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

01/06/2025

Greenlake Management Ocean Shores, LLC
Ocean Shores Assisted Living
1020 Catala Avenue SE
Ocean Shores, WA 98569

RE: Ocean Shores Assisted Living # 2615

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 52569 (Completion Date 01/06/2025) and 41726 (Completion Date 06/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/06/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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.

The Department staff who did the On Site verification:
Pamela Horlick, NCI RN Complaint Investigator

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 #: 41726
Investigator: Pamela Horlick
Investigation Date(s): 05/23/2024 through 06/05/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 130860
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

Quality of Care/treatment: Report of staff not getting residents medications refilled timely and giving residents other residents medications when they are out.
Misappropriation of Property: Report of staff not getting residents medications refilled timely and giving residents other residents medications when they are out.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Residents Social services staff
Record Reviews:	State reporting log Facility policies Care Plan MAR Face Sheet Staff List Staff Schedule Medication received invoices

Investigation Summary:

Quality of Care/treatment: Facility not following facility policy on refilling residents

medications when they run out. Failed practice identified.
Misappropriation of Property: After interview, observation and record review, unable to substantiate failed practice of medications of residents being given to other residents.

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 # 41726
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 8	Licensee: Greenlake Management Ocean Shores, LLC	06/05/2024

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 05/23/2024 and 06/06/2024 of:

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

This document references the following complaint number(s): 130163, 130860

The following sample was selected for review during the unannounced on-site visit: 5 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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

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

Cory Cisneros
Residential Care Services

06/11/2024
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

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Cory Cisneros
Residential Care Services

06/11/2024
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) Date 6/12/24

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 interview, observation and record review, the facility failed to obtain medications in a timely manner for 2 of 4 sample residents (Resident 1 (R1) and Resident 2 (R2). This failure resulted in R1 and R2 missing doses of their prescribed medications and placed residents at risk for medical complications.

Findings included...

Record review of the facility policy, titled, "Medication Refills", dated 08/10/2021, stated, "Medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available...The Nurse/Med Tech [Medication Technician] on duty contracts the dispensing pharmacy to obtain a refill at least seven (7) days prior to running out of a medication, unless medication is on a cycle refill with the pharmacy. The medication is entered on the Refill/New Order Roster...Medications are never allowed to run out unless directed by the physician."

In an interview on 05/23/2024 at 12:00PM, Staff C, Medication Technician was asked what the circle means around the initials on the MAR (Medication Administration Record), Staff C stated, it means it [the medication] was not given.

<R1>

Review of R1's face sheet showed that R1 was admitted to the facility on [redacted]/2017.

Record review of R1's Needs and Services Plan (Negotiated Service Agreement), last reviewed on 10/01/2023, under, "Medication Administration," it stated, "Administer R1's medications per physician's orders as noted on the MAR.

Acetaminophen

Review of R1's Medication Administration Record (MAR) for May 2024 showed an order for

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.

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed to obtain medications in a timely manner for 2 of 4 sample residents (Resident 1 (R1) and Resident 2 (R2). This failure resulted in R1 and R2 missing doses of their prescribed medications and placed residents at risk for medical complications.

Findings included...

Record review of the facility policy, titled, "Medication Refills", dated 08/10/2021, stated, "Medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available...The Nurse/Med Tech [Medication Technician] on duty contracts the dispensing pharmacy to obtain a refill at least seven (7) days prior to running out of a medication, unless medication is on a cycle refill with the pharmacy. The medication is entered on the Refill/New Order Roster...Medications are never allowed to run out unless directed by the physician."

In an interview on 05/23/2024 at 12:00PM, Staff C, Medication Technician was asked what the circle means around the initials on the MAR (Medication Administration Record), Staff C stated, it means it [the medication] was not given.

<R1>

Review of R1's face sheet showed that R1 was admitted to the facility on [redacted]/2017.

Record review of R1's Needs and Services Plan (Negotiated Service Agreement), last reviewed on 10/01/2023, under, "Medication Administration," it stated, "Administer R1's medications per physician's orders as noted on the MAR.

Acetaminophen

Review of R1's Medication Administration Record (MAR) for May 2024 showed an order for

Acetaminophen to be given 1 TAB by mouth every morning. the MAR showed the following missed medication doses for Acetaminophen 500MG Caplet:

05/16/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP (Primary Care Physician) notified." Under the "notes" section it stated, "Waiting on refill."

05/17/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on refill."

05/18/2024: Initials on the MAR circled indicating medication was not given Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pcp."

05/19/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "other." Under the "notes" section it stated, "Waiting on pharmacy."

In an interview on 05/23/2024 at 12:18 PM, Staff C was asked to pull out the Acetaminophen medication for R1. Staff C looked in the cart and stated R1 must be out of that [medication] too. Staff C stated, they just reordered it. Staff C stated the last time it was filled was on 04/07/2024. Staff C was asked if a refill was 30 days worth of medication, Staff C stated yes. Staff C was asked how R1 had been getting the medication if R1 ran out, they stated, "I don't know."

In an observation on 05/23/2024 at 12:18 PM, there was no Acetaminophen 500 Caplet in the medication cart for R1.

Pantoprazole

Review of R1's Medication Administration Record (MAR) for May 2024 showed an order for Pantoprazole (medication to reduce stomach acid) to be given 1 TAB by mouth every day. the MAR showed the following missed medication doses for Pantoprazole:

05/20/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

05/23/2024 – 05/27/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

05/28/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "reordered."

