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

KGC SHORELINE OPERATOR INC
Brookdale Harbor Bay
9324 NORTH HARBORVIEW DR
GIG HARBOR, WA 98332

RE: Brookdale Harbor Bay License # 1912

Dear Administrator:

This letter addresses Compliance Determination(s) 55379 (Completion Date 02/26/2025) and 43405 (Completion Date 10/17/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/26/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-1, WAC 388-78A-2210, WAC 388-78A-2210-1-a

The Department staff who did the off-site verification:
Nikolas Jennings, Community Nurse 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: Brookdale Harbor Bay
Provider Type: Assisted Living Facility
License/Cert.#: 1912
Compliance Determination #: 43405
Intake ID: 127095
Investigator: Regenia Coleman
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 06/28/2024 through 10/17/2024
Complainant Contact Date(s):

Allegation(s):
Neglect- Facility failed to administer named resident's prescribed seizure medication.

Investigation Methods:

Sample:
Total residents: 23
Resident sample size: 3
Closed records sample size: 2

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Residents
Family members
Health and Wellness Director

Record Reviews:
Medical records
Hospital records
Grievance log
State reporting log
Incident investigation
Facility policies
Personnel files
Staff training records

Investigation Summary:
Neglect- Named resident had a diagnosed [redacted] and was prescribed medication to treat/prevent seizures. Named resident had seizure which required transfer and subsequent admission to local hospital where the medication error was discovered. Facility conducted an investigation and concluded named resident's seizure medication was discontinued in error despite orders from the hospital to continue the medication. As a result, named resident missed multiple doses of their

seizure medication. Failed facility practice identified. WAC 388-78a-02210 Medication Services.

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 #: 1912	Compliance Determination #:43405
Plan of Correction	Brookdale Harbor Bay	Completion Date
Page 1 of 9	Licensee: KGC SHORELINE OPERATOR INC	10/17/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 08/28/2024 and 10/17/2024 of:

Brookdale Harbor Bay
9324 NORTH HARBORVIEW DR
GIG HARBOR, WA 98332

This document references the following complaint number(s): 127095

The following sample was selected for review during the unannounced on-site visit: 3 of 23 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Regena Coleman, ALF NCI CI

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 — 10/29/2024 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.

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Residential Care Services

Date

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Administrator (or Representative) 10/30/24 Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules, and

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(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 facility failed to ensure residents were administered their medications as ordered for 2 of 3 sampled residents (Resident 1 and Resident 2). This failure resulted in Resident 1 (R1) and Resident 2's (R2) decline in medical conditions and a diminished quality of life.

Findings included...

Review of the facility's Medication Reconciliation Policy, revised November 2018, "medication reconciliation (the process of creating the most current, complete, and accurate medication list possible) should be performed and documented every time a resident is received and transferred to another level of care." The policy described the process of medication reconciliation and documented facility staff were to review medications prescribed for a resident " during transition from levels of care, such as Assisted Living community to Hospital to Assisted Living community." The policy further clarified the receiving community "will review the resident's medications ordered and/or taken prior to admission to the hospital, during the hospital admission, and continued orders obtained during transfer back to the community..."

Record review of the facility's Medication Administration Record Audit policy, revised in November 2020, documented, "change of shift audits should be completed for each

Administrator (or Representative) Date

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Record review of the facility's Medication Administration Record Audit policy, revised in November 2020, documented, "change of shift audits should be completed for each

shift or during the change of each shift. The MAR audit is defined as verifying that all medications are administered and signed-off during the current shift as per physician/healthcare provider order."

Record review of the Facility's Medications & Treatments Administration Assistance policy, revised in December 2019, documented, "medication administration/assistance and or treatment shall be provided in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider."

Record review of the Facility's Medications & Treatments Medication Availability policy, revised December 2017, documented, "it is Brookdale's policy that all currently ordered medications will be available to the resident."

Review of the facility's medication error policy, revised in July 2023, documented one type of medication error was failure to administer a medication. If a medication error occurred, "the nurse/designee was responsible for reporting the error to the prescribing healthcare provider (HCP), the resident, the legally responsible party, and to the state, if applicable. The details of the medication error should then be documented in the Resident Log or Progress notes in PointClickCare (PCC, the facility's electronic charting system)."

