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 License # 2627

Dear Administrator:

This letter addresses Compliance Determination(s) 38440 (Completion Date 03/18/2024) and 34697 (Completion Date 01/29/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/18/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2640-1-a

The Department staff who did the on-site verification:
Michael Goulet, Complaint Investigator

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

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Gig Harbor Memory Care **Provider Type:** Assisted Living Facility
License/Cert.#: 2627
Compliance Determination #: 34697 **Intake ID:** 110686
Investigator: Michael Goulet **Region/Unit #:** RCS Region 3 / Unit D
Investigation Date(s): 01/03/2024 through 01/29/2024
Complainant Contact Date(s): 01/02/2024, 01/29/2024

Allegation(s):
1) Odor of urine, feces and filth
2) Large puddle in dining area
3) Bruise to resident's left eye
4) No soap or trash can liners
5) No notification of resident falls/ injuries to resident's physician

Investigation Methods:

Sample:	Total residents: Resident sample size: 12 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Staff Collateral Contacts (4)
Record Reviews:	Facility Incident Report Facility Progress Notes Resident Care Plan Photographs of resident

Investigation Summary:
1,2,4) Per observation of facility residents, there was no indication during visit of unattended incontinence issues or unattended refuse. Trash can liners were observed to be in use and soap was observed to be in place in facility bathrooms. Per complainant, the puddle mentioned was a spilled drink in the dining area, likely soda or juice. No spilled food or drink was noted during facility visit. Unable to substantiate any lack of care in association with the above listed allegations.
3,4) During interview with the named resident, slight bruising was noted around the resident's left eye area. Per facility incident report this bruising was related to an injury which occurred on 12-5-23, and this was considered to be related to a fall. The

exact nature of the injury was not determined, but there was no indication that this was related to any resident to resident altercation due to the lack of any prior altercation history for the named resident or peers on the resident's unit. Per record review of the facility incident report related to this injury, there was no indication that the named resident's primary care physician's (PCP) office was notified of the injury. Per record review of photographs of the named resident provided by the complainant, the resident was noted to have the same healing bruise around their left eye on 12-24-23, but no other injury to the resident's face was apparent in this photo. Per record review of photographs taken of the named resident the following day (12-25-23), there was redness noted to the named resident's forehead which appeared to be related to either bruising or abrasion. Per interviews with several facility staff, no injury was noted to have occurred to the named resident at this time, and no incident report or notification to the resident's PCP was made. Per interview, the complainant stated they were notified of the injury by unnamed facility staff, and phone records provided by the complainant do show that the complainant did receive a call from the facility on 12-24-23 at 5:39pm, supporting the complainant's claim that facility staff did contact them regarding the injury to the resident occurring on 12-24-23. The complainant stated they had contacted the resident's Home and Community Services (HCS) case manager regarding this injury, and per interview, the HCS case manager stated they had filed a department report regarding the injury. Record review of reports made to the department did support that a report was made, but this report was not forwarded to investigative field staff. The above listed information served to support that the facility did not contact the resident's PCP as required in regard to either injury (12-5-23 and 12-24-23).
Cited as per WAC 388-78A-2640 (1a), Reporting significant change in a resident's condition.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

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 01/03/2024 and 01/03/2024 of:

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

This document references the following complaint number(s): 110686, 115738

The following sample was selected for review during the unannounced on-site visit: 12 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

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

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

02/01/2024
Date

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

P Stahl
Administrator (or Representative)

2.12.24
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interviews and records review, the Assisted Living Facility (ALF) failed to notify the primary care physician (PCP) for 1 of 2 residents (Resident 1) regarding two separate instances where injury was noted to the resident's head by facility staff. This failure placed the resident at risk of not receiving appropriate medical care.

Findings included...

Record review on 01/02/2024 at 11:25am of the facility incident report related to Resident 1's (R1) fall on 12/05/2023 did not note any notification to R1's Primary Care Physician (PCP).

Record review on 01/02/2024 at 11:25am of facility progress notes showed that bruising was noted to R1's face on 12/05/2023, but no notification to family or the resident's PCP was noted.

Record review on 01/29/2024 at 7:00am of photographs of R1 taken on 12/24/2023 and 12/25/2023 (photographs were noted to be date and location stamped) showed significant change to the resident regarding redness noted to R1's forehead area, likely due to bruising and/or abrasion, which had occurred sometime between the photographs taken on 12/24/2023 at 11:30am and those taken on 12/25/2023 at 8:55am.

Record review on 01/29/2024 at 7:00am of the phone records for R1's daughter did show that a call was placed from the facility to R1's daughter on 12-24-23 at 5:39pm. This document supported the resident's daughter's statement that staff (unnamed) from the facility had called to inform R1's daughter of a fall on 12/24/2023.

During an interview on 01/03/2024 at 9:15am, facility Health and Wellness Director (Staff A) stated there had been no known fall or injury for R1 other than the fall on 12/05/2023.

During an interview on 01/16/2024 at 3:00pm, the office manager at R1's physician's office stated that there had been no notification of any fall for R1 in December 2023.

During an interview on 01/17/2024 at 3:10pm, R1's co-primary care physician (PCP) stated that there had been no notification made by the facility regarding any fall for R1 during December 2023, and the PCP stated they had only known of the fall occurring on 12/05/2023 because the resident's daughter had informed them of this.

During an interview on 01/26/2024 at 10:10am, facility Resident Care Coordinator (Staff B) stated that there had been no known fall or injury for R1 other than the fall on 12/05/2023.

During an interview on 01/29/2024 at 8:20am, R1's Home and Community Services (HCS) Case Manager (CM) stated that they had contacted the facility about R1's apparent injury from 12/24/2023, and that "no one there seemed to know anything about it." R1's CM also stated, "no one was notified and there was no incident report."

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) 02.28.24 .

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

Jarlette Stark — Administrator (or Representative)

2.12.24 — Date