



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

09/22/2025

Greenlake Management Gig Harbor, LLC
Gig Harbor Memory Care
3025 14TH AVE NW
GIG HARBOR, WA 98335

RE: Gig Harbor Memory Care # 2627

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 65926 (Completion Date 09/22/2025) and 63876 (Completion Date 08/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/22/2025 and found no deficiencies.

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

WAC 388-78A-2210 Medication services.

- (1) An assisted living facility providing medication service, either directly or indirectly, must:
 - (b) Develop and implement systems that support and promote safe medication service for each resident.
 - (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 :
 - (b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

The Department staff who did the On Site verification:
Susan Carmichael, Nursing Consultant Institutional

If you have any questions, please contact me at (253)442-3013.

This document was prepared by Residential Care Services for the Locator website.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2627	Compliance Determination # 63876
Plan of Correction	Gig Harbor Memory Care	Completion Date
Page 1 of 3	Licensee: Greenlake Management Gig Harbor, LLC	08/08/2025

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 follow-up on 08/08/2025 of:

Gig Harbor Memory Care
3025 14TH AVE NW
GIG HARBOR, WA 98335

This document references the following SOD dated: 08/08/2025

The following sample was selected for review during the unannounced on-site visit: 7 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Heinz, Long Term Care Surveyor
Susan Carmichael, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2627	Compliance Determination # 63876
Plan of Correction	Gig Harbor Memory Care	Completion Date
Page 2 of 3	Licensee: Greenlake Management Gig Harbor, LLC	08/08/2025

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

08/20/2025

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.

Virginia M. Kunde
Administrator (or Representative)

8-25-25

Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement medication services with parameters (additional medication directions from the physician) for 1 of 2 sampled residents (Resident 1 [R1]) that was safe and supported the needs of each resident as required. This failure resulted in R1 not receiving medications as prescribed and placed R1 at risk of illness.

Findings included...

Review of R1's August 2025 Medication Administration Record (MAR) showed an order dated 07/07/2025 for Losartan 50 milligrams daily for blood pressure, with parameters to hold (not give) the medication when systolic blood pressure (top number) was less than 100 or heart rate less than 60 beats per minute. The MAR failed to show R1's blood pressure and pulse were documented as taken from 08/01/2025 through 08/08/2025 before the medication was given to R1 by ALF staff.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2627	Compliance Determination # 63876
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During an interview on 08/08/2025 at 11:45 AM, Staff A, Health Services Director, stated R1's blood pressure and pulse were not documented on the MAR by ALF staff before the medication was given.

This was an uncorrected and recurring deficiency previously cited on 06/18/2025 and 04/07/2025.

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, Gig Harbor Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>September 10, 2025</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Virginia McFend</u> Administrator (or Representative)	<u>8-25-2025</u> Date

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AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2627	Compliance Determination # 60819
Plan of Correction	Gig Harbor Memory Care	Completion Date
Page 1 of 12	Licensee: Greenlake Management Gig Harbor, LLC	06/18/2025

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 follow-up on 06/09/2025, 06/10/2025 and 06/11/2025 of:

Gig Harbor Memory Care
3025 14TH AVE NW
GIG HARBOR, WA 98335

This document references the following SOD dated: 06/18/2025

The following sample was selected for review during the unannounced on-site visit: 9 of 46 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

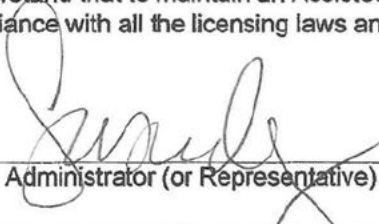
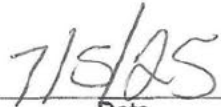
Kathy Heinz, Long Term Care Surveyor
Susan Carmichael, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

This document was prepared by Residential Care Services for the Locator website.

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.

 _____ Residential Care Services	07/03/2025 _____ 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.	
 _____ Administrator (or Representative)	 _____ Date

WAC 388-112A-0700 What is CPR training? Cardiopulmonary resuscitation training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests.

WAC 388-112A-0710 What is CPR/first-aid training? CPR/first-aid training is training that meets the guidelines established by the Occupational Safety and Health Administration (OSHA). Under OSHA guidelines, training must include hands on skills development through the use of mannequins or trainee partners.

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 1 of 1 caregiver (Staff D) had a valid First Aid card. This failure placed 46 of 46 residents at risk of not receiving emergency medical care in a timely manner.

Findings included...

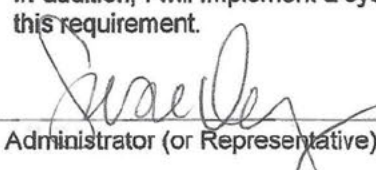
Review of the personnel file for Staff D (Medication Technician) showed they were hired

This document was prepared by Residential Care Services for the Locator website.

on 08/21/2022. The file showed Staff D did not have a valid First Aid card.

During an interview on 06/10/2025 at 12:00 PM, Staff A, Executive Director, stated Staff D did not take a First Aid class.

This is an uncorrected deficiency previously cited on 04/07/2025.

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, Gig Harbor Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>8/11/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>7/5/25</u> Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure the environment for 46 of 46 residents was kept safe, clean and in good repair. This failure placed residents at risk of a diminished quality of life.

Findings included...

<Exterior>

Observation on 06/09/2025 at 10:00 AM of a dirt pathway located in the parking area showed an unidentified person sitting in a wheelchair and smoking. Located in the same area was a large pile of dried tree limbs.

Observation on 06/11/2025 at 1:30 PM of the front of the ALF, showed cigarette butts in the same area as the large pile of dried tree limbs and the pathway. Cigarette butts were observed littered throughout the parking area and the beauty bark in the flower beds of the facility.

Observation 06/11/2025 at 1:30 PM of the designated smoking area showed cigarette butts lying in a planter amongst some litter.

Observation on 6/11/2025 at 1:30 PM showed the lid to the industrial size waste receptacle located in the parking area, was not shut. Crows were observed in the waste receptacle. Bits and pieces of litter were strewn throughout the parking area and the bordering flower beds.

Staff A, Executive Director was interviewed on 6/11/2025 at 2:00 PM. Staff A said she was unaware there was a path between the ALF and another business and it was being used as a smoking area. Staff A said she has talked with staff about using the metal smoking receptacle for their cigarette butts in the designated smoking area.

<North Wing>

Bathrooms

Observation on 06/09/2025 at 1:00 PM showed a black transition strip between the bathroom and the dining room had a cloth-like appearance. The strip was peeling up and shredded. The door jamb leading into the bathroom was chipped, gouged and showed peeling paint.

Observation on 06/09/2025 at 1:05 PM, showed in the bathroom near resident bedroom #2 the caulking was missing between the floor and the shower.

TV room

Observation on 06/09/2025 at 1:00 PM, showed a TV sitting on a wood finished stand. Multiple areas of the stand were chipped and gouged. All the small windowpanes were missing from the cupboard doors.

Laundry room

Observation on 06/09/2025 at 3:00 PM, showed a section approximately 14 by 14 inches of linoleum flooring in front of the washing machine was missing, exposing the sub floor. The wall behind the sink was chipped, gouged, and showed peeling paint. The wall adjacent to the washing machine was chipped and gouged.

<East Wing>

Observation on 06/09/2025 at 11:30 AM showed in the bathroom shower room nearest resident bedroom #10 the light above the sink was not working and the bathroom lighting was dim.