According to an article published in the Merk Manual Professional Version, titled Drug-Related Problems in Older Adults, reviewed/revised in July 2021, "hospitalization rates due to adverse drug effects [effects that are unwanted, uncomfortable, or dangerous] are 4 times higher in older patients [more than 65 years of age] than in younger patients. Adverse drug effects are thought to be preventable in at least 25% of cases in older adults. One such preventable cause of adverse drug effects is poor communication, when drugs are inappropriately dosed, duplicated, continued, or stopped when care is transitioned between providers and/or facilities."

<Resident 1>
R1 was admitted to the facility on [redacted]/2023 with multiple diagnoses including [redacted].

Record review of R1's Personal Service Plan dated 03/22/2024, documented R1 had a seizure disorder, and R1 had no reluctance to accept/was cooperative with all care.
Record review of R1's March 2024 Medication Administration Record (MAR) documented an order for levetiracetam (a medication used to treat seizures). R1's MAR documented the following:
Levetiracetam 500 mg (milligrams)
Directions: take 1 tablet by mouth 2 times daily
Indications for use: anticonvulsant (insert definition)
Start date: 09/28/2023
Stop date: 03/06/2024 at 9:09AM

[redacted]/2024 PM dose: resident did not receive medication due to hospitalization.
/2024 AM dose: resident did not receive medication due to hospitalization.
/2024 PM dose: resident did not receive medication due to hospitalization.
/2024 AM dose: resident did not receive medication due to hospitalization.
/2024 PM dose: resident did not receive medication due to hospitalization.
[redacted]/2024 AM dose: resident did not receive medication due to hospitalization.
/2024 PM dose: resident did not receive medication due to hospitalization.
/2024 AM dose: resident did not receive medication due to hospitalization.
/2024 PM dose: resident did not receive medication due to hospitalization.
/2024 at 9:09 AM: medication discontinued.
/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/07/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/07/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/08/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/08/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/09/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/09/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/10/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/10/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/11/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/11/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/12/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
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03/13/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
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03/15/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/15/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/16/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/16/2024 PM dose: R1 did not receive medication due to medication discontinued in error.

03/17/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/17/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/18/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/18/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/19/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/19/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/20/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/20/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/21/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/21/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/22/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/22/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/23/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/23/2024PM dose: R1 did not receive medication due to medication discontinued in error.
03/24/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/24/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/25/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/25/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/26/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/26/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/27/ 2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/27/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/28/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/28/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/29/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/29/2024 PM dose: R1 did not receive medication due to medication discontinued in error.

03/30/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/30/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
03/31/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
03/31/2024 PM dose: R1 did not receive medication due to medication discontinued in error.

R1's March 2024 MAR documented a total of 41 missed doses of levetiracetam due to levetiracetam being discontinued in error on 03/06/2024 at 9:09 AM.

Record review of R1's April 2024 MAR did not document an order for levetiracetam due to the medication being discontinued in error on 03/06/2024.
04/01/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
04/01/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
04/02/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
04/02/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
04/03/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
04/03/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
04/04/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
04/04/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
04/05/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
04/05/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
04/06/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
04/06/2024 PM dose: R1 did not receive medication due to medication discontinued in error.
[redacted]/2024 AM dose: R1 did not receive medication due to medication discontinued in error.
[redacted]/2024 PM dose: R1 did not receive medication due to being hospitalized.
R1 did not return to facility after being hospitalized. R1's April MAR documented a total of 13 missed doses of levetiracetam due to levetiracetam being discontinued in error on March 6, 2024 at 9:09 AM.

Record review of R1's nursing note by Staff C, Registered Nurse (RN) and Health and Wellness Director (HWD), dated 03/072024 at 11:40 AM documented Staff C was aware of changes to R1's medication upon return from the hospital.

Record review of an entry made by CC1, RN, Care Manager St Anthony hospital, documented the following notes:
03/04/2024 at 12:30 PM: Staff C was given a discharge plan update and completed an onsite assessment of R1. Staff C said the facility would accept R1 back to the community when R1 was medically ready.
03/06/2024 at 9:15 AM: telephone call was made to Staff C to coordinate R1's return to the facility.
03/06/2024 at 9:15 AM: Staff C was given RN to RN report (call made to the receiving facility by hospital staff where events of the patient's hospital care/treatment are discussed, and the receiving facility is provided an update of the patient's current medical status).

