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

12/05/2025

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) 69630 (Completion Date 12/05/2025) and 56744 (Completion Date 03/21/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/05/2025 and found no deficiencies.

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

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

(7) Not allow any staff person to abuse or neglect any resident.

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs,

capabilities, and preferences.

The Department staff who did the On Site verification:
Maria Salas, ALF Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, Adult Family Home Nurse 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 #: 56744
Investigator: Maria Salas
Investigation Date(s): 02/25/2025 through 03/21/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 168680
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Concerns that cares are being provided to residents.
2. Concerns that call system is not in working order.
3.Allegation of staff stealing cleaning supplies.
4. Concerns about lack of medication services.
5. Concerns of physical altercations.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Identified resident Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Staff development coordinator
Record Reviews:	Medical records Hospital records State reporting log Facility policies Personnel files Staff training records

Investigation Summary:

1. Based on record review, observation and interview the facility did not have a system in place for staff to provide proper care to resident. Failed practice identified.

2. Based on observation and interview the call system was in working order. No failed practice identified.
3. Based on observation and interview staff have proper supplies to perform cleaning tasks as needed. No failed practice identified.
4. Medication service currently being investigated under intake 163289.
5. Physical altercation between residents currently under investigation in CD 55507.

Conclusion / Action:

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

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800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2615	Compliance Determination # 56744
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 8	Licensee: Greenlake Management Ocean Shores, LLC	03/21/2025

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 02/25/2025 of:

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

This document references the following complaint number(s): 168680

The following sample was selected for review during the unannounced on-site visit: 3 of 49 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF 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

04.01.2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Debbie Smathers
Administrator (or Representative)

4/7/25
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on record review, observation and interview the facility failed to ensure staff had necessary information to meet resident needs, resident rights were upheld and residents were free from neglect for 1 of 1 residents (Resident 1). This failure resulted in Resident 1 being hospitalized, enduring unmanaged pain and resulted in diminished quality of life.

Findings included...

WAC 388-78A-2020 "Definition... "Neglect" means:
(2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100..."

Record review of Resident 1's (R1) face sheet on 02/25/2025, showed R1 admitted to the facility on [redacted]/2025. There was no history information provided on R1's face sheet.

Record review of R1's Pre-Admission Assessment, dated 01/27/2025, showed R1 was assessed as requiring medication assistance. Medication assistance would be provided by a qualified staff person specified as a nurse or medication technician. R1 was assessed as not being able to take medications without assistance. R1 was assessed to have a history of Diabetes Mellitus (an inadequate control of glucose in the blood) and neuropathy (nerve damage causing pain or numbness). R1 was noted to have bilateral foot and lower leg pain related to neuropathy R1 was assessed as having decreased mobility due to neuropathy. R1 was assessed and noted to have constant intense sharp, shooting, aching, throbbing and stabbing pain due to neuropathy.

Record review of R1's Physician Report, dated 02/18/2025, showed R1 required assistance with diabetic management. R1 had admission orders for Basaglar Insulin Kwikpen 100units per milliliters (medication to regulate blood sugar levels), inject 5 units subcutaneously (under the skin) once daily for diabetes and Gabapentin 100 mg (milligram) capsules (nerve pain medication), administer 100mg by mouth three times daily for neuropathy.

Record review of R1's Electronic Medication Administration Record (EMAR), dated [redacted]/2025 through 02/25/2025, showed no orders for medications to be administered by staff were available to review.

Record review of R1's Progress/Alert Notes, dated [redacted]/2025 through 02/27/2025, showed an entry on 02/23/2025 that R1 was showing signs of agitation and anxiety. R1 had asked Staff A, medication technician, about her medications. Staff A documented that it was explained to R1 that R1 was not in the EMAR system and no medication list was available to be able to administer medications to her. Staff A documented that Staff E, Licensed Practical Nurse (LPN), had been called and notified. On 02/25/2025, Staff B, Medication Technician, documented R1 was having difficulty ambulating, R1 reported to Staff B that she was not able to ambulate to the counter and needed to rest every couple of minutes if up and moving.

In an interview on 02/25/2025 at 11:44am, R1 stated that she admitted to the facility on Friday [redacted]/2025. R1 stated that she was diabetic and had not had insulin or her blood sugars checked since admitting. R1 stated that the facility gave her a call pendant because she was weak and unsteady on her feet. R1 voiced that she was in a lot of pain. R1 stated she had a history of neuropathy in her lower legs and feet and causing severe pain. R1 stated that she felt she was just lying in bed to die because the facility was not doing anything about her medications. R1 stated that when she asked the staff about her medications, she had been told by the medication technician that they could not administer any of her medications because there was no profile with medications orders in the EMAR system for her. R1 stated that she had not been administered any of her medications since admitting to facility to include Gabapentin for the neuropathy and insulin for her diabetes.