Observation on 06/09/2025 at 11:40 AM showed in the bathroom nearest resident bedroom #6 the light above the sink was not working and the bathroom lighting was dim.

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Observation on 06/09/2025 at 11:45 AM showed the gate and fence panel attached to the gate in the courtyard (near the breaker room exit) showed significant movement when pushed as the fencepost appeared not to be secured properly to the ground.

During a telephone interview on 06/18/2025 at 11:20 AM, Staff A stated she would have the maintenance director look at the fence and secure it.

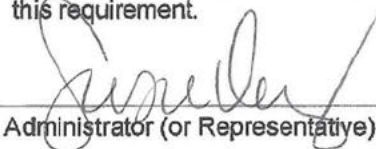
<South Wing>

Observation on 06/09/2025 at 11:00 AM, showed multiple areas of the walls surrounding the windows in the dining room were chipped and gouged.

Observation on 06/09/2025 at 11:05 AM showed the transition strips of the bathroom closest to resident bedroom #3 was missing.

During an interview on 06/18/2025 at 10:40 AM, Staff A said she had developed an action plan with the maintenance director, to complete the repairs that were not fixed by the back in compliance date.

This is an uncorrected deficiency previously cited on 04/07/2025.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>7/5/25</u> Date

WAC 388-78A-2210 Medication services.

- (1) An assisted living facility providing medication service, either directly or indirectly, must:
 - (b) Develop and implement systems that support and promote safe medication service for each resident.
- (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 :

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(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the Assisted Living Facility (ALF) failed to implement medication services for 4 of 9 sampled residents (Residents 2, 4, 5, and 9 [R2, 4, 5, and 9]) that was safe, and supported the needs of each resident as required. This failure resulted in the residents not receiving medications as prescribed and placed residents at risk for illness.

Findings included...

R2

The facility characteristic roster dated 06/09/2025 showed R2 moved into the facility on [REDACTED]/2025.

Review of a facility document titled "Prescribers Move in Orders", dated 05/09/2025 showed R2 had a diagnosis of [REDACTED]. In the section titled "Parameter Notification", the physician did not note parameters (when to hold or give the medication). The physician signed the orders.

Review of an "After Visit Summary", with physician orders, dated [REDACTED]/2025 showed a list of medications prescribed for R2 that included Lisinopril (used to treat high blood pressure) and Metoprolol (used to treat high blood pressure). There were no parameters noted.

Review of R2's May and June 2025 Medication Administration Records (MARs) failed to show the medications used to treat R2's high blood pressure was listed.

Observation on 06/11/2025 at 10:30 AM, of the medication cart showed the Lisinopril and Metoprolol were available for staff to administer.

During an interview on 06/09/2025 at 11:50 AM, Staff B, Licensed Practical Nurse, said he instructed staff to not give R2 the medications used to treat high blood pressure because the physician had not established parameters.

R4

Review of progress note dated [REDACTED]/2025 showed R4 was admitted to the ALF on [REDACTED]/2025.

Review of a document titled "Current Medications" dated [REDACTED]/2025 showed a physician order for an enema (liquid medication inserted into the rectum used to help with bowel movements) with directions to administer to R4 daily.

Review of the June MAR showed an enema was administered to R4 on 06/01/2025, 06/04/2025, 06/05/2025, 06/07/2025, and 06/08/2025 at 8:00 AM. Staff C, Resident Care Coordinator, initialed the MAR on 06/07/2025 that they administered the enema to R4.

During an interview on 06/11/2025 at 11:45 AM, Staff C stated they marked R4's MAR in error on 06/07/2025, and they did not administer the enema to R4. Staff C stated R4 was not administered an enema by the other staff on the other dates listed, and that R4's June MAR was marked in error by the other staff.

Observation on 06/11/2025 at 11:50 AM showed an unopened enema package in the medication cart for R4. Staff C stated the unopened enema was the only enema the ALF had in the medication supply for R4.

During an interview on 06/11/2025 at 12:00 PM, R4 stated they had not been given an enema by the ALF staff since they moved into the ALF.

R5

Review of the MARs for May 2025 and June 2025 showed an order for Lantus (insulin) to be administered one time per day if R5's blood sugar was greater than 120.

Review of the May 2025 MAR showed between 05/17/2025 and 05/31/2025 that staff documented they administered insulin on 05/21/2025 when R5's blood sugar was 95, and on 05/25/2025 when R5's blood sugar was 103.

Review of the June 2025 MAR showed between 06/01/2025 and 06/11/2025 that staff documented they administered insulin on 06/03/2025 when R5's blood sugar was 65, on 06/05/2025 when R5's blood sugar was 81, and on 06/11/2025 when R5's blood sugar was 95.

R9

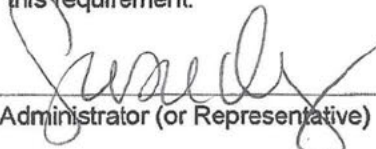
Review of the progress note dated 06/03/2025 showed R9 was admitted to the ALF on [REDACTED]/2025. A progress note dated [REDACTED]/2025 showed that R9 left the facility with a family member on [REDACTED]/2025 at 12:30 PM.

During an interview on 06/09/2025 at 1:10 PM, Staff C stated R9 left the ALF on [REDACTED]/2025 and had not yet returned to the ALF.

Review of R9's June 2025 MAR showed Tamsulosin for a prostate (male gland) condition one time daily. The medication was marked as being given by ALF staff on [REDACTED]/2025 at 5:00 PM when R9 was out of the facility. R9's June MAR also showed Acetaminophen for pain three times daily. The medication was marked as given by ALF staff on 06/09/2025 at 12:00 PM when R9 was out of the facility.

During an interview on 06/11/2025 at 12:00 PM, Staff C stated R9's medications were charted in error when the resident was out of the facility.

This is an uncorrected deficiency previously cited on 04/07/2025.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>7/5/25</u> _____ Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

- (i) Bathrooms and toilet rooms;
- (ii) Resident living rooms and resident sleeping rooms; and
- (iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to ensure the communication system was operable in 3 of 3 sampled living areas (Chapel, East Wing, and North Wing). This failure resulted in the communication system being inoperable and placed all 46 of 46 residents at risk of having their health and safety needs go unmet.

<Chapel>

Department staff pulled the cord to activate the communication system on 06/09/2025 at 2:00 PM. The communication system did not activate, and ALF staff did not respond.

<East Wing>

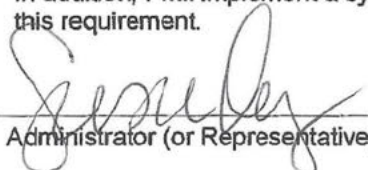
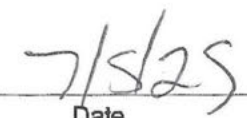
Department staff pulled the cord and activated the communication system in resident bedroom #10 on 06/09/2025 at 2:12 PM. ALF staff responded to the alert at 2:19 PM and stated that they went to resident bedroom #1 instead of resident bedroom #10 by mistake.

Department staff pulled the cord and activated the communication system in the bathroom located closest to resident bedroom #2 on 06/10/2025 at 2:40 PM. No caregivers were observed working on the East Wing at the time the system was activated. Staff C, Resident Care Coordinator, was observed entering the East Wing at 2:47 PM with a pager. Staff C was unable to find the alert and stated that she did not know the location of bathroom #8, as that was the location of the alert on the pager.

