interview on 04/21/2023 at 1:53PM, Staff B was asked why there was no progress note, and alert charting documented in the resident record for R8; Staff B shook their head and stated, "There should have been."

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/10/23.

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

Administrator (or Representative)

Debbie Smathers Date 5/18/23

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;

(f) In response to medical emergencies;

(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 record review and interview, the facility failed to implement their policies and procedures and notify the resident's physician following a medication error for one of one

Staff B confirmed that the medication error occurred. When asked what date this error occurred, Staff B stated they had difficulty determining the date of the medication error due to the lack of documentation, but after conferring with Staff A and Staff D, they eventually determined the incident had occurred on 03/29/2023. When asked what was done after becoming aware of the error, Staff B stated they called R8's doctor to notify them of the error, to which they were instructed to hold all of R8's medications for the remainder of that day. When asked to provide documentation of that physician notification, Staff B was unable to provide it. Staff B stated that they do not remember if they wrote a progress note on the incident or not, and stated they remembered completing an incident report.

Review of the facility Incident Log on 04/21/2023 showed no progress note of the medication error, and no monitoring of R8 for adverse reactions for the minimum period of 48 hours. Review of R8's Medication Administration Record, showed no mention of a medication error in the notes.

During an interview on 04/21/2023 at 1:53PM, Staff B was asked why there was no progress note, and alert charting documented in the resident record for R8, Staff B shook their head and stated, "There should have been."

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Administrator (or Representative)

Date

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This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to implement their policies and procedures and notify the resident's physician following a medication error for one of one

Statement of Deficiencies

License #: 2615

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

resident reviewed (Resident B, R8). This failure placed the resident at risk for not receiving appropriate medical care after and prevented the physician from being informed of the resident's status.

Findings included...

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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-2260:

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

(b) Together for each resident and physically separated from other residents' medications;

Review of the facility "Medication Errors" policy, last reviewed on 08/10/2021, under the "Procedure" category, numeral "1" it stated, "The individual identifying the medication error immediately reports it to the Wellness Director. If the Wellness Director is not available, the report is made to the nurse or Executive Director." Under numeral "2" it stated, "The resident's prescribing physician is immediately notified of the medication error. When reporting the error to the physician, do not speculate as to how the error occurred, simply report the facts of the situation."

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, "Yeah, they gave me the wrong medication." R8 stated that they were pressuring the Med Tech to give them their medications quickly, because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally do. R8 stated that they had no reason to believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and

resident reviewed (Resident 8, R8). This failure placed the resident at risk for not receiving appropriate medical care after and prevented the physician from being informed of the resident's status.

Findings included...

WAC 388-78A-2210 Medication services.

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(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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Review of the facility "Medication Errors" policy, last reviewed on 08/10/2021, under the "Procedure" category, numeral "1" it stated, "The individual identifying the medication error immediately reports it to the Wellness Director. If the Wellness Director is not available, the report is made to the nurse or Executive Director." Under numeral "2" it stated, "The resident's prescribing physician is immediately notified of the medication error. When reporting the error to the physician, do not speculate as to how the error occurred, simply report the facts of the situation."

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, "Yeah, they gave me the wrong medication." R8 stated that they were pressuring the Med Tech to give them their medications quickly, because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally do. R8 stated that they had no reason to believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and

Statement of Deficiencies:

License #: 2816

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident's medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, "No, I was in pain all day!" When asked how this incident made the resident feel they stated, "That made me feel like shit, really bad. That could kill me." R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. "One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn't take, things that I don't need. Things that I am afraid of."

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:59PM, Staff D stated, "[Staff A] told me that [R8] was asking, well, really demanding [their] meds." Staff D stated that while getting the medications ready, they accidentally prepared another resident's medications, and administered them to R8. "[Staff A] came back and asked about R8's [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get. I was not told to do anything else at that point, I did not do an incident report which I should have."

