STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT 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) 68008 (Completion Date 11/18/2025) and 66002 (Completion Date 09/19/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/18/2025 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-2600-2-j-i, WAC 388-78A-2600-2-j-ii, WAC 388-78A-2600-2-j-iii

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, Community Field Manager
Region 3, Unit D
Residential Care Services

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

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 follow-up on 09/05/2025 and 09/19/2025 of:

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

This document references the following SOD dated: 09/19/2025

The following sample was selected for review during the unannounced on-site visit: 2 of 0 current residents and 0 former residents.

The department staff that inspected 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

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.

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-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.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement policies and procedures to address aggressive or assaultive behavior for 1 of 1 resident (Resident 2). This failure placed Resident 1, Resident 3 and Resident 4 at risk for additional physical harm from an assaultive resident, and this failure placed the other 12 residents on the same facility unit at risk of harm or injury.

Findings included...

Review of the assisted living facility's own incident report, dated 09/02/2025, showed that on 08/30/2025 without warning, Resident 2 pushed Resident 1 to the floor.

Review of prior facility citations, dated 02/13/2025 and 07/31/2025, showed that Resident 2 previously assaulted facility residents in a similar manner which led to significant injuries for Resident 3 and Resident 4.

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Review of Resident 2's negotiated service agreement, dated 05/07/2025, showed no documentation any effective behavioral interventions were implemented and used.

Review of Resident 2's psychiatric evaluation, dated 09/04/2025, noted that the evaluating psychiatrist recommended changing Resident 2's antipsychotic medication Zyprexa/Olanzapine, five mg from as needed (PRN) to scheduled twice daily. The evaluation stated to "continue supportive measures". There was no documentation in any of Resident 2's records that showed the facility implemented any supportive measures to address Resident 2's assaultive behavior.

During an interview on 09/19/2025 at 12:20 PM, Staff A, Executive Director, stated that Resident 2's medication change ordered by the evaluating psychiatrist on 09/05/2025 was not entered into the facility medication administration record. Staff A stated that staff did not administer this medication as per the medication change ordered by the psychiatrist. Staff A stated that there was no policy or procedure the facility developed to address residents with assaultive or aggressive behaviors.

This is an uncorrected deficiency previously cited on 07/31/2025 for subsection (2)(j)(iii).

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Gig Harbor Memory Care
Provider Type: Assisted Living Facility

License/Cert.#: 2627
Intake ID: 185715
Compliance Determination #: 62602
Region/Unit #: RCS Region 3 / Unit D
Investigator: Michael Goulet
Investigation Date(s): 07/15/2025 through 07/31/2025
Complainant Contact Date(s): 07/14/2025, 07/31/2025

Allegation(s):

1) Resident-to-resident altercation with significant injury (compound displaced fracture of resident's ankle/ lower leg)

Investigation Methods:

Sample:	Total residents: Resident sample size: 16 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 Care Plan Prior facility incident reports and investigation reports related to similar behaviors

Investigation Summary:

1) Per prior investigations involving the same-named resident perpetrator (AP), this named resident has been involved in numerous altercations resulting in harm to peers and staff, and the facility has been cited previously (on 2/12/25) regarding the failure to safeguard residents in regard to the AP's behavior. Per prior investigations, the named resident (AP) was noted per their pre-admission evaluation as having "extensive behavioral issues requiring supervision and a professionally authorized behavioral management program, and/or professional consultation and intervention", but there has been no indication that any such interventions have been instated by the facility. Per recent record review of the named resident's (AP) care plan, there was no indication that any such interventions had been put in place, with the only behavioral interventions contained in the resident's care plan being to "back away, remove others and call 9-11". Per staff interviews and per prior incident reports regarding this resident's behavior, the

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resident will act without warning, pushing other residents to the floor when the named resident feels these peers are "too close" to the named resident's room. Per interviews the named resident has continually denied any such actions and has taken no responsibility for harming peers. The named AP has presented per interviews and per cognitive testing as not exhibiting significant memory impairment and has continually presented as experiencing detrimental psychiatric issues more so than any cognitive impairment, yet there has been no indication that the facility has addressed these issues effectively, leading to a continuing threat of harm to peers and staff.
Cited (as previously) per WAC 388-78A-2600 (2Ji, ii, iii)

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 # 62602
Plan of Correction	Gig Harbor Memory Care	Completion Date
Page 1 of 3	Licensee: Greenlake Management Gig Harbor, LLC	07/31/2025

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 07/15/2025 and 07/31/2025 of:

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

This document references the following complaint number(s): 183953, 184629, 185715, 187192

The following sample was selected for review during the unannounced on-site visit: 16 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

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.

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-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.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to address the assaultive behavior exhibited by 1 of 1 facility resident (Resident 2 [R2]), although this behavior was known to the facility both through the resident's prior actions and had been cited previously. This failure resulted in a significant injury for 1 of 2 residents (Resident 1 [R1]) and placed all facility residents and staff at risk of physical harm.

Findings included...

During an interview on 07/15/2025 at 12:10pm, Staff A, Director of Nursing Services, stated that the facility had not attempted to send the resident perpetrator (R2) out to a hospital or psychiatric facility for evaluation or treatment following the resident-to-resident altercation that led to significant injury (compound lower leg fracture) for R1, stating "no one will take him (R2) and police don't care."

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During an interview on 07/21/2025 at 2:15pm, Staff B, Executive Director, stated that the resident perpetrator (R2) remains at the facility following multiple assaults against peers due to police and emergency services personnel (EMS/ Fire Department) refusing to transport the resident.

Record review on 07/23/2025 at 7:00am of R2's care plan showed that R2 was noted to have "extensive behavioral issues requiring supervision, a professionally authorized behavior management program, and/ or professional consultation and intervention," but no intervention other than to "back away, remove others and call 9-11" was noted in the resident's care plan. As noted above, calling 9-11 was considered to be an ineffective strategy for addressing this resident's (R2) behavior by both the facility Executive Director and the Director of Nursing Services, yet no other intervention was noted in R2's care plan. Per prior investigation, the same behaviors were noted in the resident's care plan from the resident's admission to the facility on [redacted]/2024, and there was no indication that any behavior management program or professional psychiatric intervention had been instated to address R2's behavior since that time, in spite of the resident's continuing assaultive behavior, and in spite of this issue having been cited previously on 20/12/2025 in relation to prior resident-to resident altercations initiated by R2.

The is a recurring deficiency previously cited on 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)_____ .

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

_____ _____

Administrator (or Representative) Date

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