<North Wing>

Department staff pulled the cord and activated the communication system in the bathroom located closest to resident bedroom #2 on 06/10/2025 at 2:43 PM. ALF staff did not respond. Observation on 6/10/2025 at 2:45 PM showed Staff D, Caregiver, preparing drinks in the kitchen area. Staff D was asked on 06/10/2025 at 2:46 PM if she was aware department staff activated the communication system in the bathroom. Staff D walked over to the medication cart and picked up a pager. Staff D acknowledged she was not aware the system had been activated because she was not wearing the pager.

This is an uncorrected deficiency previously cited on 04/07/2025.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	 Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, record review, and interview, the Assisted Living Facility (ALF), failed to ensure the Negotiated Service Agreements (NSA, Service Plans) for 4 of 9 sampled residents (Resident 1, 6, 7, and 8 [R1, R6, R7, and R8]) were updated to reflect the current needs of the residents when there was a significant change in resident's health status and physical ability. This failure placed residents at risk of having their care needs go unmet.

Findings included...

<R1>

Review of a document titled "DSHS Current Annual Assessment" dated 07/09/2024 showed a section "Seizures" that included R1 had a history of seizures, the frequency was "annually" and that R1 took medication for the seizures.

Review of progress notes dated 03/08/2025 and 03/17/2025 showed R1 had seizures.

Review of R1's Service Plan dated 04/10/2025 failed to show it was updated with any information about R1's seizures, including how to identify a seizure, how to care for the resident when a seizure occurred to keep them safe, and who to notify if a seizure occurred.

During an interview on 06/10/2025 at 2:40 PM, Staff B, Licensed Nurse, stated they updated R1's Service Plan on 04/10/2025, however he stated he was unaware of R1's seizure disorder.

During a telephone interview with Staff A, Executive Director, and Staff B on 06/16/2025 at 2:00 PM, Department staff requested additional R1 progress notes.

Review of a progress note dated 04/09/2025 showed Staff B wrote he was "informed...that R1 has been experiencing seizures" and that Staff B requested a referral for a neurology consult from R1's medical provider.

<R6>

Review of a progress note dated 02/23/2025 showed R6 was on hospice (end of life) and received wound care.

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Review of the service plan dated 05/07/2025 failed to show it was updated to show R6 received wound care.

Review of a second service plan dated 06/13/2025 was given to Department staff on 06/17/2025. The service plan showed under the section titled "wound/ pressure ulcer," R6 received wound care from hospice.

Staff B was interviewed on 06/17/2025 at 10:45 AM. Staff B acknowledged the plan was updated after department staff entered to conduct the follow-up inspection on 06/09/2025.

<R7>

Review of a physician order dated 03/27/2025 showed R7 was prescribed a mechanical soft diet (easy to chew and swallow).

Review of R7's service plan, dated 05/07/2025, given to department staff on 06/09/2025, failed to show R7 was prescribed a mechanical soft diet.

<R8>

Review of a progress note dated 5/25/2025 showed staff noticed there were three small blisters on the back of R8's right leg and a blister on their left heel.

Review of a progress note dated 05/29/2025, showed R8 refused to be seen by podiatry for the two wounds on both heels.

Observation on 06/09/2025 at 2:00 PM, showed R8 sitting outside. R8 was wearing capris style pants. There was a bandage covering part of their right shin.

Review of R8's service plan dated 05/07/2025 failed to show they had any skin related issues.

Staff B was interviewed on 06/12/2025 at 1:30 PM about updating the care plan to reflect the current needs of the residents. Staff B said he was responsible for updating the care plans.

This is an uncorrected deficiency previously cited on 04/07/2025.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies

License #: 2627

Compliance Determination # 60819

Plan of Correction

Gig Harbor Memory Care

Completion Date

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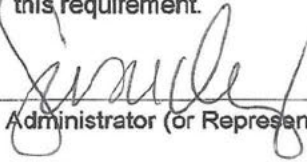
Licensee: Greenlake Management Gig Harbor, LLC

06/18/2025

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, Gig Harbor Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/1/25.

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



Administrator (or Representative)



Date

This document was prepared by Residential Care Services for the Locator website.



Residential Care Services Investigation Summary Report

Provider/Facility: Gig Harbor Memory Care **Provider Type:** Assisted Living Facility

License/Cert. #: 2627

Intake ID: 172294

Compliance Determination #: 56589

Region/Unit #: RCS Region 3 / Unit D

Investigator: Susan Carmichael

Investigation Date(s): 03/19/2025 through 04/07/2025

Complainant Contact Date(s):

Allegation(s):

The POA alleged the AV was sent to the hospital after being unresponsive. While at the hospital it was discovered the AV had two open areas on her heels, redness in the chest area and bruising to the back and buttocks.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 11 Closed records sample size:
Observations:	Resident rooms Staff to resident interactions residents environment dining
Interviews:	medication technicians caregivers Executive Director Nurse Delegator Resident Care Coordinator
Record Reviews:	care plans medication administration records staff records progress notes hospital paperwork

Investigation Summary:

Based on observation, interview and record review, failed practice was identified and citations were written under 388-78A- 2130 (service agreement planning), 388-78A-2150 (signing of the service agreement), 388-78A-2120 (monitoring well being) and 388-78A- 2210 (medication services).

Conclusion / Action:

- ☒ 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
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2627	Compliance Determination # 56589
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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 the unannounced on-site full inspection and complaint investigation on 03/19/2025, 03/20/2025, 03/21/2025, 03/24/2025, 03/27/2025 and 03/28/2025 of:

Gig Harbor Memory Care
3025 14TH AVE NW
GIG HARBOR, WA 98335

This document references the following complaint numbers: 172294.

The following sample was selected for review during the unannounced on-site visit: 11 of 48 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Susan Carmichael, Nursing Consultant Institutional
Kathy Heinz, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit D
PO Box 99250
Lakewood, WA 98496

This document was prepared by Residential Care Services for the Locator website.

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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 for Manfay Chan
Residential Care Services

04/15/2025
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.

Paulette M. Stahl
Administrator (or Representative)

4.22.25
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 5 sampled staff (Staff C), obtained home care aide (HCA) certification within 200 days of hire. This failure may have resulted in all 48 of 48 residents receiving care from an unqualified staff.

Findings included...

WAC 388-112A-0105

Who is required to obtain home care aide certification and by when?

(1) All long-term care workers must obtain home care aide certification as provided in chapter 246-980 WAC.

(2) The following individuals must obtain home care aide certification as follows:

(c) Assisted living facility administrators or their designees, within 200 calendar days of the date of hire.

Review of the personnel file for Staff C, Caregiver, showed they were hired on 08/12/2022. The file contained documentation of Staff C completing 75 hours of long-term care basic training on 11/24/2024. The file contained a current Department of Health (DOH) nursing assistant registration (NAR).

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Staff A, Administrator, was interviewed on 03/24/2025 at 1:00 PM. Staff A said Staff C held a current NAR and was not a certified HCA.

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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, Gig Harbor Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>5/14/25</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Pm. Stahl</u> Administrator (or Representative)	<u>4.22.25</u> Date

WAC 388-112A-0700 What is CPR training? Cardiopulmonary resuscitation training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests.

WAC 388-112A-0710 What is CPR/first-aid training? CPR/first-aid training is training that meets the guidelines established by the Occupational Safety and Health Administration (OSHA). Under OSHA guidelines, training must include hands on skills development through the use of mannequins or trainee partners.