During an interview with Staff B, the Health Services Director, on 04/21/2023 at 1:53PM, when asked to discuss the facility process when it was determined a medication error had occurred, Staff B stated that staff were instructed to notify them, ensure the resident was safe and call Emergency Medical Services (EMS) if needed. Staff B stated that staff were to document the incident in a progress note. Staff B stated that they would do an incident report, do an online report to the state, and notify the resident's physician of the error, and resident family if necessary. Staff B stated that the resident would be placed on alert and staff would be responsible for monitoring the resident for any adverse reactions, and document these in the resident progress notes for 3 days minimum and extended if necessary. When asked if they were aware of a reported medication error regarding R8, Staff B confirmed that the medication error occurred. When asked what date this error occurred, Staff B had difficulty determining the date of the medication error due to the lack of documentation, but after conferring with Staff A and Staff D, they eventually determined the incident to have occurred on 03/29/2023. When asked what was done after becoming aware of the error, Staff B stated they called R8's doctor to notify them of the error, to which they were instructed to hold all of R8's medications for the remainder of that day. When asked to provide documentation of that physician notification, Staff B was unable to provide it. Review of R8's progress notes showed no progress note of the medication error, and no documentation of notification to the resident's provider.

Plan/Attestation Statement

they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident's medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, "No, I was in pain all day!" When asked how this incident made the resident feel they stated, "That made me feel like shit, really bad. That could kill me." R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. "One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn't take, things that I don't need. Things that I am afraid of."

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:59PM, Staff D stated, "[Staff A] told me that [R8] was asking, well really demanding [their] meds." Staff D stated that while getting the medications ready, they accidentally prepared another resident's medications, and administered them to R8. "[Staff A] came back and asked about R8's [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get. I was not told to do anything else at that point. I did not do an incident report which I should have."

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Statement of Deficiencies

License #: 2615

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/19/23.

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

Administrator (or Representative)

*Debbie Smathers*Date 5/18/23**WAC 388-78A-2210 Medication services.**

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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-2260:

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure safe medications systems were implemented for 4 of 6 residents reviewed (Resident 1 (R1), Resident 2 (R2), Resident 3 (R3) and Resident 8, R8), and 2 of 2 medication carts reviewed. This failure resulted in R8 experiencing pain, and placed all residents receiving medication services at risk for harm due to medication errors and not receiving prescribed medications to address their health conditions.

Findings Included...**<MISSED MEDICATIONS>**

Review of the facility "Med Room Workflow" policy, last reviewed on 08/10/2021, under "Refills" stated, "It is the responsibility of every staff member involved with medications to ensure the medications are ordered appropriately. Medications are ordered at least 7 days

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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Date

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Based on observation, record review and interview, the facility failed to ensure safe medications systems were implemented for 4 of 6 residents reviewed (Resident 1 (R1), Resident 2 (R2), Resident 3 (R3) and Resident 8, R8), and 2 of 2 medication carts reviewed. This failure resulted in R8 experiencing pain, and placed all residents receiving medication services at risk for harm due to medication errors and not receiving prescribed medications to address their health conditions.

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Statement of Deficiencies	License #: 2815	Compliance Determination #: 22436
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page of 25	Licensee: Greenlake Management, Ocean Shores, LLC	04/28/2023

before running out (more days may be needed when needed due to difficult or mail order pharmacies, upcoming holidays/weekends, and controlled substances). "Each shift the Nurse/Med Tech is to follow through with refills pending (re-fax, call pharmacy, call family etc.)."

<R1>

Review of R1's face sheet showed that the resident was admitted to the facility on [REDACTED]/2004.

Review of R1's Medication Administration Record (MAR) for March of 2023, and April of 2023, showed that the resident had the following missed medication doses:

-03/29/2023: Multivitamins Men's 50+ Tab (tablet): Under the "Exceptions" section it listed the reason for the missed dose as "Medication requires refill authorization PCP notified." Under the "Notes" for that missed dose, it stated, "Med not here."

-03/30/2023: Multivitamins Men's 50+ Tab Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "med not here."

