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

AHR Port Orchard WA ALF TRS SUB, LLC
Orchard Pointe Senior Alzheimer Community
300 S Kitsap Blvd
Port Orchard, WA 98366

RE: Orchard Pointe Senior Alzheimer Community License # 2724

Dear Administrator:

This letter addresses Compliance Determination(s) 57574 (Completion Date 04/08/2025) and 54030 (Completion Date 02/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/08/2025 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-2210-2

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: Orchard Pointe Senior Alzheimer Community
License/Cert.#: 2724
Compliance Determination #: 54030
Investigator: Michael Goulet
Investigation Date(s): 01/30/2025 through 02/10/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 164940
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) Staff med tech continued to administer one resident's long acting insulin after this medication had been discontinued by the resident's physician, leading to harm for the named resident (low blood glucose leading to seizure)

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms Medication administration computer system readout for named resident
Interviews:	Resident Staff
Record Reviews:	Facility incident report Medication Administration Record (MAR) (2) Medication Order History Written statements by staff med tech (2) Physician Order Review Progress Notes Vital Sign History Facility Policy r/t discontinued medications email from facility nursing director

Investigation Summary:

1) Per interviews with facility staff, it was determined on 1/28/25 that one facility med tech (AP) had been administering long-acting insulin to one resident (AV) for 19 days following the order for discontinuation of the medication made by the resident's primary care physician on 1/9/25. The continuation of this medication administration was noted due to the resident having experienced a seizure on 1/28/25. Upon questioning by the facility director of nursing services (DNS), the

facility med tech in question (AP) did admit to having continued to administer the resident's long-acting insulin after it was discontinued. Per interview, the facility med tech (AP) stated that the medication was not initially removed from the facility computer system, but per record review of the named resident's Medication Order History, this medication had been removed from the facility medication administration system on 1/9/25. The facility med tech (AP) did also state that they had been administering this medication "from memory", and not based on the medication order being present in the facility medication administration system. Observation of the computer display of the facility's medication administration system for the named resident did not show that the long-acting insulin was listed among the resident's medication orders. Record review of the facility policy for Discontinuance of Medications (policy MP21) showed that discontinued medications 'will not be retained' in the facility. Record review of an email communication from the facility DNS noted that although the named resident's long-acting insulin pen was removed from the medication cart, additional long-acting insulin pens for the named resident did remain in the facility refrigerator, leading to this medication being available in the facility after it had been discontinued.
Cited as per WAC 388-78A-2210 (2) 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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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 01/30/2025 of:

Orchard Pointe Senior Alzheimer Community
300 S Kitsap Blvd
Port Orchard, WA 98366

This document references the following complaint number(s): 162022, 164940

The following sample was selected for review during the unannounced on-site visit: 4 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

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-2210 Medication services.

(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 :

This requirement was not met as evidenced by:

Based on interview, observation and record review, the Assisted Living Facility (ALF) failed to ensure that 1 of 1 resident's (Resident 1 [R1]) medication was not administered following the medication order being discontinued by the resident's physician. This failure resulted in harm (seizure, abnormal electrical activity in the brain) for the resident.

Findings included...

Record review on 02/03/2025 at 8:15am of the facility's “Medication Order History” for R1 showed that R1's order for long-acting (Glargine) insulin was discontinued per their physician's orders on 01/09/2025, and that this discontinuation had been noted in the facility’s medication administration system by Staff C, the facility Resident Care Coordinator on 01/09/2025.

Record review on 02/03/2025 at 8:15am of a written statement made by Staff A, the facility Med Tech noted that Staff A had continued to administer long-acting (Glargine) insulin to R1 from 01/09/2025 to 01/28/2025. Staff A wrote in this statement, "I did not realize that insulin pen had been discontinued on 01/09/2025."

Record review on 02/03/2025 at 8:15am of the January 2025 Medication Administration

Record (MAR) for R1 showed that the resident's long-acting (Glargine) insulin was noted as "D/C" (discontinued) in the MAR from 01/10/2025.

Record review on 02/10/2025 at 1:40pm of facility's policy (MP21) regarding Permanent Discontinuance of Medications showed that the facility policy stated that 'discontinued medications will not be retained' in the facility.

Record review on 02/10/2025 at 1:40pm of an email communication from Staff B, the facility Director of Nursing Services (DNS) noted that although R1's long-acting (Glargine) insulin pen was removed from the facility medication cart upon being discontinued (01/09/2025), that additional long-acting (Glargine) insulin pens for R1 did remain in the facility refrigerator, allowing the medication to be available for administration after it was discontinued.

During an interview on 02/04/2025 at 9:55am, Staff A stated that although they believed that R1's long-acting (Glargine) insulin order was not immediately removed from the facility computer system when the medication was discontinued (01/09/2025), that they (Staff A) had administered this medication to R1 for at least some period of time without any current order being reviewed. Staff A stated, "She (R1) had two insulin pens, I was just giving it (long-acting insulin) to her by memory."

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, Orchard Pointe Senior Alzheimer Community 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