STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 77004 (Completion Date 05/06/2026) and 71930 (Completion Date 03/19/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/06/2026 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-2120-2-a, WAC 388-78A-2640-1-b

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,

*Laurie Anderson*

Laurie Anderson, Community 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:** 207210
**Compliance Determination #:** 71930
**Region/Unit #:** RCS Region 3 / Unit D
**Investigator:** Michael Goulet
**Investigation Date(s):** 01/14/2026 through 03/19/2026
**Complainant Contact Date(s):** 01/07/2026, 03/23/2026

**Allegation(s):**

1) Resident hospitalized related to sepsis (infection), crystalized urine and new decubitus ulcer (wound)
2) Resident not safe to return to facility due to inadequate staffing, no notification of resident being sent to hospital and multiple falls
3) Resident refused return at prior facility (adult family home) due to need for 1:1 sitter

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents:<br>Resident sample size: 19<br>Closed records sample size: 1 |
| **Observations:** | General environment<br>Residents in facility<br>Staff to resident interactions |
| **Interviews:** | Residents<br>Staff |
| **Record Reviews:** | Facility Progress Notes<br>Resident Care Plan<br>Facility Incident Report<br>Staffing Schedules (2)<br>Hospital Medical Records |

**Investigation Summary:**

1) Per facility staff interviews and facility records review, the named resident ambulated independently and had no decubitus ulcer (wound) or other skin breakdown. Per review of hospital medical records, the named resident had some redness around their coccyx (lower back area) on hospital admission. No skin breakdown or decubitus ulcer was noted in the hospital record. Review of hospital medical records showed that the named resident's urinary catheter was completely occluded (blocked) at time of hospital admission. Named resident had a significant urinary tract infection which led to sepsis, and acute renal (kidney) injury, likely in direct relation to their occluded urinary catheter tubing. Per review of facility

records, there was no documentation that staff noticed this issue. Citation issued under WAC 388-78A-2120 (2a) Monitoring resident's well-being.
2) Per observation of multiple facility residents and staff in the facility, there was no apparent lack of staffing or lack of care noted for residents observed over several recent visits to the facility. Per facility staff interviews, review of facility records (care plan, progress notes), and review of hospital medical records, there was no indication of falls or fall related injuries for the named resident. Per facility staff interview, Power of Attorney (POA) interview, and review of facility incident report, the named resident's POA was not informed of the resident's hospitalization by facility staff. Citation issued under WAC 388-78A-2640 (1b) Reporting significant change in a resident's condition.
3) Per facility staff interviews, the named resident exhibited no behavioral issues and did not require one to one staff monitoring while at this facility.
Failed facility practice cited as noted above.

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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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| Statement of Deficiencies | License #: 2627 | Compliance Determination #71930 |
|---|---|---|
| Plan of Correction | Gig Harbor Memory Care | Completion Date |
| Page 1 of 4 | Licensee: Greenlake Management Gig Harbor, LLC | 03/19/2026 |

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 01/14/2026 and 03/19/2026 of:

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

This document references the following complaint number(s): 207210

The following sample was selected for review during the unannounced on-site visit: 19 of 0 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

From:
DSHS, Home and Community Living 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.

Laurie Anderson
Residential Care Services

03/23/2026
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 Kunde
Administrator (or Representative)

3-30-26
Date

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

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

**This requirement was not met as evidenced by:**

Based on interview and record review, the assisted living facility failed to monitor the urinary catheter for 1 of 1 residents (Resident 1; R1). This failure resulted in significant physical harm to R1.

Findings included...

Review of facility records showed the facility admitted R1 on [redacted]/2025.

Review of facility progress notes, dated 11/16/2025 through 01/02/2026, showed no documentation that facility staff monitored or provided care of R1's catheter. There was no documentation that showed staff were aware of any issue until R1 became unresponsive on [redacted]/2025.

Review of hospital medical records, dated [redacted]2025 through 01/02/2026, showed that R1 arrived at the hospital with urinary catheter completely occluded (blocked) by crystalized urine. The records showed that R1 was diagnosed with [redacted] and [redacted] considered secondary to (caused by) [redacted] and [redacted].

During an interview on 01/07/2026 at 9:27 AM, Collateral Contact 1 (CC1), hospital case manager, stated that the hospital admitted R1 on [redacted]2025 from the assisted living facility. CC1 stated that upon admission, R1's urinary catheter was occluded with crystalized urine.

**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) 4/27/2026.

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

Virginia Kunde
Administrator (or Representative)

3/30/26
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:

(b) The resident is relocated to a hospital or other health care facility; or

**This requirement was not met as evidenced by:**

Based on interview and record review, the assisted living facility failed to notify 1 of 1 resident's (Resident 1; R1) power of attorney (POA) when the resident was sent out to hospital in relation to a significant change in condition. This failure placed R1 at risk of not receiving immediate critical care during a medical crisis.

Findings included...

Review of facility Incident Report, dated [redacted]/2025, showed that notification to Power of Attorney (POA)/Guardian/Physician was not completed by Staff B after R1 was sent out to hospital on [redacted]/2025.

During an interview on 03/08/2026 at 10:05 AM, Collateral Contact 2, R1's POA, stated that they were not notified by facility staff of R1's hospitalization on [redacted]/2025. CC2 stated that they were only notified the following morning by hospital staff.

During an interview on 01/14/2026 at 10:25 AM, Staff A, Executive Director, stated that Staff B, med tech, was on duty when R1 was sent out to hospital on [redacted]/2025. Staff A stated that Staff B had not contacted R1's representative when R1 was hospitalized.

**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) 4/27/2026 .

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

Virginia Kinder
Administrator (or Representative)

3-30-2026
Date