-04/05/2023: Atorvastatin (medication for cholesterol) 80mg (milligrams) tab: Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "notes" for that missed dose, it stated, "Have not received medication from pharmacy."

-04/11/2023: Lantus (insulin medication to treat diabetes) 100U/1ml (milliliters) Vial: Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "Have not received medication from pharmacy."

-04/12/2023: Lantus 100U/1ml Vial: Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "Still waiting on pharmacy Delivery."

Review of R1's Medication Re-Order History in their medical record showed that the facility had the following re-orders:

- Multivitamins Men's 50+ Tab: Medication was re-ordered by the facility on 03/29/2023 at 4:28AM.
- Atorvastatin 80mg Tab: Medication was re-ordered by the facility on 04/04/2023 at 4:13AM.
- Lantus 100U/1ml Vial: Medication was re-ordered by the facility on 04/01/2023 at 4:19PM.

before running out (more days may be needed when needed due to difficult or mail order pharmacies, upcoming holidays/weekends, and controlled substances)." "Each shift the Nurse/Med Tech is to follow through with refills pending (re-fax, call pharmacy, call family etc.)."

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-04/11/2023: Lantus (insulin medication to treat diabetes)100U/1ml (milliliters) Vial: Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "Have not received medication from pharmacy."

-04/12/2023: Lantus 100U/1ml Vial. Under the "Exceptions" section it listed the reason for the missed dose as "Physically unable to take." Under the "Notes" for that missed dose, it stated, "Still waiting on pharmacy Delivery."

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- Multivitamins Men's 50+ Tab: Medication was re-ordered by the facility on 03/29/2023 at 4:28AM.
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- Lantus 100U/1ml Vial: Medication was re-ordered by the facility on 04/01/2023 at 4:19PM.

Statement of Deficiencies	License #: 2816	Compliance Determination #: 22436
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page of 25	Licensee: Greenlake Management, Ocean Shores, LLC	04/26/2023

The record showed the facility re-ordered the medication again on 4/11/2023 at 4:57PM, however no follow-up was completed to ensure the medication was on site after the initial ordering on 04/01/2023 until 04/11/2023.

<R2>

Review of R2's face sheet showed that the resident was admitted to the facility on [REDACTED]/2020.

Review of R2's MAR for March of 2023, and April of 2023, showed that the resident had the following missed medication doses:

-04/06/2023: Buspirone (medication to treat anxiety) 10mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Waiting on Pharmacy."

-04/11/2023: Acetaminophen (pain relief medication) 500mg Caplet Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "No meds in overflow, reordered."

-04/12/2023: Allopurinol (acid reducing medication) 300mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Waiting on Pharmacy Delivery."

Review of R2's Medication Re-Order History in their medical record, showed that the facility had the following re-orders:

-Buspirone 10mg tab: Medication was re-ordered by the facility on 03/26/2023 at 8:08PM. The record showed the facility received a status code of "Rejected" on 04/06/2023 at 7:33PM stating, "Failed: Pharmacy Rejected - Refill too soon."

-Allopurinol 300mg Tab: Medication was re-ordered by the facility on 04/12/2023 at 6:44AM.

-There was no Medication Re-Order History for Acetaminophen 500mg Caplet.

<R3>

Review of R3's face sheet showed that the resident was admitted to the facility on [REDACTED]/2022.

Review of R3's MAR for March of 2023, and April of 2023, showed that the resident had the following missed doses:

-03/08/2023: Sulfamethoxazole (antibiotic to treat infections) DS 800-160mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not delivered."

-03/09/2023: Sulfamethoxazole DS 800-160mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not here."

The record showed the facility re-ordered the medication again on 4/11/2023 at 4:57PM, however no follow-up was completed to ensure the medication was on site after the initial ordering on 04/01/2023 until 04/11/2023.

<R2>

Review of R2's face sheet showed that the resident was admitted to the facility on [REDACTED]/2020.

