STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

05/19/2026

Greenlake Management Ocean Shores, LLC
Ocean Shores Assisted Living
1020 Catala Avenue SE
Ocean Shores, WA 98569

RE: Ocean Shores Assisted Living # 2615

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 77637 (Completion Date 05/19/2026) and 73209 (Completion Date 03/10/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/19/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

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The Department staff who did the On Site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

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Statement of Deficiencies	License #: 2615	Compliance Determination # 73209
Plan of Correction	Ocean Shores Assisted Living	Completion Date
Page 1 of 7	Licensee: Greenlake Management Ocean Shores, LLC	03/10/2026

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 02/20/2026 and 03/10/2026 of:

Ocean Shores Assisted Living
1020 Catala Avenue SE
Ocean Shores, WA 98569

This document references the following complaint number(s): 211674, 212692, 213499

The following sample was selected for review during the unannounced on-site visit: 4 of 50 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

This document was prepared by Residential Care Services for the Locator website.

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.

Clinton Fridley RN
Residential Care Services

03/19/2026
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.

Debbie Smathers
Administrator (or Representative)

3/24/26
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to investigate, document investigative actions, and protect residents after they became aware of an allegation of abuse for 1 of 1 resident reviewed [Resident 1, (R1)]. This failure resulted in R1's allegation of staff to resident altercation not being investigated, R1 not being protected during the investigation and no documentation of appropriate measures taken to prevent ongoing altercations and placed R1 at risk for ongoing abuse.

Findings included...

Review of the facility policy titled, "Abuse, Neglect, or Exploitation Policy," last revised 02/15/2021, stated that for allegations of verbal abuse an investigation would be conducted, and that if the alleged abuser was a staff member, that the supervisor on duty would obtain an interview from that staff member, and that staff member would be informed that they are not allowed in the facility until the investigation was completed in order to protect the resident from any potential ongoing abuse. It stated that a "Resident Abuse Investigation File" would be established, which would include a copy of

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the incident report, all interview documentation, and copies of any disciplinary actions.

Review of Department records showed an anonymous public report made to the Department on 02/13/2026, which alleged that Staff B, Food Services Director, got into a verbal altercation with R1. During the verbal altercation, it was reported that Staff B instructed R1 to go to their room and that R1 was no longer allowed to eat their meals in the dining room.

Record review of facility resident records showed a facility admission date for R1 of [redacted]/2022 with diagnoses including [redacted].

On 02/19/2026 at 10:33 AM, R1 confirmed that they were involved in an altercation with Staff B but was unsure of the date. R1 stated that Staff A, Executive Director, approved them getting a glass of milk for their coffee between meals. R1 stated that on this particular day, they poked their head into the kitchen to ask the staff for some milk. R1 stated that Staff B yelled at them and stated that they could not have any milk, that they would have to wait until mealtimes, and to get out of the kitchen. R1 stated that they continued to argue with Staff B and notified them that Staff A gave approval for milk. R1 then stated that Staff B began mocking them, making crying baby noises, "Waaah, waaah, waaah!" and again stated they could not have any milk. R1 stated, "I said a few words to [Staff B] that I shouldn't have" and then stated that Staff B yelled at them to "go to your room and don't come out!" R1 then stated that Staff B completely removed the table that they normally sat at for mealtimes from the dining room. When asked how this treatment by Staff B made them feel, R1 stated "I felt pissed off."

On 02/19/2026 at 11:03 AM, Staff C, Medication Aide, stated that they observed the altercation between Staff B and R1. Staff C stated that they overheard R1 open up the kitchen door to ask for milk and heard Staff B "holler" at R1 that they were not allowed into the kitchen. Staff C stated that they then saw Staff B exit the kitchen and begin yelling at R1, telling them that there are only certain times where R1 can ask for things and that they cannot go into the kitchen. Staff C stated that there is no reason why R1 should not be able to get milk whenever they wanted, but they were instructed by Staff B to not provide milk to R1. Staff C stated they were not sure the reason for this and stated they would normally just get the milk for R1 anyway. Staff C stated that Staff B was then seen carrying and removing R1's table from the dining room and yelling at R1, "Go to your room! You are not welcome to eat out here anymore," this was done after R1 was seen knocking things off the table in retaliation. Staff C stated, "I was just in awe." Staff C stated that Staff B then instructed them "do not entertain anything [R1] wants at all" and stomped away.