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 3 of 5 sampled staff (Staff B, D, and F) had a valid Cardiopulmonary/First Aid (CPR/FA) card. Failure to ensure staff were adequately trained in CPR/FA placed all 48 of 48 residents at risk of decline in their health status during a medical emergency.

Findings included...

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Review of the personnel file for Staff B, Medication Technician, showed they were hired on 10/04/2024. The file showed they had taken an online (computer based) CPR course.

Review of the personnel file for Staff D, Medication Technician, showed they were hired in 08/21/2022. The file showed they had taken an online CPR/FA course.

Review of the personnel file for Staff F, Medication Technician, showed their CPR/FA card expired on 12/2024.

During an interview on 03/28/2025 at 12:00 PM, Staff I, Executive Director, provided the names of the Staff who took a "hands-on" CPR/FA class on 03/25/2025. Staff B, D, and F did not take the class.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>G. M. Staal</u> Administrator (or Representative)	<u>4.22.25</u> Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure, 1 of 5 sampled staff (Staff F) completed a Washington state name and date of birth background check as required. Failure to complete a Washington state name and date

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of birth may have resulted in staff with a criminal history providing care to all 48 of 48 residents.

Findings included...

Review of the personnel file for Staff F, Medication Technician, showed they were hired on 08/01/2022. The State of Washington name and date of birth background showed it expired on 01/12/2025.

Staff I, Executive Director, stated during an interview on 03/26/2025 at 10:45 AM, the Business Office Manager was responsible for ensuring the criminal background checks were completed, and it was not completed for Staff F.

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, Gig Harbor Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/17/25.

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

PM Stahl
Administrator (or Representative)

4.22.25
Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 4 of 5 sampled staff (Staff B, D, E and F) completed continuing education as required. Failure to ensure staff completed their continuing education hours as required, placed

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all 48 of 48 residents at risk from receiving care from unqualified staff.

Findings included...

Review of the personnel file for Staff B, Medication Technician, showed they were hired on 10/24/2024 and their date of birth was listed March 10. Their file failed to contain continuing education hours taken by their birthday.

Review of the personnel file for Staff D, Medication Technician, showed they were hired on 08/01/2022 and their date of birth was listed as February 2. Their file failed to contain continuing education hours taken by their birthday.

Review of the personnel file for Staff E, Medication Technician, showed they were hired on 09/26/2022 and their date of birth was listed as November 4. Their file failed to contain continuing education hours taken by their birthday.

Review of the personnel file for Staff F, Medication Technician, showed they were hired on 08/01/2022 and their date of birth was listed as March 2. Their file failed to contain continuing education hours taken by their birthday.

Staff A, Administrator, said during an interview on 03/20/2025 at 11:00 AM, Staff B, D, E, and F did not have their continuing education hours.

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, Gig Harbor Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/17/25.

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

PM Stahl
Administrator (or Representative)

4.22.25
Date

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic

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introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 5 of 5 sampled staff (Staff B, C, D, E, and F) completed facility orientation before having routine interactions with residents. Failure to complete facility orientation as required may result in staff not knowing how to respond and communicate during emergencies specific to the ALF, placing all 48 of 48 residents at risk of harm.

Findings included...

Review of the personnel file for Staff B, Medication Technician, showed they were hired on 10/04/2024.

Review of the personnel file for Staff C, Caregiver, showed they were hired on 08/28/2022.

Review of the personnel file for Staff D, Medication Technician, showed they were hired on 08/01/2022.

Review of the personnel file for Staff E, Resident Care Coordinator, showed they were hired on 09/26/2022.

Review of the personnel file for Staff F, Medication Technician, showed they were hired on 08/01/2022.

Review of a document titled Fire Protection Bureau Fire/Fire and Life Safety Inspections showed Staff B, C, D, E, and F took facility orientation on 01/03/2025.

Staff E said during an interview on 03/22/2025 at 1:20 PM, they helped the previous maintenance director conduct facility orientation on 01/03/2025 for Staff B, C, D, E, and F.

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 Administrator (or Representative)	<u>4.22.25</u> Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure on-site food service for 1 of 1 kitchens to remain in compliance with Washington State Retail Food Code chapter 246-215 WAC Food Service by not having equipment in good repair, inaccurate temperature logs for freezer, refrigerator, and hot food prior to serving the food, and 1 of 1 kitchen manager was not certified as a food protection manager by Washington State Department of Health. This failure placed 48 of 48 residents at risk of illness from ingestion of potentially unsafe food.

Findings included...

WAC 246-215-04500

Subpart E - Maintenance and Operations 04500 Equipment--Good repair and proper adjustment (FDA Food Code 4-501.11). (1) EQUIPMENT must be maintained in a state of repair and condition that meets the requirements specified under Part 4, Subpart A and Part 4, Subpart B of this chapter. (2) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates must be kept intact, tight, and adjusted in accordance with the manufacturer's specifications.

WAC 246-215-02107

Certified food protection manager (FDA Food Code 2-102.12).

(1) By March 1, 2023, food establishments must have at least one certified food protection manager on staff as evidenced by a valid certificate available from an accredited program. The certificate must be available upon request. If the certified food protection manager leaves employment for any reason, the food establishment must have another certified food protection manager on staff within sixty days.

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EQUIPMENT

Observation on 03/20/2025 at 3:30 PM the large freezer door and the large refrigerator door in the ALF kitchen showed rubber seals on the interior of both doors were loose and were not secured to the inside of the door to provide a tight seal.

During an interview on 03/20/2025 at 3:30 PM, Staff H, kitchen manager stated the loose rubber seals were reported to the ALF maintenance director.

TEMPERATURE LOGS

During further inspection of the kitchen, the large freezer and large refrigerator showed temperature logs taped to the exterior of the doors. The temperature logs were dated for each day of the month with temperatures recorded twice each day at 6:00 AM and 6:00 PM for the freezer and refrigerator. On 03/20/2025 at 3:30 PM, the temperatures for the freezer and refrigerator were already recorded in the 6:00 PM time slot.

Review of a clipboard in the ALF kitchen showed the temperature log for hot food before it was taken from the kitchen to the resident living areas. The temperature log was dated for each day of the month with temperatures recorded three times a day at breakfast, lunch, and dinner for each entrée, starch, vegetable, and other food categories. On 03/20/2025 at 3:45 PM, the temperatures for the hot foods were already recorded in the dinner time slot.

During an interview on 03/20/2025 at 3:35 PM, Staff H stated they did not know why one of the other kitchen staff filled in the temperature logs for the freezer, refrigerator, and hot foods ahead of time.

FOOD PROTECTION MANAGER CERTIFICATION

During the inspection of the ALF kitchen on 03/20/2025 at 3:45 PM, a certification of Staff H, Kitchen Manager, as a Certified Food Protection Manager by the Washington State Department of Health (DOH) was not observed.

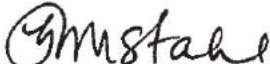
During an interview on 03/20/2025 at 3:45 PM Staff H stated they were not aware of the requirement for the DOH certification as a Food Protection Manager.

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


Administrator (or Representative)

4.22.25
Date

WAC 388-78A-2300 Food and nutrition services.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(ii) Approved by a dietitian; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure on-site food service compliance with Washington State Retail Food Code chapter 246-215 WAC Food Service by not preparing and serving food to according to ALF diet manuals and menus approved by a dietitian. This failure placed 48 of 48 residents at risk of illness from ingestion of potentially unsafe food.

Findings included...