Review of R2's MAR for March of 2023, and April of 2023, showed that the resident had the following missed medication doses:

-04/06/2023: Buspirone (medication to treat anxiety) 10mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Waiting on Pharmacy."

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Review of R2's Medication Re-Order History in their medical record, showed that the facility had the following re-orders:

-Buspirone 10mg tab: Medication was re-ordered by the facility on 03/26/2023 at 8:08PM. The record showed the facility received a status code of "Rejected" on 04/06/2023 at 7:33PM stating, "Failed: Pharmacy Rejected – Refill too soon."

-Allopurinol 300mg Tab: Medication was re-ordered by the facility on 04/12/2023 at 6:44AM.

-There was no Medication Re-Order History for Acetaminophen 500mg Caplet.

<R3>

Review of R3's face sheet showed that the resident was admitted to the facility on [REDACTED]/2022.

Review of R3's MAR for March of 2023, and April of 2023, showed that the resident had the following missed doses:

-03/08/2023: SulfaTrimeth (antibiotic to treat infections) DS 800-160mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not delivered."

-03/09/2023: SulfaTrimeth DS 800-160mg Tab. Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not here."

Statement of Deficiencies

License #: 2615

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023

-03/09/2023: Vitamin D3 1000U (units). Under the "Exceptions" section it listed the reason for the missed dose as "Physically Unable to take." Under the "Notes" for that missed dose, it stated, "Med not here."

Review of R3's Medication Re-Order History in their medical record, showed that the facility had the following re-orders:

- Vitamin D3 1000U Cap: Medication was re-ordered by the pharmacy on 03/05/2023 at 1:10PM
- There was no Medication Order History provided for SulfaTrimeth DS 800-160mg Tab.

During an interview with the Staff A, the Health Services Director, on 04/12/2023 at 12:56PM, when asked what their expectation of staff is regarding medication re-ordering, they stated their expectation of staff is to re-order a medication when there is 7 days left of a medication. Staff A stated that this is currently a problem in the facility, and that they are working on re-educating staff to ensure this process is followed.

<STORAGE OF MEDICATIONS>

Review of The Institute for Safe Medical Practices article, "Guidelines for Timely Medication Administration," last reviewed on 01/13/2011, stated that professionals who dispense medications, due to the pressure of timeliness, will often take shortcuts in an attempt to accelerate the drug administration process. It defined one of these shortcuts as pre-pouring medications, which is the process of preparing medications in advance and then storing them until ready to administer to the resident at a later time. Pre-pouring medications is not a safe medication practice because the medications cannot be accurately compared to the Medication Administration Record (MAR) once they have been removed from their labeled packaging. Storing these opened, unlabeled resident medications together dramatically increases the probability of medication errors.

Review of the facility "Medication Storage of Centrally Stored Medications" policy, last reviewed 12/15/2021, stated, "Medications will be stored in a manner that ensures maintenance of both the integrity of the medication, and the safety of all residents residing in the community." Under numeral 3, it stated, "The Community must ensure all medications under the community's control are properly stored; in containers with pharmacist-prepared label or original manufacturer's label, together for each resident, and physically separated from other resident's medications."

During an interview with Staff C, a Medication Technician (Med Tech), on 04/21/2023, at 09:58AM, when asked if they ever pre-poured their medications to speed up their medication administration process, Staff C stated, "No, we do not pre-pour medications." When asked if they ever carry two or more resident medication cups at one time while administering medications, Staff C stated they would only carry and administer medications to one resident at a time. After the interview, Staff C was asked to open their medication cart for inspection. Observation showed six, pre-poured medication cups, all stacked on

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Statement of Deficiencies

License #: 2615

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/26/2023

top of one other. Each medication cup had open, unlabeled medications ready for administration to residents.

