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) 55071 (Completion Date 02/19/2025) and 50157 (Completion Date 12/30/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/19/2025 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-2210-2, WAC 388-78A-2240

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 #: 50157
Investigator: Phan Pham
Investigation Date(s): 11/12/2024 through 12/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 154612
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of care - Named resident did not her medications as ordered.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named resident, residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An investigation was conducted, and allegation identified in the intake related to medication services, care and services were reviewed. The Assisted Living Facility failed to ensure a staff member followed the professional standards of practice for medication administration and did not leave medications at the resident's bedside and ensure residents received their medications as ordered, did not monitor residents and did not report to physicians when medications were not available.

Conclusion / Action:

- [x] 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 #: 50157
Investigator: Phan Pham
Investigation Date(s): 11/12/2024 through 12/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 158600
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Quality of care - Resident did not receive her medications as ordered.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named resident, residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An investigation was conducted, and allegation identified in the intake related to medication services, care and services were reviewed. The Assisted Living Facility failed to ensure a staff member followed the professional standards of practice for medication administration and did not leave medications at the resident's bedside and ensure residents received their medications as ordered, did not monitor residents and did not report to physicians when medications were not available.

Conclusion / Action:

- [x] 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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2615	Compliance Determination # 50157
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 8	Licensee: Greenlake Management Ocean Shores, LLC	12/30/2024

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 11/12/2024, 11/12/2024, 12/09/2024, 12/16/2024 and 12/16/2024 of:

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

This document references the following complaint number(s): 152500, 153832, 154472, 154612, 154643, 154810, 154783, 158600

The following sample was selected for review during the unannounced on-site visit: 4 of 49 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

01/09/2025
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)

1/21/25
Date

WAC 388-78A-2210 Medication services.

(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-2250 :

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility failed to ensure residents received their medications as ordered for three of four sampled residents (Resident 1[R1], Resident 2[R2] and Resident 3 [R3]) reviewed for medication services. These failures placed R2 at risk of harm and placed all other residents receiving medication assistance at risk for experiencing health complications and not receiving medications as prescribed.

Findings included...

R1

According to Fundamentals of Nursing, 3rd Edition, (Taylor, Lillis, & LeMone), and Basic Pharmacology for Nurses, 4th Edition, (Clayton, Stock, & Harroun), the nurse needs to stay with the client to ensure the medication is taken. Leaving the medication at the bedside is an unsafe practice as the client may forget or someone else may take the medication.

Review of R1's face sheet showed R1 was admitted to the facility on [redacted]/2024 with a diagnoses including [redacted], [redacted] and [redacted].

Review of R1's negotiated service plan dated 07/30/2024 documented R1 required staff assistance with medication administration. R1 had memory issues and forgot to take his medications. The facility was responsible for ensuring the medications were administered as prescribed.

During an observation on 11/12/2024 at 1:35 PM, the door to R1's room was unlocked, R1 was not in his room and there was a cup of medications observed on the table. There were seven and a half tablets of medications observed in a cup.

In an interview on 11/12/2024 at 1:37 PM, R1 stated he wanted to take his medications in his room and had asked Staff B, Medication Tech, to bring the medications to his room. R1 stated Staff B left the medications for him to take when he was able. R1 stated he had not taken any of his morning medications.

In an interview on 11/12/2024 at 2:05 PM, Staff C, Medication Tech, was asked to observe the cup on the table in the resident's room and Staff C stated there were eight medications in the cup. At 2:15 PM, Staff C took the medications and verified in the computer that the medications were correct and the medication cards were correct. Staff C stated there was one tablet of Methocarbamol (for pain), one tablet of Jardiance (for diabetes), one tablet of Carvedilol (treat high blood pressure), one tablet of Eliquis (prevent blood clot), one table of Lisinopril (blood pressure), one tablet of Metformin (diabetes), one tablet of Ibuprofen (pain), one half tablet of Chlorthalidone (blood pressure), and one tablet of Gabapentin (pain) in the cup. Staff C stated these were the resident's morning medications. Staff C stated the order was for two tablets of Gabapentin and there was only one in the cup. Staff C stated the noon Gabapentin had not been signed out. Staff C stated she had been trained to observe that R2 had taken the medications and did not leave the medications unattended.

