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

04/07/2025

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) 57577 (Completion Date 04/07/2025) and 53837 (Completion Date 02/12/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/07/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

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, Allied Health 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
Intake ID: 163851
Compliance Determination #: 53837
Region/Unit #: RCS Region 3 / Unit D
Investigator: Michael Goulet
Investigation Date(s): 01/28/2025 through 02/12/2025
Complainant Contact Date(s):

Allegation(s):
1) Resident-to-resident altercation, male resident pushed another male resident, no injury

Investigation Methods:

Sample:	Total residents: Resident sample size: 10 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms Staff to resident interactions Resident to resident interactions
Interviews:	Residents Staff
Record Reviews:	Resident Service Agreement Prior facility incident reports (from 8/22/24)

Investigation Summary:
1) Per interview with facility staff at the initiation of the investigation, the named resident perpetrator was noted to have pushed the same male resident (AV) again on 1/26/25, again with no injury resulting. Per record review of an additional facility report, the same resident perpetrator was also involved in another altercation of the same type on 2/5/25, pushing down a different male resident without reason, and causing skin tears and abrasions to the resident. Per record review of prior facility reports involving the same male perpetrator, it was noted that this resident had been the instigator in multiple prior resident-to-resident altercations, in which the resident perpetrator was noted to have pushed other residents to the ground without cause or reason. In this record review it was noted that the resident perpetrator had caused injury to four other residents, ranging from bruising and skin tears to head injury and hip fracture. (Of the six facility reports reviewed, four were noted to be 'quality review' reports, meaning that these reports were not disseminated to field investigative staff when they initially occurred.) Per record

review of these multiple facility reports, no intervention was noted to be instated to address the resident perpetrator's behavior, with facility staff noting 'no care plan changes at this time' in the report filed on 2/5/25. Per record review of the named resident perpetrator's negotiated service agreement (care plan), the resident was noted to have ‘extensive behavioral issues’, and it was noted that the resident ‘requires a professionally authorized behavior management program, and/or professional consultation and intervention’. Additionally, per staff interviews the named resident has continually refused to take medication, including the psychiatric medication (Olanzapine, antipsychotic medication) which had been prescribed for the resident's behavior prior to their admission to the facility. Per staff, the resident's primary care physician (PCP) was informed by the facility that the resident had continually refused this medication, and the only intervention instated by the PCP was to change the medication's indication from 'scheduled' to 'PRN' ('as needed'). Per staff, the resident also continued to refuse this medication after this change was made. There was no indication per staff interviews and per record review of the resident's care plan that any other intervention had been attempted, or that any mental health professional had been involved to address the resident's ongoing behaviors which continue to present a risk to the safety of other residents in the facility.
Cited as per WAC 388-78A-2600 (2J i-iii) Policies and Procedures

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Conclusion / Action:

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

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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 an unannounced on-site complaint investigation on 01/28/2025 of:

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

This document references the following complaint number(s): 163430, 163851

The following sample was selected for review during the unannounced on-site visit: 10 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 — Date: 02/18/2025

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 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

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(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

This requirement was not met as evidenced by:

Based on interviews and records review, the Assisted Living Facility (ALF) failed to ensure the safety of 6 of 10 residents sampled (Residents 2, 3, 4, 5, 6 and 7 [R2, 3, 4, 5, 6, and 7]) by failing to appropriately address the aggressive behavior of one resident (Resident 1 [R1]). This failure placed all facility residents at risk of physical harm, and allowed residents to be assaulted (Residents 2, 3, 4, 5, 6 and 7) and/or injured (Residents 3, 5, 6 and 7) as a direct result of the behavior of Resident 1.

Findings Included...

During an interview on 01/28/2025 at 11:00am, Staff B, facility Med Tech stated that R1 had not been compliant with taking the behavioral medication (Olanzapine, antipsychotic medication) which had been prescribed for R1 prior to their admission to the facility ([redacted]/2024). Staff B stated that R1's primary care physician had been informed of R1's refusal to take their behavioral medication, and that the only change the physician had made was to alter the indication for this medication from 'scheduled'

(given daily at specific time) to 'PRN' (given only 'as needed'). When asked if this change to the medication indication was effective, Staff B stated, "Sometimes he (R1) will take his meds, mostly he will not."

During an interview on 02/05/2025 at 10:10am, Staff A, facility Resident Care Coordinator stated that R1 "was supposed to be on behavioral medication, but he refused to take it. He (R1) had Zyprexa (aka Olanzapine) scheduled, took it for two days and then refused, so his doctor changed it (medication) to PRN.

Record review on 01/27/2025 at 9:00am of a facility incident report made to the department showed that R1 had assaulted R2 by pushing R2 to the ground without provocation on both 01/21/2025 and 01/27/2025. This incident report noted that facility staff had made no changes to R1's negotiated service agreement (care plan) other than that R1 was 'placed on alert'.

Record review on 02/07/2025 at 7:00am of a facility incident report made to the department showed that R1 had assaulted R7 by pushing R7 to the ground without provocation on 02/05/2025. This incident report noted that staff had stated 'no care plan (negotiated service agreement) changes at this time'.

Record review on 02/07/2025 at 8:00am of prior facility incident reports related to R1 showed that R1 had assaulted R3 on 08/22/2024, leading to an injury (unspecified 'head injury') being noted for R3.

Record review on 02/07/2025 at 8:00am of prior facility incident reports related to R1 showed that R1 had assaulted R4 on 08/23/2024 with no injury being noted.

Record review on 02/07/2025 at 8:00am of prior facility incident reports related to R1 showed that R1 had assaulted R5 on 10/21/2024, leading to an injury (bruising) being noted for R5.

Record review on 02/07/2025 at 8:00am of prior facility incident reports related to R1 showed that R1 had assaulted R6 on 11/26/2024, leading to an injury (hip fracture) being noted for R6.

Record review on 02/12/2025 at 12:20pm of the negotiated service plan (care plan) for R1, showed that R1 was noted to have 'extensive behavioral issues' and that R1 'requires supervision, a professionally authorized behavior management plan, and/or professional consultation and intervention'. There was no indication from the record review of R1's negotiated service agreement that any such behavioral intervention had been attempted to be instated at any time since the resident's admission to the facility ([redacted]/2024).

Statement of Deficiencies	License #: 2627	Compliance Determination # 53837
Plan of Correction	Gig Harbor Memory Care	Completion Date
Page 4 of 4	Licensee: Greenlake Management Gig Harbor, LLC	02/12/2025

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) 03.15.2025

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

Paulette Stahl
District Administrator
Western Portfolio
Administrator (or Representative)

02/21/25
Date

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)_____ .

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

_____ _____

Administrator (or Representative) Date