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) 26657 (Completion Date 07/17/2023) and 24332 (Completion Date 05/23/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/17/2023 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-2310, WAC 388-78A-2310-4

The Department staff who did the on-site verification:
Paul Aube, ALF NCI
Celeste Vashey, ALF LTC Licensor

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

Sincerely,

Cory Cisneros

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Ocean Shores Assisted Living
License/Cert.#: 2615
Compliance Determination #: 24332
Investigator: Paul Aube
Investigation Date(s): 05/23/2023 through 05/23/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 81759
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Resident/Patient/Client Neglect: Public report of facility failing to evaluate resident condition when reported to staff.
2. Resident/Patient/Client Rights: Public report of facility failing to evaluate resident condition when reported to staff.
3. Dietary Services: Public report of decline in food quality.
4. Quality of Life: Public report of facility not providing bathing services as needed.

Investigation Methods:

Sample:	Total residents: 53 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Family members Nursing staff Management
Record Reviews:	Incident investigation Medical records Vital Sign Records Progress Notes Care Plans

Investigation Summary:

1. Resident/Patient/Client Neglect: Facility failed to notify management, and respond appropriately when notified of a decline of a resident's condition. Failed practice identified.
2. Resident/Patient/Client Rights: Facility failed to notify management, and respond

appropriately when notified of a decline of a resident's condition. Failed practice identified.
3. Dietary Services: Facility providing well-rounded meals. Alternatives to meals also offered, Unable to substantiate claims.
4. Quality of Life: Resident was previously independent. Resident's plan of care adjusted to accommodate assistance with bathing. No failed practice.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2615	Compliance Determination # 24332
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 4	Licensee: Greenlake Management Ocean Shores, LLC	05/23/2023

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 05/23/2023 and 05/23/2023 of:

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

This document references the following complaint number(s): 81759, 80754

The following sample was selected for review during the unannounced on-site visit: 3 of 53 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

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

Jody Just
Residential Care Services

05/31/2023
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.

Debbie Smathers
Administrator (or Representative)

6/7/23
Date

WAC 388-78A-2310 Intermittent nursing services.

(4) In providing intermittent nursing services, the assisted living facility must observe the resident for changes in overall functioning and respond appropriately when there are observable or reported changes in the resident's physical, mental or emotional functioning.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to take appropriate action when they became aware of a change in the resident's condition for 1 of 3 sample residents, Resident 1 (R1), reviewed. This failure caused R1 to experience a delay in receiving medical care.

Findings included...

According to the Cleveland Clinic article titled, "Blood Oxygen Level," last reviewed on 02/18/2022, it stated, "For most people, a normal pulse oximeter reading for your oxygen saturation level is between 95% and 100%." "A lower-than-normal blood oxygen level is called hypoxemia. Since oxygen is essential to all of your body's functions, hypoxemia is often concerning. The lower the oxygen level, the greater likelihood for complications in body tissue and organs." "If you're using an oximeter at home and your oxygen saturation level is 92% or lower, call your healthcare provider. If it's at 88% or lower, get to the nearest emergency room as soon as possible."

During an interview with Staff C, Med Technician, when asked what they would do if they found a resident short of breath, Staff C stated that they would gather a set of vital signs, including oxygen saturation levels and let Staff A, Health Services Director, know. Staff C stated that if they felt it was an emergency, they would call the paramedics to come and assess the resident. When asked at what percentage of Oxygen Saturations would they become concerned and notify Staff A, Staff C stated, "If it was under 90%, I would let someone know."

During an interview with Staff A, Health Services Director on 05/23/2023 at 12:27PM, when asked how often vitals are to be taken for residents, they stated that vitals are normally taken only once a month, on the first of the month. However, Staff A stated that if a resident condition worsens, or incident occurs, staff will take them again at the time of the incident, or more frequently if needed.

Review of R1's face sheet shows that R1 was admitted to the facility on [redacted]/2022.

Review of the Incident Report for R1 on 05/06/2023 showed that R1 was sent to the hospital on 05/06/2023. The incident report showed that , "[R1] was complaining of shortness of breath and swelling on [their] right leg, and not completely emptying [their] bladder." Paramedics were called, and R1 was sent to the hospital for evaluation.

Review of Progress Notes for 05/06/2023 at 9:00AM showed, "Resident was sent out to the hospital due to shortness of breath, swelling on [R1's] right leg." "BP (Blood Pressure) 134/70, HR (Heart Rate) 61, R (Respirations) 14, T (Temperature) 96.4F, O2 (Oxygen Saturations) 87%."

During an interview with R1, on 05/23/2023 at 11:16AM, R1 stated that they notified the staff at the facility that they were feeling short of breath 2 or 3 days prior to them being sent to the hospital. R1 stated that staff were checking their oxygen levels during that time. "They kept telling me my oxygen in my blood was low, 88 or something like that." Despite this, R1 stated that they were not sent to the hospital. When asked why the facility finally decided to send them to the hospital on 05/06/2023, R1 stated, "I almost had to demand them to send me to the hospital. They weren't doing it. I couldn't understand why they weren't doing it."

During an interview with Collateral Contact 1 (CC1), the resident's representative, on 05/22/2023 at 09:42AM, they stated that they visited R1 on Friday, 05/05/2023. They stated during their visit, they noticed R1 was very short of breath, and notified Staff B, a Med Technician. They stated that Staff B came to see the resident and took their oxygen saturation levels, which read 88%. They stated that Staff B appeared to not be concerned but informed them they would notify Staff A so they could evaluate the resident. CC1 left the facility thinking R1 would be evaluated. Per CC1, the following day they received a call from the facility, informing them that R1 was sent to the hospital. During this call, CC1 learned that Staff A was never informed of R1's condition from the previous day.

During an interview with Staff A on 05/23/2023 at 12:27PM, when asked what staff are expected to do when there is a resident who presents short of breath, Staff A stated, "I expect them to get a full set of vitals [including oxygen saturations] and notify me." Staff A stated that if they were in the building, they would go to assess the resident. However, if they were not in the building, staff are instructed to call the paramedics. When asked about what documentation should be completed Staff A stated, "Staff should be entering the vital signs, and documenting the incident in the resident's progress notes. When asked when Staff A became aware of R1's decline in condition, Staff A stated they became aware of R1's condition on the morning of 05/06/2023 when R1 was sent to the hospital. When asked if Staff B was aware of R1's condition the previous day, Staff A stated they were notified by R1's family, after R1 was sent to the hospital, that Staff B was aware of R1's condition on 05/05/2023. Staff A stated that Staff B was notified by R1's family that R1 was short of air and having difficulty breathing. Staff A stated that family reported Staff B to have checked R1's oxygen saturation levels, which read 86 or 87%, and that Staff B informed them they would notify Staff A for R1 to be evaluated. Staff A stated this notification did not occur. Staff A stated that after they discovered the lack of notification, they interviewed Staff B about the incident, and when asked why R1's condition was not reported, Staff B replied, "I forgot."

Review of R1's Progress Notes, showed no entry for 05/05/2023.

Review of R1's Vital Sign log, showed no additional documentation for any vital signs, other than the monthly set taken on 05/01/2023.

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) 7/7/23 .

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

Debbie Smathers — Administrator (or Representative)

6/2/23 — Date