Observations on 03/24/2025 at 12:00 PM showed residents in the Elderberry (East Wing) of the ALF eating lunch which consisted of beef pot pie or Chicken Florentine, mashed potatoes, and mixed vegetables.

Review of the corporate dietitian approved ALF menu for 03/24/2025 showed lunch as beef casserole, Spanish rice, and corn relish.

During an interview on 03/24/2025 at 3:00 PM, Staff H, Kitchen Manager, stated they cooked meals for residents from menus they created and did not use the ALF corporate dietitian-approved menus. Review of Staff H's menus failed to include alternate food items, mechanical soft foods approved by a dietitian, or snacks available to the

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residents.

During an interview on 03/24/2025 at 4:00 PM, Staff I, Executive Director stated they knew Staff H was using their own menus but told them to follow the corporate dietitian-approved menus.

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<u>P.M. Staal</u> Administrator (or Representative)	<u>4.22.25</u> Date

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

- (1) Medical history;
- (2) Necessary and contraindicated medications;
- (3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;
- (4) Significant known behaviors or symptoms that may cause concern or require special care;
- (5) Mental illness diagnosis, except where protected by confidentiality laws;
- (6) Level of personal care needs;
- (7) Activities and service preferences; and
- (8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure preadmission assessments were completed as required for 3 of 3 sampled Residents (Resident 2, 5, and 9 [R2, 5, and 9]) admitted to the facility in the last six months. Failure to complete a preadmission assessment prevented staff from developing a

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service plan that met the needs of the residents, and placed the residents at risk of having their care needs unmet.

Findings included...

R2

Review of the facility characteristic roster dated 03/19/2025, showed R2 was admitted on [REDACTED]/2025. There was no evidence a preadmission assessment was completed prior to R2 being admitted.

When asked about R2's preadmission assessment, an email response dated 03/26/2025 from Staff E, Resident Care Coordinator showed the original copy of R2's preadmission assessment was given to the State licensors and a copy of the document was not retained by the ALF.

There was no evidence a preadmission assessment for R2 was included in the documents provided by the ALF to the State licensors.

R5

Review of the facility characteristic roster dated 03/19/2025, showed R5 was admitted on [REDACTED]/2024. Review of the facility preadmission assessment titled Washington Resident Assessment dated 09/24/2024, failed to show the following sections were completed: Medical History, Known Behaviors, Other Safety Considerations, Personal Identity and Lifestyle, Decision Making Authority, Activities and Routines, Ability to perform ADL's (activities of daily living), Elopement Risk Assessment, Assessment for Medication Management and Fall Risk Assessment. The assessment was not signed by facility staff, R5 or R5's representative.

R9

Review of the facility characteristic roster dated 03/19/2025, showed R9 was admitted on [REDACTED]/2025. Review of the facility preadmission assessment titled AL Advantage Resident Assessment dated 02/23/2025 failed to show the Pharmacy section was completed. The assessment was not signed by facility staff, R9 or R9's representative.

Review of a document titled Mini-Mental State Examination (MMSE) dated 02/23/2025 showed ALF staff completed the MMSE on the same day as the preadmission assessment. The MMSE required the resident to be seen in-person by the examiner.

During a telephone interview on 04/03/2025 at 2:00 PM, Collateral Contact 4, Resident Representative stated they were not aware ALF staff visited R9 in the hospital prior to admission to the ALF.

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


Administrator (or Representative)

4.22.2025
Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreements (NSA, Service Plan) for 8 of 8 sampled Residents (Resident 1, 2, 3, 4, 5, 6, 7, and 9 [R1, 2, 3, 4, 5, 6, 7, and 9]) were signed by either the resident or the resident's representative. This failure placed the residents and their responsible party at risk for not being involved in their care decisions and the services being provided.

Findings Included...

Review of the Service Plan for R1 showed it was dated 01/10/2025. It was not signed by the resident or the resident's representative.

Review of the Service Plan for R2 showed it was dated 03/18/2025. It was not signed by the resident or the resident's representative.

Review of the Service Plan for R3 showed it was dated 02/09/2025. It was not signed by the resident or the resident's representative.

Review of the Service Plan for R4 showed it was dated 03/03/2025. It was not signed by the resident or the resident's representative.

This document was prepared by Residential Care Services for the Locator website.

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Review of the Service Plan for R5 showed it was dated 02/14/2025. It was not signed by the resident or the resident's representative.

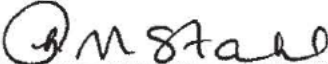
Review of the Service Plan for R6 showed it was dated 02/13/2025. It was not signed by the resident or the resident's representative.

Review of the Service Plan for R7 showed it was dated 02/14/2025. It was not signed by the resident or the resident's representative.

Review of the Service Plan for R9 showed it was dated 02/27/2025. It was not signed by the resident or the resident's representative.

During an interview on 03/26/2025 at 10:45 AM, Collateral Contact 1, Resident Representative, said they have never signed a service plan.

During an interview on 03/28/2025 at 12:15 PM, Staff L, Director of Operations stated all residents would have signed Negotiated Service Agreements by next week.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u></u> Administrator (or Representative)	<u>4.22.25</u> Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

This requirement was not met as evidenced by:

Based on observations and interview, the Assisted Living Facility (ALF) failed to ensure the environment in 3 of 3 living areas, Nannyberry, Elderberry and Strawberry (North Wing, East Wing, South Wing) was kept clean and in good repair. Failure to keep the environment clean and in good repair placed all 48 of 48 residents at risk to their health

This document was prepared by Residential Care Services for the Locator website.

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and safety and diminished quality of life.

Findings included...

North Wing

Observation on 03/20/2025 at 3:00 PM, showed the door jamb and door leading into the North Wing, was chipped, scuffed with black marks, gouged and showed peeling paint.

Observation of R4's room on 03/19 /2025 at 12:30 PM, showed a college themed blanket covering 1 of 2 exterior windows was being used as a blind. Collateral Contact 1, Resident Representative, said during an interview on the same day, at 1:00 PM, the blanket had been there for a very long time.

Bathrooms

Observation on 03/19/2025 at 1:00 PM showed a black transition strip between the bathroom and the dining room had a cloth like appearance. The strip was peeling up and shredded. The door jamb leading into the bathroom was chipped, gouged and showed peeling paint.

Observation on 03/19/2025 at 11:30 AM, showed the bathroom nearest resident bedroom #8 showed a chunk of brown matter approximately one by one inch on the shower curtain.

Observation on 03/28/2025 at 11:00 AM, showed the bathroom near resident bedroom #2 showed the caulking was missing between the floor and the shower. There was reddish brown matter smeared on the wall near the shower stall. The toilet plunger sitting near the toilet was not covered.

Kitchen

Observation on 03/20/2025 at 3:06 PM, showed a drawer approximate 30 by 15 inches, was missing from a bank of cupboards. A drawer near the bottom of bank of cupboards showed a piece of the drawer was missing. Residents were observed sitting at a counter that wrapped around part of the kitchen area. Baseboard trim was missing from the base of the counter.

TV room

Observation on 03/20/2025 at 3:06 PM showed a TV sitting on wood finished stand. Multiple areas of the stand were chipped and gouged. All the small windowpanes were missing from the cupboard doors.

Laundry room

Observation on 03/20/2025 at 3:02 PM, showed a section approximately 14 by 14 inches of linoleum flooring in front of the washing machine was missing exposing the

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sub floor. The wall behind the sink was chipped gouged and showed peeling paint. The wall adjacent to the washing machine was chipped and gouged.