In an interview on 02/25/2025 at 12:15pm Staff B stated that since R1 admitted on [redacted]/2025 no medications, blood sugar checks or insulin were administered because R1 was not in the EMAR system. Staff B stated that she and others had reported the issue to Staff E multiple times that they are not able to administer R1 any medications. Staff B stated that she had not been made aware that R1 was a diabetic and required insulin until R1 was sent out to the local hospital on 02/24/2025 and she was found to have elevated blood sugar by the medics that responded to transport R1.

In an interview on 02/25/2025 at 12:22pm Staff E stated that she had received a current medication order list for R1 and had sent it to their pharmacy to be entered into the EMAR system on Friday, [redacted]/2025, after R1 had admitted. Staff E stated that she had found out that later that the pharmacy had not entered R1's medication orders into the EMAR system. Staff E stated that she was unable to provide a confirmation fax page of the medication orders that had been faxed to the pharmacy on Friday [redacted]/2025. Staff E stated that she had found out on Monday, 02/24/2025, that no medication had been entered in the EMAR system for R1. Staff E stated that it was standard practice to have all medications and treatments set up in the EMAR system on day of admission so that the newly admitted resident could be given proper care. Staff E stated that R1 admitted at noon on Friday, [redacted]/2025. Staff E stated she had verbally instructed the medication technicians working on [redacted]/2025, to give R1 her medications so that R1 could self-administer her pills, check her own blood sugars and administer her own insulin. Staff E stated that she was unable to recall if she had completed a self- administration assessment for medications/ diabetes management on R1. Staff E stated that it usually took their pharmacy a few hours to get medications entered into the EMAR system for a new admit. Staff E stated that she did not see or assess R1 when she had admitted to the facility. Staff E stated that she had worked on Friday, [redacted]/2025, when R1 admitted and she had not completed a signed initial Negotiated Service Plan, and no care plan for staff to follow on the day R1 admitted to the facility. Staff E stated that she had verbally told the day shift and evening shift staff what cares R1 required and then instructed the evening shift to report it to the oncoming night shift and then for each shift to report it to the next over the weekend.

In an interview on 02/25/2025 at 1:03pm, Staff E stated that R1 was supposed to come to the medication cart to get her own medications. Staff E stated that R1 only needed reminders to check her blood sugars and that R1 could administer her own insulin. When asked why R1's medications were being kept in the medication cart and not in her room since R1 was supposed to be administering her own medications, Staff E stated because that was where the medications were. Staff E was asked if the medication technicians were to pour the medications for R1 and she answered no. Staff E asked if the medication technicians were supposed to hand R1 her medication bottles so R1 could distribute her own medications, and Staff E did not answer question.

In an interview on 02/25/2025 at 1:45pm, Staff B stated that residents who manage their own medications keep their medications in their rooms, not in the medication carts. Staff B stated that she took R1's vitals today and noticed that R1 had low respirations. Staff B stated that she had asked R1 if she was in pain and R1 answered, yes. R1 verbalized to Staff B that she holds her breath because when she does it stops the pain for a moment. R1 verbalized to Staff B that the pain was in her legs and feet

and it felt like stabbing and she couldn't walk. Staff B stated that R1 had been crying during this interaction due to being in pain and was visibly in distress.

In an interview on 02/25/2025 at 1:49pm Staff C, caregiver, stated that after she took R1 her meal room tray on this day R1 voiced to her that she was in severe pain and was crying. Staff C stated that she could feel that R1 was suffering in pain. Staff C stated she had reported it to the medication technician on duty.

In an observation on 02/25/2025 at 11:44am, R1 was noted to be cry during interview voicing pain and discomfort in her lower legs and feet. R1 was observed to ambulate in their room, and R1 needed to hold onto furniture and counters for balance. While walking R1 was observed attempting to walk softly and would grimace when placing weight onto each foot. After less than five minutes of being out of bed attempting to walk around apartment R1 verbalized she needed to lay back down and get off her feet. While laying in bed R1 was seen rubbing her feet and lower legs and showing signs of guarding. While talking R1 was taking sudden breaths and holding for about a couple of seconds.

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) 5/5/25 .

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

Debbie Smathers — Administrator (or Representative)

4/7/25 — Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs,

capabilities, and preferences.