On 02/19/2026 at 11:10 AM, Staff D, Cook, stated that Staff B came into the kitchen "shaking like a leaf, and hotter than a hornet. In a rage with [their] hands all balled up and told me that [R1] is not allowed to eat in the dining room anymore. [Staff B] told me that they raised their hands [to R1] and that it took everything in [them] to not hit

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[R1]." Staff D stated that they saw Staff B return to the kitchen and saw them throw all the linen and silverware from R1's table into the sink. Staff D stated that Staff B then made an announcement over the staff radios to instruct all staff that R1 was no longer allowed to eat in the dining room. Staff D stated that Staff B came back into the kitchen after the incident to vent of the situation, where they told Staff D that they were tired of all of the children in the dining room, and stated, "They are just children!"

On 02/19/2026 at 09:48 AM, Staff A stated that they did receive a complaint from R1 on 02/16/2026 regarding the altercation with Staff B. Staff A stated that that they were aware of Staff B refusing to provide R1 with milk, and about the verbal altercation which involved R1 poking their head into the kitchen to ask staff for milk. Staff A stated "I had heard about that" regarding Staff B telling staff to not allow R1 to eat in the dining room. Staff A stated they interviewed R1 and Staff B regarding the altercation, receiving different stories, but did not document it. Staff A stated they interviewed other residents but did not document. Staff A stated that no incident report was completed and no notification to the Department was made because the investigation was not complete. Staff A stated that no actions were taken regarding Staff B because of the allegation.

Record review of facility resident records did not show that the facility investigated, documented and reported the staff to resident verbal altercation as required.

On 02/19/2026 at 11:20 AM, after informing Staff A regarding the information gathered from staff members about Staff B's behavior (yelling at residents, mocking them, sending them to their room), Staff A stated that it made them "sick to my stomach."

This is a recurring deficiency previously cited on 08/22/2023 and 04/26/2023.

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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/26 .

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

Debbie Smathers — Administrator (or Representative)

3/24/26 — Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

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(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview record review, the assisted living facility failed to make report to the Department after a staff to resident verbal altercation occurred in the facility for 1 of 1 resident reviewed (Resident 1 (R1)). This failure resulted in the facility failing to report an allegation of verbal abuse to the department and placed R1 at risk of continued ongoing abuse.

Findings included...

Review of facility policy titled, "Abuse and Neglect-Resident" last revised 02/15/2024, defined verbal abuse as threatening significant physical harm or threatening or causing significant emotional harm to an adult using: Derogatory or inappropriate names, insults, verbal assaults, profanity, ridicule or harassment, coercion, threats, intimidation, humiliation, mental cruelty, or inappropriate sexual comments. The emotional harm that may result from verbal or emotional abuse includes but is not limited to anguish, distress, fear, unreasonable discomfort, loss of personal dignity, or loss of autonomy. Policy documented that any alleged or suspected abuse would be reported immediately to the supervisor on duty, the Administrator, and to the appropriate state agency, per state mandated reporting guidelines.

Review of Department records showed an anonymous public report made to the Department on 02/13/2026, which alleged that Staff B, Food Services Director, got into a verbal altercation with R1. During the verbal altercation, it was reported that Staff B instructed R1 to go to their room, and that R1 was no longer allowed to eat meals in the dining room.

Record review of facility resident records showed a facility admission date for R1 of [redacted]/2022 with diagnoses including [redacted].

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said a few words to [Staff B] that I shouldn't have" and then stated that Staff B yelled at them to "go to your room and don't come out!" R1 then stated that Staff B completely removed the table that they normally sat at for mealtimes from the dining room. When asked how this treatment by Staff B made them feel, R1 stated "I felt pissed off."

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On 02/19/2026 at 11:10 AM, Staff D, Cook, stated that Staff B came into the kitchen "shaking like a leaf, and hotter than a hornet. In a rage with [their] hands all balled up and told me that [R1] is not allowed to eat in the dining room anymore. [Staff B] told me that they raised their hands [to R1] and that it took everything in [them] to not hit [R1]." Staff D stated that they saw Staff B return to the kitchen and saw them throw all the linen and silverware from R1's table into the sink. Staff D stated that Staff B then made an announcement over the staff radios to instruct all staff that R1 was no longer allowed to eat in the dining room. Staff D stated that Staff B came back into the kitchen after the incident to vent of the situation, where they told Staff D that they were tired of all of the children in the dining room, and stated, "They are just children!"

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Review of Department records showed no report was made by the facility to report the allegations of staff to resident verbal altercation involving Staff B and R1.

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On 02/19/2026 at 11:20 AM, after informing Staff A regarding the information gathered from staff members about Staff B's behavior (yelling at residents, mocking them, sending them to their room), Staff A stated that it made them "sick to my stomach."

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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, Ocean Shores Assisted Living is or will be in compliance with this law and / or regulation on (Date) 4/13/26 .

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

Debbie Smathers — Administrator (or Representative)

3/24/26 — Date

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