Exterior

Observation on 03/19/2025 at 1:05 PM, showed there were two large black plastic bags full of debris sitting on the patio. The black plastic bags were observed in the same spot on 03/28/2025 at 12:00 PM.

East Wing:

Observation on 03/19/2025 at 12:00 PM, showed multiple areas of the door and door jamb leading into the East Wing, were chipped, gouged and showed peeling paint.

Observation on 03/19/2025 at 12:15 PM showed a strip of tape on the seam of the flooring across the width of the hallway by resident room #10 that was not attached to the floor.

Observation on 03/19/2025 at 12:30 PM showed the bathroom shower room nearest room #10 had a ripped rubber strip on the floor between the shower and the toilet area, there was dirty, standing water on the floor, and the shower chair had brown matter on the seat.

Observation on 03/19/2025 at 12:40 PM showed the bathroom by resident room #5 was clogged with toilet paper and brown matter.

South Wing:

Observation on 03/19/2025 at 2:39 PM, showed multiple areas of the door and door jamb leading into the South Wing, were chipped, gouged and showed peeling paint.

Observation on 03/19/2025 at 11:14 AM showed the hallway leading toward resident bedroom #7 was dimly lit. Some of the bulbs in the overhead light fixture were flickering.

Observation on 03/28/2025 at 11:00 AM, showed multiple areas of the walls surrounding the windows in the dining room were chipped and gouged.

Observation on 03/28/2025 at 11:00 AM showed the transition strips of the bathroom closest to resident bedroom #3 was missing.

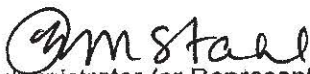
Staff I, Executive Director, said during an interview on 03/28/2025 at 1:00 PM, she was aware of the issues and their maintenance worker had recently quit.

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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, Gig Harbor Memory Care is or will be in compliance with this law and / or regulation on (Date) 5/17/25.

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


Administrator (or Representative)

Date 4/22/25

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to monitor the skin integrity for 1 of 1 sampled resident (Resident 4, [R4]). Failure to monitor R4's skin placed resident at risk of decline in their health status.

Findings included...

Review of a progress note dated 02/28/2025 showed R4 had returned from the hospital and was placed on alert charting for redness (rash) in the chest area, bruising on forearms, and "scabs" on their heels.

Review of the February 2025 and March 2025 MARs showed R4 had an order for clotrim/betamethasone (used to treat fungal infections) cream to be applied two times a day as needed for rash and skin eruption.

Review of the progress notes showed:

- 03/01/2025 "Nystatin" powder was applied to the chest.
- 03/02/2025 staff charted a "cream" was applied to the area.
- 03/05/2025 staff charted a "powder" was applied to the area.

The March 2025 MAR failed to show an order for "Nystatin" and staff documented they applied a topical treatment three times in the month of March.

Staff K, Registered Nurse Delegator, observed the rash on 03/27/2025 and said during

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an interview on 03/28/2025 at 1:00 PM, the skin infection appeared "raw" and "yeasty." Staff K educated staff on the care of skin infections.

Review of a progress note dated [REDACTED]/2025, showed R4 was sent out to a local hospital via ambulance because she was found unresponsive. R4 returned to the facility on [REDACTED]/2025. Review of a record titled "After Visit Summary" from the local hospital, dated [REDACTED]/2025, showed hospital staff documented on 02/25/2025 that R4 had wounds on both heels. Hospital staff took pictures of the wounds and placed the pictures in R4's personal health chart. Review of a home health agency document titled "Visit Note Report" dated 03/06/2025 showed R4 was receiving wound care for their heels at the facility.

During an interview on 04/04/2025 at 7:00 AM, Collateral Contact 2, Home Health Staff, said the wounds on R4's heels were too advanced to have occurred while they were in the hospital and that R4 entered the hospital with wounds on their heels.

Plan/Attestation Statement

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

P. Stahl

Administrator (or Representative)

4.22.25

Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

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Based on observations, interviews, and record reviews, the Assisted Living Facility (ALF) failed to develop medication services for 5 of 8 sampled residents (Resident 2, 3, 4, 5, and 9 (R2, 3, 4, 5, and 9)) that was safe and supported the needs of each resident as required. This failure placed the residents at risk for illness from not receiving medications as prescribed.

Findings included...

R2

Review of the February and March 2025 Medication Administration Records (MARs) showed a physician medication order for loperamide 2 milligrams (mg) one tablet three times a day for seven days for diarrhea. The MARs showed staff documented R2 received a total of 57 doses of the medication for 20 days from 02/28/2025 through 03/19/2025 when 21 total doses were ordered.

During an interview on 03/28/2025 at 11:30 AM, Staff E, Resident Care Coordinator stated that the ALF did not have 57 doses of Loperamide in the supply to give to R2 and stated that the staff probably charted the medication was given when it was not.

R3

Review of R3's January 2025, February 2025 and March 2025 MARs showed a medication order for levothyroxine 50 micrograms (mcg) for thyroid disease one tablet daily before breakfast at 6:00 AM.

Review of the January 2025 MAR showed the staff documented "OTH" (other) with the staff initials five times between 01/13/2025 and 01/31/2025.

Review of the February 2025 MAR showed the staff documented "OTH" with the staff initials seven times between 02/01/2025 and 02/28/2025.

Review of the March 2025 MAR showed the staff documented "OTH" with the staff initials seven times between 03/01/2025 and 03/19/2025.

During an interview on 03/28/2025 at 11:30 AM, Staff E stated that she was not sure if the staff gave levothyroxine 50 mcg to R3 the 19 times it was charted with the code "OTH" on the MARs.

R4

Review of a progress note dated [REDACTED]/2025 showed R4 was found unresponsive in their bed and was transported to a local hospital for evaluation. Review of a local hospital after visit summary, dated [REDACTED]/2025 to [REDACTED]/2025, showed R4 was diagnosed with [REDACTED] and [REDACTED]. R4 returned to the facility on [REDACTED]/2025.

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Review of the February 2025 and March 2025 MARs showed an order for cephalexin 500 mg tablet (antibiotic) two times a day every 12 hours for 10 doses. The MAR showed staff documented they administered a total of 21 doses of the antibiotic when 20 total doses were ordered.

Review of the MARs for January 2025, February 2025, and March 2025, showed an order for metoprolol 50 mg tablet (used to treat high blood pressure) two times per day with instructions to hold (not give) the medication if R4's pulse was less than 60.

Review of the January 2025 MAR between 01/17/2025 and 01/31/2025 failed to show R4's pulse was taken prior to the medication being administered.

Review of the February 2025 MAR, failed to show R4's pulse was taken prior to the medication being administered.

Review of the March MAR between 03/01/2025 and 03/18/2025 failed to show R4's pulse was taken prior to the medication being administered.

During an interview on 04/02/2025 at 3:30 PM, Staff E said staff started documenting the pulse on the MAR as of 03/19/2025.

R5

Review of the MARs for January 2025, February 2025, and March 2025, showed an order for Iantus (insulin) one time per day if R5's blood sugar was greater than 120.

Review of the January 2025 MAR showed between 01/13/2025 and 01/31/2025 staff documented they administered insulin 16 times and held the Insulin three times, but only checked R5's blood sugar three times when it should have been checked daily before the medication was given or held.

Review of the February 2025 MAR showed between 02/01/2025 and 02/28/2025 staff documented they administered insulin 23 times and held insulin three times, but only checked R5's blood sugar three times when it should have been checked daily before the medication was given or held.