During an interview with Staff D, Medication Technician (Med Tech), on 04/21/2023 at 10:10AM, when asked if they ever pre-pour medications, Staff D stated that they never pre-pour their medications. When asked if they ever carry multiple resident medication cups at one time while administering medications, Staff D stated they would only carry and administer medications to one resident at a time. After the interview, Staff D was asked to open their medication cart for inspection. Staff D stated, "I never usually do this, but I do have one here." Observation showed one medication cup with open, unlabeled medications, pre-poured for another resident.

During an interview with Resident 6 (R6) on 04/21/2023 at 10:42AM, when asked if they had ever witnessed the Med Techs carrying other resident medications when they were receiving their medications, R6 eyes grew wide stating, "Oh yeah. That is a big problem here." When asked to elaborate on what they had witnessed, R6 stated, "I have seen them carry other people's medications, you know, in the medication cups, all stacked up on top of each other. When they come in, they put all of the cups on my counter, and then go through them to get mine. They give me my pills, and then scoop them all up and walk out."

During an interview with Resident 7 (R7) on 04/21/2023 at 10:50AM, when asked if they had noticed staff carrying multiple resident medication cups while administering their medication, R7 stated, "Yes, the [Med Tech] came in here to give me my medicine. [They are] excellent at everything [they do], but this night [they] carried two medications cups of pills into my room and [they] handed me the wrong one. I put them in my mouth, and [they] looked in the other container and [they] saw my purplish pill in the other container, and then [they] yelled at me to stop! Then [they] told me to spit them out back in the cup. I hadn't swallowed them at that point, so I did."

During an interview with Staff B, the Health Services Director on 04/21/2023 at 1:53PM, when asked if it was acceptable for staff to pre-pour medications, Staff B stated, "Absolutely not." After notifying Staff B of what was observed in the medication carts, Staff B stated that they had provided education to staff on proper medication storage and administration. Staff B stated, "They should know that pre-pouring their medications is not acceptable."

<POLICY AND PROCEDURES>

Review of the facility "Medication Errors" policy, last reviewed on 08/10/2021, under the "Procedure" category, numeral "1" it stated, "The individual identifying the medication error immediately reports it to the Wellness Director. If the Wellness Director is not available, the report is made to the nurse or Executive Director." Under numeral "2" it stated, "The resident's prescribing physician is immediately notified of the medication error. When reporting the error to the physician, do not speculate as to how the error occurred, simply report the facts of the situation."

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Statement of Deficiencies

License #: 2616

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greenlake Management, Ocean Shores, LLC

04/28/2023

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, "Yeah, they gave me the wrong medication." R8 stated that they were pressuring the Med Tech to give them their medications quickly, because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally do. R8 stated that they had no reason to believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident's medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, "No, I was in pain all day!" When asked how this incident made the resident feel they stated, "That made me feel like shit, really bad. That could kill me." R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. "One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn't take, things that I don't need. Things that I am afraid of."

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:59PM, Staff D stated, "[Staff A] told me that [R8] was asking, well really demanding [their] meds." Staff D stated that while getting the medications ready, they accidentally prepared another resident's medications, and administered them to R8. "[Staff A] came back and asked about R8's [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get, I was not told to do anything else at that point. I did not do an incident report which I should have."

During an interview with Staff B, the Health Services Director, on 04/21/2023 at 1:53PM, when asked to discuss the facility process when it was determined a medication error had occurred, Staff B stated that staff were instructed to notify them, ensure the resident was safe and call Emergency Medical Services (EMS) if needed. Staff B stated that staff were to document the incident in a progress note. Staff B stated that they would do an incident report, do an online report to the state, and notify the resident's physician of the error, and resident family if necessary. Staff B stated that the resident would be placed on alert and staff would be responsible for monitoring the resident for any adverse reactions, and document these in the resident progress notes for 3 days minimum and extended if necessary. When asked if they were aware of a reported medication error regarding R8, Staff B confirmed that the medication error occurred. When asked what date this error occurred, Staff B had difficulty determining the date of the medication error due to the lack of documentation, but after conferring with Staff A and Staff D, they eventually determined the incident to have occurred on 03/29/2023. When asked what was done after becoming aware of the error, Staff B stated they called R8's doctor to notify them of the error, to which they were instructed to hold all of R8's medications for the remainder of that day. When asked to provide documentation of that physician notification, Staff B was unable to provide it. Review of R8's progress notes showed no progress note of the medication error, and no documentation of notification to the resident's provider.

