



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Lacey Special Care Community LLC
The Cottages at Lacey
8570 Martin Way E
Lacey, WA 98516

RE: The Cottages at Lacey License # 2443

Dear Administrator:

This letter addresses Compliance Determination(s) 59449 (Completion Date 05/12/2025) and 55599 (Completion Date 02/28/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/12/2025 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-2950-6, WAC 388-78A-2320-2-b, WAC 388-78A-2320-3-c

The Department staff who did the on-site verification:
Anissa Bearden, Licensors

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

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



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2443	Compliance Determination #55599
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 9	Licensee: Lacey Special Care Community LLC	02/28/2025

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 follow-up on 02/28/2025 of:

The Cottages at Lacey
8570 Martin Way E
Lacey, WA 98516

This document references the following SOD dated: 02/28/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 56 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

From:
DSHS, Aging and Long-Term Support 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.

Statement of Deficiencies	License # 2443	Compliance Determination # 59099
Plan of Correction	The Cottages at Lacey	Completion Date
Page 2 of 9	Licensee: Lacey Special Care Community LLC	02/28/2025

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.

Jody Just

Residential Care Services

03/13/2025

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.

[Signature]

Administrator (or Representative)

3/13/25

Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature had been maintained between 105 and 120 degrees Fahrenheit (F) for 3 of 3 areas (Cottage B, Cottage C, and Cottage D) reviewed. This failure placed 55 of 56 residents at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 12/17/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2950] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 01/03/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/31/2024."

Record review of the facility untitled, and undated document, showed it was the plan of correction from deficiencies dated 12/17/2024. The document showed the water temperature heaters were examined and descaled (removal of mineral buildup). The

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.

<u>Jody Just</u> Residential Care Services	<u>03/13/2025</u> Date
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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
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Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature had been maintained between 105 and 120 degrees Fahrenheit (F) for 3 of 3 areas (Cottage B, Cottage C, and Cottage D) reviewed. This failure placed 56 of 56 residents at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 12/17/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2950] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 01/03/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 01/31/2024."

Record review of the facility untitled, and undated document, showed it was the plan of correction from deficiencies dated 12/17/2024. The document showed the water temperature heaters were examined and descaled (removal of mineral buildup). The

water temperatures were checked frequently to ensure appropriate water temperatures.

Record review of the facility provided document titled, "Monthly Water Temperature Logs", dated "February 2025", showed the required range according to state or provincial regulation water temperature range was 105-120 degrees for resident accessible areas.

Cottage B

In an observation on 02/28/2025 at 11:33 AM, the Cottage B bathroom located across from room B06 had a water temperature of 120.1 degrees F.

In an observation on 02/28/2025 at 12:19 PM, the Cottage B laundry room showed the water tank had been set to 125 degrees F.

Cottage C

In an interview on 02/28/2025 at 11:29 AM, Staff D, Caregiver, said the water temperature within the Cottage C unit had been messed up. Staff D said the facility staff got creative with how to get the water temperature warm.

In an observation on 02/28/2025 at 12:22 PM, the Cottage C laundry room showed the water tank had been set to 125 degrees F.

Cottage D

In an observation and interview on 02/28/2025 at 11:21 AM, Cottage D's kitchenette public sink's hot water was turned on. At 11:23 AM the hot water's temperature was 97.8 degrees F. At 11:24 AM, Staff G, Caregiver, stated that the hot water gets hot. Staff G stated it takes time for the hot water to get hot. At 11:25 AM, the hot water temperature was at 97.9 degrees F.

In an observation on 02/28/2025 at 11:29 AM, inside the resident's accessible shower and bathroom across from room D-12, the hot waters temperature was 122.2 degrees F.

In an observation on 02/28/2025 at 12:12 PM, Staff A went into the resident accessible shower and bathroom located across from room D12. Staff A used the facility's thermometer and checked the hot water temperature. The hot water temperature had

Statement of Deficiencies	License #: 2443	Compliance Determination # 55599
Plan of Correction	The Cottages at Lacey	Completion Date
Page 4 of 9	Licensor: Lacey Special Care Community LLC	02/28/2025

been observed to reach 115.5 degrees F and then quickly dropped to 113 degrees F. Staff A took the thermometer out of the water. The Department requested for Staff A to continue to monitor the water temperature since the numbers would go up and down rapidly and was still changing before Staff A removed the thermometer out of the water. The hot water temperature stopped at 120.8 degrees F. Staff A acknowledged that the water temperature was above regulation temperature.

In an observation on 02/28/2025 at 12:29 PM, the Cottage D laundry room showed the hot water tank had been set to 125 degrees F.