This requirement was not met as evidenced by:

Based on record and interview the facility failed to develop and implement an initial service plan and care plan for 1 of 1 residents (Resident 1). This failure placed resident 1 at risk for staff being untrained and unmet resident care needs.

Findings included...

Record review of Resident 1's (R1) face sheet on 02/25/2025, showed R1 admitted to the facility on [redacted]/2025. There was no history information provided on R1's face sheet.

Record review of R1's Initial Negotiated Service Plan, on 02/25/2025, showed there was no initial signed service plan available to review.

Record review R1's care plan, on 02/25/2025, showed there was no care plan for R1 available to review.

Record review of R1's Pre-Admission Assessment, dated 01/27/2025, showed R1 was assessed as needing medication administration. R1 required injections and nurse delegation. R1 was insulin (a medication to manage blood sugars) dependent. R1 had no skin/ wound issues. The assessment showed the persons responsible for assisting with medication administration were qualified staff listed as Med-Tech (Medication Technician) and/or nurse. R1 was assessed as not able to take medications without assistance. R1 was assessed to have neuropathy in her feet causing decreased mobility due to pain and discomfort rated at 7-8 intense pain (on a scale of 1-10, 10 being the highest level of pain). R1 was able to express pain and was actively feeling pain and discomfort. Skin evaluation showed R1 had no skin wounds or skin issues. No other assessments for R1 were provided to review as of 02/25/2025.

In an interview on 02/25/2025 at 12:15pm, Staff B, Medication Technician, stated that they were not notified that R1 was a diabetic (a condition that affects how the body uses sugar) and that she was on insulin. Staff B stated that R1 was not in the electronic medication administration record to be able to administer medications.

In an interview on 02/25/2025 at 12:22pm, Staff E, Licensed Practical Nurse, stated that a preadmission assessment was completed for R1, and stated that it was done over ZOOM (video call) on 01/27/2025. Staff E stated that she was currently working on R1's initial negotiated service plan. Staff E stated that R1 was not reassessed upon admission. Staff E stated that she did receive a current medication order for R1 and had faxed it to their pharmacy on Friday, [redacted]/2025. Staff E stated that she was unable to

provide a fax confirmation page of the medication orders to the pharmacy. Staff E stated that she had found out on Monday 02/24/2025, that no medication orders had been uploaded in the EMAR (Electronic Medication Administration Record) system for R1. Staff E stated that it was standard practice for the facility to have all the medications, treatments and care plan set up so the new resident can be given proper care after admission. Staff E stated that she had instructed the medication technicians to give R1 her medications so she could self-administer her pills and check her own blood sugars and administer her own insulin. Staff E stated that she was unsure if she had completed a self- administration assessment for medications/ diabetes management for R1. Staff E stated that she did not have a signed initial negotiation service plan for R1 and no care plan had been made for staff to follow. Staff E stated that she had worked on Friday, [redacted]/2025, when R1 was admitted. Staff E stated that she verbally told day shift and evening shift staff what cares R1 required and then had instructed the evening shift staff to pass the report to the night shift staff and then for each shift to report it to the next over the weekend. Staff E stated that it usually took their pharmacy a few hours to get medications entered into the EMAR system for a new admit. Staff E stated that she did not see or assess R1 the day she had admitted.

In an interview on 02/25/2025 at 1:03pm, Staff E stated that R1 was supposed to come to the medication cart to get her own medications. Staff E stated that R1 only needed reminders to check her blood sugar and she could administer her own insulin. When asked why R1's medications were in the medication cart and not in her room, Staff E stated because that was where the medications were. Staff E was asked if the medication technicians were to pour the medications for R1 and she stated no. Staff E was asked if the med-techs were supposed to hand R1's medication bottles to her and then R1 would distribute her own medications, and Staff E did not answer question.

In an interview on 02/25/2025 at 1:07pm, R1'sSelf-Medication Assessment and Diabetes Management Assessment were requested for review. Staff E stated they were not available to review, and she was unable to recall if she had completed them for R1.

In an interview on 02/25/2025 at 1:37pm, Staff D, caregiver, stated that the nurse usually will give the caregivers the care plan to review upon admission with new residents. Staff D stated that there was no care plan for R1 provided to review on [redacted]/2025 and also as of current. Staff D stated that she had not been advised on the cares R1 required.

Statement of Deficiencies	License #: 2615	Compliance Determination # 56744
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 8 of 8	Licensee: Greenlake Management Ocean Shores, LLC	03/21/2025

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) 5/5/25 .

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

Administrator (or Representative) Debbie Smethers Date 4/2/25