During an interview with R8 on 04/21/2023 at 11:01AM, when asked if they experienced any issues regarding medication administration from staff, R8 stated, "Yeah, they gave me the wrong medication." R8 stated that they were pressuring the Med Tech to give them their medications quickly, because they were in pain. R8 stated that the Med Tech returned and handed them a cup of medications, and they put apple sauce on them and ate them as they normally do. R8 stated that they had no reason to believe that the medications did not belong to them, stating there were just as many pills in the cup as they normally have, and they looked like their normal medications. R8 stated after a while, their pain did not improve, and they asked for more pain medication to which they were denied. R8 stated that a short while later, Staff A, the Executive Director, and Staff B, the Health Services Director, called them to the office and notified R8 that R8 had ingested another resident's medications, and that staff were instructed to not give them any of their normally scheduled medications for the remainder of the day. When asked if R8 was able to receive any pain medication after the incident, R8 stated, "No, I was in pain all day!" When asked how this incident made the resident feel they stated, "That made me feel like shit, really bad. That could kill me." R8 stated that Staff A and Staff B went through all of the incorrect medications that they consumed, which consisted of approximately 17 different medications. "One [medication] that was drilled in my head had to do with breast cancer, and a thyroid medication. Things that I wouldn't take, things that I don't need. Things that I am afraid of."

During an interview with Staff D, a Medication Technician, on 04/21/2023 at 1:59PM, Staff D stated, "[Staff A] told me that [R8] was asking, well really demanding [their] meds." Staff D stated that while getting the medications ready, they accidentally prepared another resident's medications, and administered them to R8. "[Staff A] came back and asked about R8's [pain medication] at this point I realized the wrong meds were given and mentioned this immediately to [Staff A] who then called [Staff B]. In this case, [Staff A] told me that per [Staff B], to not give R8 any more medications. When [Staff B] got here [they] told me that [they] faxed and called the doctor about the meds she did get. I was not told to do anything else at that point. I did not do an incident report which I should have."

During an interview with Staff B, the Health Services Director, on 04/21/2023 at 1:53PM, when asked to discuss the facility process when it was determined a medication error had occurred, Staff B stated that staff were instructed to notify them, ensure the resident was safe and call Emergency Medical Services (EMS) if needed. Staff B stated that staff were to document the incident in a progress note. Staff B stated that they would do an incident report, do an online report to the state, and notify the resident's physician of the error, and resident family if necessary. Staff B stated that the resident would be placed on alert and staff would be responsible for monitoring the resident for any adverse reactions, and document these in the resident progress notes for 3 days minimum and extended if necessary. When asked if they were aware of a reported medication error regarding R8, Staff B confirmed that the medication error occurred. When asked what date this error occurred, Staff B had difficulty determining the date of the medication error due to the lack of documentation, but after conferring with Staff A and Staff D, they eventually determined the incident to have occurred on 03/29/2023. When asked what was done after becoming aware of the error, Staff B stated they called R8's doctor to notify them of the error, to which they were instructed to hold all of R8's medications for the remainder of that day. When asked to provide documentation of that physician notification, Staff B was unable to provide it. Review of R8's progress notes showed no progress note of the medication error, and no documentation of notification to the resident's provider.

Statement of Deficiencies

License #: 2816

Compliance Determination #: 22436

Plan of Correction

Ocean Shores Assisted Living

Completion Date

Page of 25

Licensee: Greentake Management, Ocean Shores, LLC

04/26/2023

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/19/23.

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

Administrator (or Representative)

Debbie Smathers

Date

5/18/23

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____.

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

Administrator (or Representative)

Date

Plan of Correction

[illegible]

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