In an interview on 02/28/2025 at 11:54 AM, Staff C, Maintenance Director, said all three cottages water tanks were descaled and since they were descaled the hot water temperatures had been up to temperature. Staff C said they checked the hot water temperatures monthly. Staff C said since there had been hot water temperature problems sometimes, they checked the hot water temperatures daily if not three times a week. Staff C said they did not document every time they checked the hot water temperature. Staff C said there have been times since descaling the hot water tanks that the hot water temperature was outside of the 105 degree F through 120 degree F range. Staff C said that one sink would be really hot and another sink would be within the regulation. Staff C said they had to turn the water temperature gage on the hot water tanks settings up over 120 degrees F for the water in the facility's cottages to read within the normal range. Staff C said that even though the hot water tanks were five to six degrees higher, the hot water temperatures at the sinks of the cottages were two degrees less than the setting. Staff C said they thought the water gages were currently set at 125 degrees F. Staff C said at times they noticed the water temperature would be off from anywhere between eight to 15 degrees. Staff C confirmed they had to set the water temperature gage over the 120 degree F maximum to get the facility water temperature within regulation.

This is an uncorrected and recurring deficiency previously cited on 12/17/2024 and 10/14/2024.

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, The Cottages at Lacey is, or will be in compliance with this law and / or regulation on (Date) 4/14/25.

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


Administrator (or Representative)

3/13/25
Date

been observed to reach 115.5 degrees F and then quickly dropped to 113 degrees F. Staff A took the thermometer out of the water. The Department requested for Staff A to continue to monitor the water temperature since the numbers would go up and down rapidly and was still changing before Staff A removed the thermometer out of the water. The hot water temperature stopped at 120.8 degrees F. Staff A acknowledged that the water temperature was above regulation temperature.

In an observation on 02/28/2025 at 12:29 PM, the Cottage D laundry room showed the hot water tank had been set to 125 degrees F.

In an interview on 02/28/2025 at 11:54 AM, Staff C, Maintenance Director, said all three cottages water tanks were descaled and since they were descaled the hot water temperatures had been up to temperature. Staff C said they checked the hot water temperatures monthly. Staff C said since there had been hot water temperature problems sometimes, they checked the hot water temperatures daily if not three times a week. Staff C said they did not document every time they checked the hot water temperature. Staff C said there have been times since descaling the hot water tanks that the hot water temperature was outside of the 105 degree F through 120 degree F range. Staff C said that one sink would be really hot and another sink would be within the regulation. Staff C said they had to turn the water temperature gage on the hot water tanks settings up over 120 degrees F for the water in the facility's cottages to read within the normal range. Staff C said that even though the hot water tanks were five to six degrees higher, the hot water temperatures at the sinks of the cottages were two degrees less than the setting. Staff C said they thought the water gages were currently set at 125 degrees F. Staff C said at times they noticed the water temperature would be off from anywhere between eight to 15 degrees. Staff C confirmed they had to set the water temperature gage over the 120 degree F maximum to get the facility water temperature within regulation.

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Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 4 staff (Staff D and Staff F) were documented to have been trained and verified to administer Registered Nurse (RN) delegated tasks to 4 of 4 sampled residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]). These failures placed all 4 residents at risk to receiving medications from untrained caregivers and placed them at risk for unmet medical care needs.

Findings included...

Washington Administrative Code (WAC) 246-840-930

"(1) In community-based and in-home care settings, before delegating a nursing task, the registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. ASSESS... (5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient... (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision... PLAN... (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes... (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide... (l) Document teaching done and a return demonstration, or other method for verification of competency... IMPLEMENT (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator. (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). EVALUATE... (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse

delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

Record review of the untitled, undated, showed it was the facility's plan of correction. Review of the plan of correction for WAC 388-78-2320 intermittent nursing services systems, showed the facility reviewed the nurse delegation requirements and audit of current documentation to ensure compliance with regulations."

R1

Record review of R1's "Transfer/Move Out Report", dated 12/31/2024, showed R1 moved into the facility on [REDACTED]/2024 with multiple medical diagnoses that included [REDACTED].

Record review of R1's "Nurse Delegation: Nursing Visit", dated 11/30/2024, showed R1 required nurse delegation for their blood sugar being checked, oral and topical medications and treatments. The document showed there were nine long-term care workers that were listed that had been trained and delegated to administer R1's delegated tasks. Staff D, Caregiver, and Staff F, Caregiver, were not listed as a long-term care worker that were delegated for R1's medications.

Record review of R1's Medication Administration Record (MAR), dated 01/01/2025 through 01/31/2025, showed Staff F administered R1's oral medications on 01/31/2025 at 8:00 PM, that was the day the facility alleged to be back in compliance with the regulation.