On 02/08/2025, the MAR was marked "other" with no explanation.

Review of the March 2025 MAR showed between 03/01/2025 and 03/15/2025 staff documented they administered insulin 15 times but only checked R5's blood sugar three times when it should have been checked daily before the medication was given or

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held.

On 03/03/2025, staff recorded R5's blood sugar was 94 and they administered the insulin when it should have been held.

Staff E said during an interview on 03/20/2025 at 1:00 PM, the facility recently adopted a new electronic system for recording the administration of medications and the pharmacy was responsible for ensuring all orders were input into the system.

R9

Review of progress notes dated [REDACTED]/2025 showed R9 was admitted to the ALF on [REDACTED]/2025. Additionally, review of progress notes showed R9 went to the hospital on [REDACTED]/2025 and returned to the ALF on [REDACTED]/2025.

Review of February 2025 MAR, showed the following medications were not marked as given to R9 on [REDACTED]/2025 and 02/27/2025:

- Donepezil 10 mg, one half tablet every evening for dementia
- Melatonin 3 mg, two tablets every evening for sleep
- Olanzapine 20 mg, one tablet every evening for dementia
- Divalproex 125 mg, four capsules daily for dementia

Review of March 2025 MAR showed the previous medications listed were not marked as given to R9 on [REDACTED]/2025 and 03/21/2025, in addition to the following medications:

- Amlodipine 5 mg, one tablet daily for blood pressure
- MiraLAX powder 17 grams in water daily for constipation
- Sertraline 50 mg, one tablet daily for depression
- Vitamin B1, one tablet daily for vitamin deficiency

During an interview on 03/24/2025 at 11:30 AM, Staff E stated that R9 received medications from an outside pharmacy and the medications were either not available for the staff to give to the resident, or the staff did not document on the MARs that the medication was given to R9.

Observation of the medication cart on 03/24/2025 at 1:00 PM with Staff J, Medication Technician showed the following medications were not in the supply for R9:

- Donepezil 10 mg tablets
- Sertraline 50 mg tablet and Vitamin B-1 tablets. Both medications were marked as given on the MAR 03/22/2025; however, the medications were not in the supply.

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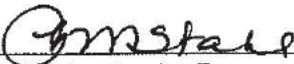
-Olanzapine 20 mg tablets and melatonin 3 mg tablets. Both medications were marked as given on the MAR 03/23/2025; however, the medications were not in the supply.

During an interview with Staff J on 03/24/2025 at 1:00 PM, the staff stated that the ALF did not have all of R9's medications in the supply for staff to give to the resident.

Plan/Attestation Statement

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


Administrator (or Representative)

4.22.2025
Date

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

- (i) Bathrooms and toilet rooms;
- (ii) Resident living rooms and resident sleeping rooms; and
- (iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that 2 of 3 sampled resident living areas, Elderberry and Strawberry (East Wing and South Wing) had systems for 33 of 33 residents to summon staff in an emergency. Failure to ensure Residents had a system to call for help placed them at risk to have their health and safety needs go unmet.

Findings included...

East Wing

Observation on 03/28/2025 at 11:02 AM showed facility staff failed to respond to an emergency pull cord in resident room #5. Department staff pulled the emergency cord and waited a few minutes. Facility staff did not respond. Department staff then pulled

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an emergency cord in resident room #10 at 11:05 AM and waited a few minutes. Facility staff did not respond.

Staff M, Medication Technician, was interviewed at 11:10 AM on 03/28/2025 and was asked about the system for residents to alert staff in case of an emergency. Staff M said there was a pager in the medication cart which was activated by the pull cord. Staff M located the pager, and the pager did not work.

South Wing

Observation on 03/28/2025 at 11:14 AM, showed facility staff failed to respond to an emergency pull cord in a bathroom located near resident room #7. Department staff pulled the emergency cord and waited a few minutes. Facility staff did not respond.

Staff D, Caregiver, was interviewed at 11:20 AM on 03/28/2025 and was asked about the system for residents to alert staff in case of an emergency. Staff D said she did not have the pager with her. Staff D located the pager, and the pager did not work.

During an interview on 03/25/2025 at 1:15 PM, Collateral Contact 3, Resident Representative, stated that ALF staff told them the emergency pull cords did not work.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u><i>Im stake</i></u> Administrator (or Representative)	<u>4.22.2025</u> Date

WAC 388-78A-3040 Laundry.

(3) The assisted living facility must use washing machines that have a continuous supply of hot water with a temperature of 140 F measured at the washing machine intake, that automatically dispenses a chemical sanitizer as specified by the manufacturer, or that employs alternate sanitization methods recommended by the manufacturer.

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF), failed to ensure

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clothing and bedding for 15 of 15 residents was washed as required in the Nannyberry Living Unit (North Wing). Failure to wash residents' clothing and bedding as required, placed residents at risk of wearing clothes that were not clean and sleeping on bedding that was not clean.

Findings included...

Observation on 03/20/2024 at 12:00 PM showed a significant amount of brown matter located around the base of the toilet, and on the wall in the bathroom located adjacent to the dining area. An unidentified staff entered the bathroom with a mop, and mop bucket and shut the door.

Observation of the laundry room on 03/20/2025 at 3:00 PM, showed a pink plastic tub on top of the washing machine. The tub contained a thick white substance. The chemical dispenser behind the washing machine was not connected to the machine. Multiple piles of clothing, bedding, and a basket full of mop heads were sitting on a table across from the washing machine.

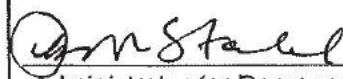
Staff F, Medication Technician, stated during an interview on 03/20/2025 at 3:00 PM, she thought the substance in the pink tub was the laundry detergent staff used to wash clothes.

Staff G, Caregiver, was interviewed on 03/24/2025 at 2:30 PM. Staff G said the mop heads were washed in the same washing machine as resident laundry.

Plan/Attestation Statement

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


Administrator (or Representative)

4.22.25
Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(a) Within a reasonable time consistent with the needs of the resident following any

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change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, record review and interview, the Assisted Living Facility (ALF), failed to ensure the Negotiated Service Agreements (NSA, Service Plans) for 6 of 11 sampled residents (Resident 1, 3, 4, 6, 7, and 9 [R1, 3, 4, 6, 7, and 9]) were updated to reflect the current needs of the residents when there was a significant change in the resident's health status and physical ability. Failure to update the Service Plans, placed residents at risk of having their care needs go unmet.

Findings included...

R1

Review of a document titled DSHS Current Annual Assessment dated 07/09/2024 showed a section "Seizures" that included R1 had a history of seizures, the frequency was "annually" and that R1 took medication for the seizures.

Review of an Incident Report dated 02/10/2025 showed R1 "had a seizure and rolled off (their) bed." R1 suffered a head injury and was sent to the hospital.

Review of R1's January, February and March 2025 Medication Administration Records (MARs) failed to show R1 took medication for seizures.

Review of progress notes dated 03/08/2025 and 03/11/2025 showed R1 had seizures on both dates.

Review of R1's Service Plan dated 01/10/2025 failed to show any information about R1's seizures, including how to identify a seizure, how to care for the resident when a seizure occurred to keep them safe, and who to notify if a seizure occurred.

R3

Review of R3's Service Plan dated 02/09/2025 showed under the section titled Meal Consumption, the resident's level of assistance was "minimal. Resident can feed self, chew and swallow foods."