Record review of R1's discharge instructions dated [redacted]/2024, which summarized the care and treatment R1 received during their hospital stay, documented the following order:
R1 to continue taking levetiracetam, 500 mg twice a day at 8:00 AM and 8:00 PM.
R1 last dose of levetiracetam was given on [redacted]/2024 at 8:29 AM.

Record review of the facility's investigation of R1's missed levetiracetam dated 04/09/2024 documented:
Person(s) Conducting Investigation: Staff B.
Type of Alleged Incident: Seizure Medication Discontinued
Summary of Allegations: [CC2, daughter of R1] inquiring if her mother had been receiving their seizure medication (levetiracetam). Upon investigation in PCC the medication [levetiracetam] was discontinued on 03/06/2024 by previous HWD whom no longer works for the facility.
Summary of Findings: Staff B was not able to find an order for the levetiracetam to be discontinued.
Immediate Actions Taken: Resident had a seizure on Sunday [redacted]/2024 and she fell. 911 called and resident taken to the hospital where she was admitted. Staff B spoke to the doctor at the hospital on 04/08/2024 and notified them R1 had not been getting levetiracetam since 03/06/2024.

In an interview with CC2 on 10/04/2024 at 3:54 PM, CC2 said R1 had been taking levetiracetam "for years" to control their seizures. CC2 said since R1's last two seizures [[redacted]/2024 and [redacted]/2024] they have not been the same. CC2 stated, "I lost my mom because of Brookdale."

<Resident 2>
R2 was admitted to the facility on [redacted]/2023 with multiple diagnoses including [redacted].

Record review of R2's Personal Service Plan dated 05/29/2024, documented R2 had constipation, and staff were to observe R2 for any signs of constipation such as, fewer bowel movement, trouble having a bowel movement, and abdominal swelling and/or

pain. R2's Personal Service Plan documented R2 would have their care managed by facility provider.

Record review of R2's May 2024 MAR documented an order for Citrucel (a medication used to treat and/or prevent constipation). R2's MAR documented the following:
Citrucel 500 mg (milligram) tablet
Directions: take 1 tablet by mouth daily
Indications for use: constipation
Start date: 05/31/2023
Stop date: 05/29/2024 at 2:19 PM
O5/27/2024 AM dose: R2 did not receive medication; pharmacy action required.
O5/28/2024 AM dose: R2 did not receive medication; pharmacy action required.
O5/29/2024 AM dose: R2 did not receive medication; pharmacy action required.
R2's May 2024 MAR documented a total 3 missed doses of Citrucel due to pharmacy action being required.

Record review of R2's nursing note by Staff D, Medication Technician, dated 05/29/2024 at 1:51 PM documented facility staff had made a request for Citrucel to be refilled on 05/18/2024 and pharmacy suggested an alternative medication be subscribed as there were supplier constraints on Citrucel at this time. R2's nursing notes did not document follow-up communication with provider or pharmacy and did not document the medication error.

In an interview with Staff D on 06/28/2024 at 3:30 PM, Staff D said they would look into R1's missed levetiracetam. Staff D stated, "It sounded strange because they [the doctor] doesn't just stop someone's seizure medication." Staff D said pharmacy action required meant the resident's medication is not in the facility and staff "needed to contact the pharmacy to figure out what's going on."

In an interview with Staff B on 06/28/2024 at 4:03PM, Staff B said they reviewed the discharge instructions provided to the facility by the hospital and stated, "I found it actually said continue the seizure medication [levetiracetam]. Staff B said audits of a resident's MARs are done monthly.

In an interview with Staff A, Executive Director, on 06/28/2024 at 4:43 PM, they said once the investigation into R1's missing levetiracetam was concluded, Staff C was suspended and eventually terminated from employment.

In an interview with Staff A on 10/17/2024 at 11:24 AM, they said the expectation was the HWD reviewed all orders received from a resident's provider and follow the facility's policies and procedures to implement the orders. Staff A said the person responsible for the accuracy of a resident's new or changed orders was the facility's HWD.

Statement of Deficiencies	License #: 1912	Compliance Determination # 43495
Plan of Correction	Brookdale Harbor Bay	Completion Date
Page 9 of 9	Licensee: KGC SHORELINE OPERATOR INC	10/17/2024

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, Brookdale Harbor Bay is or will be in compliance with this law and / or regulation on (Date) 10/30/24 .

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

Angie Chaney 10/30/24

Administrator (or Representative) Date

Plan/Attestation Statement

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