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
1020 Catala Avenue SE
Ocean Shores, WA 98569

RE: Ocean Shores Assisted Living License # 2615

Dear Administrator:

This letter addresses Compliance Determination(s) 38215 (Completion Date 03/12/2024) and 30950 (Completion Date 01/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/12/2024 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-2600, WAC 388-78A-2600-2, WAC 388-78A-2600-2-I

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

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 #: 30950
Investigator: Paul Aube
Investigation Date(s): 10/11/2023 through 01/25/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 99280
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of Care/Treatment: Facility report of a medication error that occurred in the community.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Housekeeping staff Business office manager Management
Record Reviews:	Medical records Incident investigation Facility policies Maintenance logs Negotiated Service Agreements Admission Agreements Eviction Notice Bed-Hold Policy

Investigation Summary:

Quality of Care/Treatment: Facility failed to follow medication policies and administer medication as prescribed per Physician Order. Unknown medication observed to be left at resident bedside, unattended. Failed practice identified.

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 # 30950
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 4	Licensee: Greenlake Management Ocean Shores, LLC	01/25/2024

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 10/11/2023 and 01/25/2024 of:

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

This document references the following complaint number(s): 97980, 100762, 99280, 100790, 103777

The following sample was selected for review during the unannounced on-site visit: 3 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI
Cory Cisneros, Field Manager

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

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

Cory Cisneros
Residential Care Services

01/29/2024
Date

Statement of Deficiencies	License #: 2615	Compliance Determination # 30950
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 2 of 4	Licensee: Greenlake Management Ocean Shores, LLC	01/25/2024

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)

2/1/24 — Date

WAC 388-78A-2600 Policies and procedures.

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

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

This requirement was not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure staff were following policies and procedures to address what staff persons must do to manage resident medications for 1 of 2 mediation errors reviewed. This failure placed all residents receiving delegated medication services at risk for harm due to medication errors.

Findings included...

Record review of a facility policy, titled, "Med-28 Medication Errors", last reviewed 08/10/2021, stated, "A medication error is defined as: 1. The wrong medication. 2. The wrong person. 3. The wrong dose. 4. The wrong route. 5. The wrong time. 6. Missed dose. 7. Not initiating an order. Medications are handled in a way that minimizes the risk of medication error."

Record review of a facility policy, titled, "Med-03 Med Room Workflow", last reviewed on 08/10/2021, under "Signing of Medications", stated, "All staff will pour the medication each gives, verifying the medication three times during the pour process...When assisting the resident with self-administration, the Nurse/Med Tech will: Check the 6 rights (right resident, right medication, right time, right dosage, right route, and right documentation...When assisting the resident with self-administration, the Nurse/Med Tech will observe the resident to ensure that all medications scheduled for that med pass are consumed by the resident. No medication can be left with the resident to self-administer at a later time."

During an interview and observation with Resident 1, (R1) on 10/11/2023 at 11:45AM, Staff B, a Medication Technician, was observed entering the resident's room to provide R1 with medications. After taking the medication that was brought in by Staff B, R1 asked staff B what another medication was that was on their bedside in a medication cup. Observed a single, whole, white tablet in the medication cup. R1 stated Staff C, another Medication

Technician, gave them a cup of medications this morning, and they did not want to take this white pill because they did not know what it was. Staff B stated that they did not know what the medication was, and stated they would find out. A few minutes later, Staff B returned with Staff A, the Director of Nursing. Staff A notified R1 that the medication in the cup was their Spironolactone (a diuretic). After learning this, R1 instructed Staff A to give them the pill and that they would take it. Staff A stated that they could not allow them to take the medication, and stated that R1's ordered dose was for 12.5mg, and that this pill was not cut in half as it should have been. Staff A explained to R1 that the full pill would be a dose of 25mg. After Staff A and Staff B left the room, asked R1 if they ever noticed a medication/tablet to be cut in half during their morning medication pass. R1 stated, "They have never cut a pill in half."

In a statement for Staff C, obtained by Staff A, on 10/11/2023 at 5:30PM, Staff C stated they entered R1's apartment to give them their medications at 8:30AM on 10/11/2023. Staff C stated that they turned to leave the resident's room after noticing that R1 started taking their medications. Staff C reported that they thought R1 took them all. Staff C then reported that they may have given two incorrect doses [10/11/2023 & 10/10/2023].

Review of R1's Medication Administration Record for October 2023 showed an active physician order for R1 written as the following: "Spironolactone 25mg tab: 0.5 tab (12.5mg) by mouth every day." Review of administration of medications for Spironolactone for 10/10/2023, and 10/11/2023 showed that Spironolactone was signed as being given by Staff C for both dates.

During an interview with Staff D, a Medication Technician, on 10/11/2023 at 3:03PM, Staff D was asked if it was normal for them to have to cut resident's tablets prior to administration. Staff D stated, "Yes, we should be." Staff D was asked if pill cutters were on both of the medication carts. Staff D opened the medication cart to show that pill cutters were available for Medication Technicians to use.

During an interview with Staff A, the Director of Nursing, on 10/11/2023 at 3:30PM, when asked if staff were allowed to leave medications unattended at the resident's bedside, Staff A stated, "No, absolutely not." Staff A was asked if staff were to be checking the dosage of medications prior to administering them to the residents to ensure accuracy, Staff A stated, "Absolutely, they should be. They should be checking the dose before going into the resident room."

This is a recurring deficiency, previously cited on 04/26/2023.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2615	Compliance Determination # 30950
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 4 of 4	Licensee: Greenlake Management Ocean Shores, LLC	01/25/2024

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) 3/10/24 .

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

Debbie Smathers — Administrator (or Representative)

2/1/24 — Date