In an interview on 05/23/2024 at 12:18 PM, Staff C was asked to pull out R1's Pantoprazole 40MG TAB. Staff C stated, it [medication] was not in there. They stated they don't see where it has come in.

In an observation on 05/23/2024 at 12:18 PM, there was no Pantoprazole 40MG TAB in the medication cart for R1.

<R2>

Review of R2's face sheet showed that R2 was admitted to the facility on [redacted]/2022.

Record review of R2's Needs and Services Plan (Negotiated Service Agreement), last reviewed on 06/10/2023, under, "Medication Administration," it stated, "Administer R1's medications per physician's orders as noted on the MAR.

Pantoprazole

Review of R2's Medication Administration Record (MAR) for May 2024 showed an order for Pantoprazole to be given 1 TAB by mouth every day. The MAR showed the following missed medication doses for Pantoprazole:

05/23/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "This order requires PCP clarification." Under the "notes" section it stated, "waiting on refills to come from pharmacy."

05/24/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

05/26/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

05/27/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the

"notes" section it stated, "Waiting on pharmacy."

05/28/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "reordered."

05/29/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "waiting for delivery."

05/30/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "This order requires PCP clarification." Under the "notes" section it stated, "waiting for medications to come in."

Vitamin D3

Review of R2's MAR for May 2024 showed an order for Vitamin D3 Capsule to be given 1 TAB by mouth every day. The MAR showed the following missed medication doses for Vitamin D3:

05/16/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on refill."

05/17/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

05/18/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pcp."

05/19/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Other." Under the "notes" section it stated, "Waiting on pharmacy."

05/20/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on refill."

05/21/2024: Initials on the MAR circled indicating medication was not given. Under the

"reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Med Reordered."

05/22/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "reordered."

05/23/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "This order requires PCP clarification." Under the "notes" section it stated, "Waiting on refills to come from pharmacy."

05/24/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

05/26/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

05/27/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

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05/29/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting for delivery."

05/30/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "This order requires PCP clarification." Under the "notes" section it stated, "Waiting for medications to come in."

05/31/2024: Initials on the MAR circled indicating medication was not given. Under the "reason" section it listed "Medication requires refill authorization. PCP notified." Under the "notes" section it stated, "Waiting on pharmacy."

In an interview on 05/23/2024 at 12:32PM, Staff C was asked to pull R2's Vitamin D3. Staff C stated there was none. Staff C stated they are waiting on PCP and Pharmacy. Staff C stated it was ordered today.

In an observation on 05/23/2024 at 12:32 PM, there was no Vitamin D3 in the medication cart for R2.

In an interview on 05/23/2024 at 3:10PM, Staff A, Resident Care Coordinator, was asked what the process was when ordering medications, Staff A stated, they get the orders from the doctor or the doctor sends them to the pharmacy, then the pharmacy sends them here, or we have to go online to order them. Staff A stated if they don't use the in house pharmacy they will call the doctor. Staff A was asked what the policy was when reordering a medication, they stated, we will reorder it when there is two weeks left of the medication. Staff A was asked who is responsible to reorder the residents medications, Staff A stated the med techs are responsible for reordering medications. Staff A stated its been a struggle with the pharmacy, I don't like working with them. Staff A stated they are not happy with them.

In an interview on 05/31/2024 at 1:47 PM, Staff D, Medication Technician, was asked who was responsible to make sure residents have their medications, Staff D stated, the Med Techs, but not all the time because we get busy. They stated they will reorder them and when we get busy we will write them [medications] down and leave them with Staff A. Staff D states there is a problem getting residents their medications. They believe it's due to a lack of communication.

In an interview on 05/23/2024 at 12:54PM, Staff C stated there was a problem with the ordering of medications to ensure medications are here and on time. Not every med tech was ordering when they should.

In an interview on 05/31/2024 at 12:15 PM, Staff B, Medication Technician, stated, the system was broken and needed to be fixed.

This is a recurring deficiency previously cited on 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) 7/20/24 .

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

In an observation on 05/23/2024 at 12:32 PM, there was no Vitamin D3 in the medication cart for R2.

In an interview on 05/23/2024 at 3:10PM, Staff A, Resident Care Coordinator, was asked what the process was when ordering medications, Staff A stated, they get the orders from the doctor or the doctor sends them to the pharmacy, then the pharmacy sends them here, or we have to go online to order them. Staff A stated if they don't use the in house pharmacy they will call the doctor. Staff A was asked what the policy was when reordering a medication, they stated, we will reorder it when there is two weeks left of the medication. Staff A was asked who is responsible to reorder the residents medications, Staff A stated the med techs are responsible for reordering medications. Staff A stated its been a struggle with the pharmacy, I don't like working with them. Staff A stated they are not happy with them.

In an interview on 05/31/2024 at 1:47 PM, Staff D, Medication Technician, was asked who was responsible to make sure residents have their medications, Staff D stated, the Med Techs, but not all the time because we get busy. They stated they will reorder them and when we get busy we will write them [medications] down and leave them with Staff A. Staff D states there is a problem getting residents their medications. They believe it's due to a lack of communication.

In an interview on 05/23/2024 at 12:54PM, Staff C stated there was a problem with the ordering of medications to ensure medications are here and on time. Not every med tech was ordering when they should.

In an interview on 05/31/2024 at 12:15 PM, Staff B, Medication Technician, stated, the system was broken and needed to be fixed.

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Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 8 of 8	Licensee: Greenlake Management Ocean Shores, LLC	06/05/2024

Debbie Smathers
Administrator (or Representative)

6/12/24
Date

Administrator (or Representative) Date