Observation on 03/20/2025 at 12:10 PM showed R3 sitting and eating lunch in the Elderberry (East Wing) of the ALF. The meal consisted of uncut beef steak which measured approximately three inches by three inches, potatoes, and green beans. During an interview with R3 at 12:13 PM, when asked if she needed the steak cut into

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smaller pieces, R3 stated "yes."

During an interview on 03/25/2025 at 1:15 PM, Collateral Contact 3, Resident Representative, stated that R3 was supposed to have their food cut up into bite-sized pieces and that "it was supposed to be on the care plan."

R4

Review of the Service Plan dated 03/03/2025 showed under the section titled Mobility and Ambulation, R4 used a walker for ambulation. Staff H said during an interview on 03/24/2025 at 11:15 AM, R4's level of care has increased, and they required staff assistance for mobility including the use of a wheelchair.

Collateral Contact 1, Resident Representative, said during an interview on 03/26/2025 at 10:45, R4 had been observed sitting in a wheelchair that does not belong to them, and they used to use a walker. Review of the Service Plan failed to show R 3 used a wheelchair for mobility with the assistance of staff.

Review of hospital discharge summary dated [REDACTED]/2025, showed R4 had wounds on both of her ankles. Review of home health (outside agency) documents, dated 03/07/2025, 03/12/2025, 03/17/2025 and 03/24/2025 showed R4 was receiving wound care. Review of the Service Plan failed to show R4 was receiving home health services and had any issues with skin integrity.

R6

Review of a progress note dated 02/23/2025 showed R6 was seen by a hospice (end of life care) nurse and received wound care. Review of the Service Plan dated 02/13/2025, failed to show under the section titled "wound/skin tear," R6 had a wound on her heel.

R7

Observation on 03/28/2025 at 12:30, showed Staff J, Medication Technician, feeding R7 a mixture of finely ground/ chopped macaroni and cheese with a spoon.

Department staff asked to review the diet order for R7. Staff I, Executive Director, provided the licensors with a physician order dated 10/17/2024. The order showed R7 was prescribed a pureed diet.

Review of R7's Service Plan failed to show R7 was prescribed a pureed diet.

R9

Review of R9's Service Plan dated 02/27/2025 showed under the section titled Meal Consumption, the resident's level of assistance was "moderate. Resident requires cutting up food."

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Review of progress notes showed R9 was discharged from the hospital on [REDACTED]/2025.

During an interview on 03/27/2025 at 1:00 pm, Staff J, Medication Technician stated that R3 needed to be fed since they returned from the hospital, and that the resident could not chew food but liked applesauce.

R9's service plan was not updated after they returned from the hospital with a change in condition.

Staff E, Resident Care Coordinator, said during an interview on 03/24/2025 at 1:00 PM, she was responsible for updating the care plans.

Plan/Attestation Statement

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

J M Stahle

Administrator (or Representative)

4.22.25

Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to ensure the bathrooms in 3 of 3 resident living areas, Nannyberry, Elderberry, and Strawberry (North Wing, East Wing and South Wing) were supplied with soap, paper towels, toilet paper, and that personal protection equipment (PPE) was available for staff use in the event of an outbreak of an infectious disease. Failure to provide methods to prevent the spread of infection placed all 48 of 48 residents at risk of decline in their health status.

Findings included...

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North Wing Bathrooms:

Observation on 03/19/2025 at 12:30 PM, of the bathroom closest to the dining room, showed there was no soap or toilet paper available for use.

Observation on 03/21/2025 at 11:30 AM showed of the bathroom closest to the dining room, showed there was no soap available for use.

Observation on 03/24/2025 at 11:30 AM of the bathroom closest to resident bedroom #2, showed there was no toilet paper, soap or paper towels available for use. Observation of the two bathrooms closest to resident bedroom #10, showed no soap, paper towels, or toilet paper available for use.

East Wing Bathrooms:

Observation on 03/19/2025 at 12:15 PM, of the bathroom closest to the dining room, showed there was no soap or toilet paper available for use.

Observation on 03/24/2025 at 1:40 PM showed there was no soap available for use and no waste can.

Observation on 03/19/2025 at 12:30 PM, of the bathroom with the shower by resident bedroom #10 showed there was no soap at the sink, no paper towels, and no waste can. Observation on 03/24/2025 at 1:50 PM showed no soap at the sink, no paper towels, and no waste can.

Observation on 03/19/2025 at 12:40 PM, of the bathroom closest to resident bedroom #5, showed there was no soap, paper towels or toilet paper available for use. Observation on 03/24/2025 at 1:30 PM showed, there was no soap available for use.

South Wing Bathrooms:

Observation on 03/19/2025 at 11:00 AM of the 2 bathrooms closest to resident bedroom # 7, showed there was no toilet paper, paper towels or soap available for use.

Observation on 03/19/2025 at 12:10 PM of the bathroom closest to resident bedroom #1 showed there was no soap or paper towels available for use.

Observation 03/24/2025 at 2:00 PM, of the bathroom closest to resident bedroom #1 showed there was no soap and no toilet paper available for use. The bathroom closest to resident bedroom #8 showed no toilet paper. The bathroom closest to resident bedroom #7 showed no soap and no toilet paper.

Observation on 03/27/2025 at 11:14 AM of the bathroom closest to resident bedroom

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#7, showed there was no toilet paper, soap or paper towels available for use.

During an interview on 03/10/2025 at 12:55 PM, Staff C, Caregiver stated it was the job of the Housekeeper to replace the soap, toilet paper, and paper towels in the resident bathrooms. and the Housekeeper worked three days per week.

Personnel Protection Equipment (PPE):

Observation on 03/24/2025 at 2:00 PM of the Personal Protection Equipment (PPE) supply located in the "chapel" showed a minimal supply of gowns, respirators, gloves, face shields, and goggles.

During an interview at the same time, Staff E, Resident Care Coordinator said they went through most of their supplies during the most recent outbreak of a communicable disease.

Plan/Attestation Statement

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

Pm. Stah
Administrator (or Representative)

4.22.25
Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Greenlake Management Gig Harbor, LLC
Gig Harbor Memory Care
3025 14TH AVE NW
GIG HARBOR, WA 98335

RE: Gig Harbor Memory Care # 2627

Dear Administrator:

This document references the following complaint numbers 172294.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 04/07/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Return the Plan/Attestation Statement and report with signatures to:

Manfay Chan, Allied Health Field Manager
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

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Region 3, Unit D

Preferred methods:

eFax: (253) 589-7240

Email: rcsregion3email@dshs.wa.gov

Optional method:

PO Box 99250

Lakewood, WA 98496

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

Intermittent Nursing Services/Nurse Delegation of medications was not established for one resident who required medication assistance and/or medication administration from non-licensed facility staff. Qualified facility staff were delegated by a registered nurse to assist the resident with medications as required. This was corrected to the Department's satisfaction prior to exiting.

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

The Assisted Living Facility (ALF) did not have a licensed nurse in the building 5 days per week totaling 40 hours per week as stated in the ALF Disclosure of Services. The ALF hired a nurse. This was corrected to the Department's satisfaction prior to exiting.

You Are Not:

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

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- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
 - o Send your request to:

Email: RCSIDR@dshs.wa.gov; or

Fax: (360) 725-3225

If You Have Any Questions:

- Please contact me at (253)442-3013.

Sincerely,



Cory Cisneros for
Manfay Chan, Allied Health Field Manager
Region 3, Unit D
Residential Care Services

Enclosure