Record review of R1's MAR, dated 02/01/2025 through 02/28/2025, showed Staff F administered R1's delegated medications and tasks ten of 27 administrations. Staff D administered R1's delegated tasks on 02/22/2025 at 8:00 AM.

R2

Record review of R2's "Transfer/Move Out Report", dated 09/30/2024, showed R2 moved into the facility on [REDACTED] 2018 with multiple medical diagnoses that included [REDACTED].

Record review of R2's "Nurse Delegation: Nursing Visit", dated 11/30/2024, showed R2 required nurse delegation for oral and topical medications and treatments. The document showed there were nine long-term care workers that were listed that had been trained and delegated to administer R2's delegated tasks. Staff D and Staff F were not listed as a long-term care worker that were delegated for R2's medications.

Record review of R2's MAR, dated 02/01/2025 through 02/28/2025, showed Staff F administered R2's delegated medications and tasks at 11 of 27 administrations. Staff D administered R2's delegated tasks on 02/22/2025 at 8:00 AM.

R3

Record review of R3's "Transfer/Move Out Report", dated 09/30/2024, showed R3 moved into the facility on [REDACTED]/2022 with multiple medical diagnoses that included [REDACTED].

Record review of R3's "Nurse Delegation: Nursing Visit", dated 11/30/2024, showed R3 required nurse delegation for their oral and topical medications and treatments and eye drops/ointments. The document showed there were nine long-term care workers that were listed that had been trained and delegated to administer R3's delegated tasks. Staff D and Staff F were not listed as a long-term care worker that were delegated for R3's medications.

Record review of R3's MAR, dated 01/01/2025 through 01/31/2025, showed Staff F administered R3's oral medications on 01/31/2025 at 5:00 PM and 8:00 PM, that was the day the facility alleged to be back in compliance with the regulation.

Record review of R3's MAR, dated 02/01/2025 through 02/28/2025, showed Staff F administered R3's delegated medications and tasks at 11 of 27 administrations. Staff D administered R3's delegated tasks on 02/22/2025 at 8:00 AM.

R4

Record review of R4's "Transfer/Move Out Report", dated 12/31/2024, showed R4 moved into the facility on [REDACTED]/2023 with multiple medical diagnoses that included [REDACTED].

Record review of R4's "Nurse Delegation: Nursing Visit", dated 11/30/2024, showed R4 required nurse delegation for their oral and topical medications and treatments, block sugar checks, and insulin administration. The document showed there were nine long-term care workers that were listed that had been trained and delegated to administer R4's delegated tasks. Staff D and Staff F were not listed as a long-term care worker that were delegated for R4's medications.

Record review of R4's MAR, dated 01/01/2025 through 01/31/2025, showed Staff F administered R4's oral medications on 01/31/2025 at 5:00 PM and 8:00 PM, that was the

day the facility alleged to be back in compliance with the regulation.

Record review of R4's MAR, dated 02/01/2025 through 02/28/2025, showed Staff F administered R4's delegated medications and tasks at 11 of 27 administrations. Staff D administered R4's delegated tasks on 02/22/2025 at 8:00 AM and 12:00 PM.

In an interview on 02/28/2025 at 11:29 AM PM, Staff D Caregiver, said they were a caregiver who had worked for the facility for approximately a month and a half. Staff D said at their previous job they worked as a medication technician. At 12:39 PM, Staff D said they thought the RN delegator for the facility had been Staff A, Executive Director. Staff D said they had not given any residents their medications. Staff D said they were added to the facility EMAR (electronic medication administration record) system recently. Staff D said they were scheduled for a medication technician shift the following day on 03/01/2025. Staff D said they had delegation training from their former facility. Staff D said they trained with Staff E, Medication Technician, for three days.

In an interview on 02/28/2025 at 12:40 PM, Staff F stated they do work the medication cart and pass medications to all the residents that reside at the facility. Staff F was unaware of who the RN delegator was. Staff F stated they were only trained by another medication technician when they started at the facility in December 2024. Staff F stated they had not met Staff B, RN Delegator, or had been taught or observed passing resident medications and delegated tasks. Staff F stated, "I do not know who the RN delegator is".

In an interview on 02/28/2025 at 1:05 PM, Staff A, Executive Director, stated Staff B had come out to the facility twice a month but had been only monthly recently. Staff A stated R4 did not require insulin administration and unsure why R4 would be delegated for insulin administration. Staff A stated they were under the impression that Staff F and Staff D were delegated to administer RN delegated tasks to the residents that required them.