Review of R1's physician order dated 09/11/2024 for Gabapentin 600 milligrams per tablet, and two tablets were to be administered three times daily. The medication was scheduled for 5:00 AM, 12:00 PM and 5:00 PM. Review of the medication administration record for 11/12/2024 showed R1's 5:00 AM Gabapentin had been signed off and the resident had not taken the medication. The resident did not receive his 12:00 PM Gabapentin and only one Gabapentin was in the cup for the 5:00 AM dosage.

In an interview on 11/12/2024 at 3:05 PM, Staff B stated she had left R2's morning medications in his room per the resident request. Staff B stated she had been trained to follow the medication administration procedures to ensure residents received their medications as prescribed. Staff B stated she was supposed to watch the residents had taken their medications and not left them unattended as she was trained.

In an interview at 11/12/2024 at 3:05 PM, Staff A, Executive Director, stated staff members had been trained on medication administration and staff were to stay with the residents to ensure the residents had taken their medications.

R2

Review of R2's face sheet showed R2 was admitted to the facility on [redacted]/2022 with a diagnoses including [redacted], [redacted] and [redacted].

Review of R2's negotiated service plan dated 07/09/2024 documented R2 required staff assistance with medication administration. R2 was able to communicate her needs. The

facility was responsible for ensuring the medications were administered as prescribed.

On 11/12/2024 at 1:12 PM, R2 was observed sitting in her wheelchair in her room. R2 stated she had difficulty breathing and pneumonia (lungs infection) and was hospitalized. R2 stated she returned to the assisted living facility on [redacted]/2024 with an antibiotic and a steroid and staff did not administer the medications timely. R2 stated she was not able to breathe when staff did not administer the medications.

Review of R2's charting notes records revealed on 10/24/2024 at 9:38 AM, staff documented R2's oxygen saturation was below normal, had shortness of breath and difficulty breathing. Staff called 911 and R2 was transported to the hospital. R2 returned to the assisted living facility on [redacted]/2024 at 4:15 PM.

Review of R2's hospital discharge record dated [redacted]/2024 documented the resident was admitted for airways constriction and diagnosed with [redacted]. R2 was discharged to assisted living facility (ALF). The medications ordered were Amoxicillin/Potassium Clavulanate 875 mg – 125 mg tablet to be administered one tablet twice daily, quantity 10 tablets and Prednisone (anti-inflammatory) 20 milligrams (mg) tablet. The Prednisone was to be administered 60 mg daily for two days, then 50 mg daily for two days, then 40 mg daily for two days, then 30 mg daily for two days, then 20 mg daily for two days, then 20 mg daily for two days, then 10 mg daily for two days and then discontinue.

Review of R2's medication administration record (MAR) from October 1, 2024, to November 12, 2024, showed the Amoxicillin/Potassium Clavulanate 875 mg – 125 mg tablet was not recorded as given. The MAR showed the Prednisone was started on 11/04/2024 and completed 11/09/2024. According to the MAR on 11/05/2024 staff administered 1.5 tablets and staff members did not clearly show the dosage given on 11/04 and from 11/6 to 11/09/2024. The Prednisone treatment course would have taken 12 days to complete, and R2 received the medication for six days then discontinued.

In an interview on 12/09/2024 at 10:28 AM, Staff D, Health Service Director (HSD), stated she reviewed R2's records and was not able to determine that the resident received her antibiotic, the correct dosages of the Prednisone were administered, and why the Prednisone treatment was delayed. Staff D stated the Prednisone dosages administered were not clearly documented and the length of treatment was not in accordance with the orders. Staff D stated the Prednisone was discontinued after six days because the medication ran out. Staff D stated the Registered Nurse (RN) usually review the resident hospital discharge paper for new orders. Staff D stated the hospital normally fax the prescriptions to the pharmacy and if the resident return with prescriptions, then staff would fax the prescriptions to the pharmacy. Staff D stated the pharmacy staff would enter the prescriptions into the computer and alert ALF staff member to review. Staff D stated the RN reviewed the prescriptions entered by pharmacy staff to ensure the orders were correctly transcribed and approve the orders. Staff D stated staff members were to contact the RN when they had questions related to the orders and/or medications. Staff D stated the incident occurred prior to her employment at the ALF.

R3

Review of R3's face sheet showed R3 admitted to the facility on [redacted]/2024 with diagnoses including [redacted] and [redacted].

Review of R3's negotiated service plan dated 10/13/2024 documented R3 required staff assistance with medication administration. Staff members were responsible for ensuring R3 received her medications as ordered and monitor the medications effectiveness. R3 was able to communicate her needs to the facility.

On 12/16/2024 at 11:34 AM, R3 was observed sitting in a chair in her room. R3 stated staff did not administer her HIV medication for eight days. R3 stated the medication was to treat "AIDS" (acquired immunodeficiency syndrome) and felt sick when she did not receive the medication. R3 stated staff were supposed to assist her with medication administration and ordering.

Review of R3's record physician orders revealed on 09/15/2024 R3 had physician orders for Biktarvy 50-200-25 milligrams (mg) tablet, to be administered one tablet daily for HIV and Glucophage 500 mg tablet, to be administered one tablet daily for diabetes. Review of the MAR from 11/01/2024 to December 12/16/2024 showed the Biktarvy was not available, and the resident did not receive the medication on 11/04, 11/05, 11/06, from 11/15 to 11/18, and from 12/10 to 12/12/2024. The MAR also showed staff did not administer the Glucophage from 12/11 to 12/14/2024 cited the medication was not available.

In an interview on 12/16/2024 at 11:34 AM, Staff D stated the medication techs were responsible for reordering the residents' medications when there were seven-days supply of the medication left. Staff D stated staff members were to immediately notify her and/or the pharmacy when there were issues with getting the residents' medications refilled. Staff D stated the resident was out of her Biktarvy for five days before staff notified her.

In an interview on 12/16/2024 at 11:47 AM, Staff E, Medication Tech, stated she had been trained to reorder residents medications when there were 10 days supply left. Staff E stated she would notify the HSD and/or the pharmacy when a medication was not available and/or had problems getting a medication refilled.

This is a recurring deficiency previously cited on 09/01/2023 and 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) 2/13/25 .

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

Debbie Smathers — Administrator (or Representative)

1/21/25 — 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 observations, interview and record review, the assisted living facility failed to obtain prescribed medications for 2 of 4 sampled residents (Resident 2 [R2] and Resident 3[R3]). This failure resulted in both residents not receiving their prescribed medications as ordered, R3 experiencing health complications, and placed both residents at risk for diminished quality of life.

Findings included...

Review of the facility's Medication Non-availability policy, dated 02/15/2024, showed the Community would make every effort to ensure that medications were available as prescribed for each resident. Staff members providing medication assistance were responsible for requesting refills when the medication supply was at 10-day level, communicate with appropriate staff members and document in R3's health record.

R2

Record review of R2's face sheet showed R2 was admitted to the facility on [redacted]/2022 with a diagnosis including [redacted], [redacted] and [redacted].

Record review of R2's negotiated service plan, dated 07/09/2024, showed R2 required staff assistance with medication administration. R2 was able to communicate her needs. The facility's staff were responsible for ordering and ensuring the medications were administered as prescribed.

On 11/12/2024 at 1:12 PM, R2 was observed sitting in her wheelchair in her room. R2

stated she had difficulty breathing and pneumonia (lungs infection) and was hospitalized. R2 stated she returned to the assisted living facility on [redacted]/2034 with an antibiotic and a steroid and staff did not administer the medications timely. R2 stated she was not able to breathe when staff did not administer the medications.

Record review of R2's facility charting notes showed on 10/24/2024 at 9:38 AM, showed R2's oxygen saturation was at 75%, had shortness of breath and difficulty breathing. Staff called 911 and R2 was transported to the hospital. R2 returned to the assisted living facility on [redacted]/2024 at 4:15 PM.

Record review of R2's hospital discharge record, dated [redacted]/2024, showed R2 was admitted for airways constriction and diagnosed with [redacted]. R2 was discharged to an assisted living facility (ALF). The medications ordered were Amoxicillin/Potassium Clavulanate (treat infection) 875 mg – 125 mg tablet to be administered one tablet twice daily, quantity 10 tablets and Prednisone (anti-inflammatory) 20 milligrams (mg) tablet. The Prednisone was to be administered 60 mg daily for two days, then 50 mg daily for two days, then 40 mg daily for two days, then 30 mg daily for two days, then 20 mg daily for two days, then 20 mg daily for two days, then 10 mg daily for two days and then discontinue.

Record review of R2's medication administration record (MAR) from October 1, 2024, to November 12, 2024, showed R2's medication Amoxicillin/Potassium Clavulanate 875 mg – 125 mg tablet was not recorded as given. R2's MAR showed the Prednisone was started on 11/04/2024 and completed 11/09/2024. According to the MAR on 11/05/2024 staff administered 1.5 tablets and staff members did not clearly show the dosage given on 11/04/2024 and from 11/06/2024 to 11/09/2024. The Prednisone treatment course would have taken 12 days to complete, and R2 received the medication for six days then discontinued.

R3

Record review of R3's face sheet showed R3 was admitted to the facility on [redacted]/2024 with a diagnosis including [redacted] ([redacted]) and [redacted].

Record review of R3's negotiated service plan, dated 10/13/2024, showed R3 required staff assistance with medication management and administration. Staff members were responsible for ensuring R3 received her medications as ordered and monitor the medications effectiveness. R3 was able to communicate her needs to the facility.

On 12/16/2024 at 11:34 AM, R3 was observed sitting in a chair in her room. R3 stated staff did not administer her HIV medication for eight days. R3 stated the medication was to treat "AIDS" (acquired immunodeficiency syndrome) and felt sick when she did not receive the medication. R3 stated staff were supposed to assist her with medication administration and ordering.

Record review of R3's MAR showed on 09/15/2024 R3 had physician orders for Biktarvy 50-200-25 milligrams (mg) tablet, to be administered one tablet daily for HIV and Glucophage 500 mg tablet, to be administered one tablet daily for diabetes. Review of the MAR from 11/01/2024 to 12/16/2024 showed the Biktarvy was not available, and R3 did not receive the medication on 11/04/2024, 11/05/2024,11/06/2024, from 11/15/2024 to 11/18/2024, and from 12/10/2024 to 12/12/2024. The MAR also showed staff did not administer the Glucophage from 12/11/2024 to 12/14/2024 cited the medication was not available.

In an interview on 12/16/2024 at 11:34 AM, Staff D stated R3 needed assistance with medication management and the medication techs were responsible for reordering R3's medications when there were seven-day supply of the medication left. Staff D stated staff members were to immediately notify her and/or the pharmacy when there were issues with getting R3s' medications refilled. Staff D stated R3 was out of her Biktarvy for five days before staff notified her.

In an interview on 12/16/2024 at 11:47 AM, Staff E, Medication Tech, stated she had been trained to reorder residents' medications when there were 10-day supply left. Staff E stated she would notify the HSD and/or the pharmacy when a medication was not available and/or had problems getting a medication refilled.

This is a recurring deficiency previously cited on 06/05/2024 and 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) 2/13/25 .

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

Debbie Smathers — Administrator (or Representative)

1/21/25 — Date