In an interview on 02/28/2025 at 1:55 PM, Staff B stated they were the RN delegator for the facility. Staff B stated they document on the nurse delegation Nursing visit form when a long-term care work, had been trained, observed, and verified to administer residents delegated tasks. Staff B stated they tried to meet the new medication technicians as soon as they were notified by the facility. Staff B stated they were out at the facility two times a month. Staff B stated their last visit to the facility was in January 2025. Staff B stated that during their visits they try and coordinate with the medication technician's schedules to observe, teach, and review the resident's delegated tasks.

This is an uncorrected and recurring deficiency previously cited on 12/17/2024 and 10/14/2024.

Statement of Deficiencies	License # 2443	Compliance Determination # 55535
Plan of Correction:	The Cottages at Lacey	Completion Date
Page 9 of 9	Licensee: Lacey Special Care Community LLC	02/26/2025

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 4/14/25

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



Administrator (or Representative)

3/13/25

Date

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date)_____.

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Administrator (or Representative)

Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2443	Compliance Determination #51532
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 17	Licensee: Lacey Special Care Community LLC	12/17/2024

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 follow-up on 12/10/2024 and 12/10/2024 of:

The Cottages at Lacey
8570 Martin Way E
Lacey, WA 98516

This document references the following SOD dated: 12/17/2024

The following sample was selected for review during the unannounced on-site visit: 4 of 51 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Celeste Vashey, ALF LTC Licensors

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

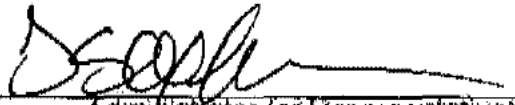
Jody Just
Residential Care Services

12/24/2024
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.

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

Statement of Deficiencies	License #: 2443	Compliance Determination # 51532
Plan of Correction	The Cottages at Lacey	Completion Date
Page 2 of 17	Licensed: Lacey Special Care Community LLC	12/17/2024


Administrator (or Representative)

1/3/2025
Date

WAC 358-78A-2610 Infection control:

- (1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.
- (2) The assisted living facility must:
 - (c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections.
 - (d) Provide all resident care and services according to current acceptable standards for infection control.
 - (e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the facility staff members washed their hands per the acceptable standards for 3 of 3 staff members (Staff B, Staff D, and Staff F) reviewed. The facility also failed to ensure 1 of 2 laundry rooms (Cottage C Laundry room) had appropriate infection control for soiled linens. These failures placed 51 of 51 residents and 31 staff at risk of contracting and spreading communicable diseases.

Findings included...

Record review of the Centers of Disease Control (CDC) document titled, "about handwashing", dated 02/16/2024, showed many diseases and conditions were spread by not washing hands with soap and clean, running water. Handwashing with soap was one of the best ways to stay healthy. Handwashing could keep a person healthy and prevent the spread of respiratory and diarrheal infections. Germs could spread from person to person or from surface to people when a person touches their eyes, nose, or mouth with unwashed hands, if a person touches surfaces or objects that have germs on them, blow their nose, cough, or sneeze into their hands and then touch other person's hands or common objects. Hands were to be washed often.

Record review of the CDC's document titled, "clinical safety: hand hygiene for healthcare workers", dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with handwashing with water and soap or antiseptic hand rub. When a healthcare worker cleans their hands it reduces the potential spread of deadly germs to patients, spread of germs that include ones that were resistance to antibiotics, and reduces the risk of healthcare

Administrator (or Representative)

Date

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(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the facility staff members washed their hands per the acceptable standards for 3 of 3 staff members (Staff B, Staff D, and Staff F) reviewed. The facility also failed to ensure 1 of 2 laundry rooms (Cottage C Laundry room) had appropriate infection control for soiled linens. These failures placed 51 of 51 residents and 31 staff at risk of contracting and spreading communicable diseases.

Findings included...

Record review of the Centers of Disease Control (CDC) document titled, "about handwashing", dated 02/16/2024, showed many diseases and conditions were spread by not washing hands with soap and clean, running water. Handwashing with soap was one of the best ways to stay healthy. Handwashing could keep a person healthy and prevent the spread of respiratory and diarrheal infections. Germs could spread from person to person or from surface to people when a person touches their eyes, nose, or mouth with unwashed hands, if a person touches surfaces or objects that have germs on them, blow their nose, cough, or sneeze into their hands and then touch other person's hands or common objects. Hands were to be washed often.

Record review of the CDC's document titled, "clinical safety: hand hygiene for healthcare workers", dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with handwashing with water and soap or antiseptic hand rub. When a healthcare worker cleans their hands it reduces the potential spread of deadly germs to patients, spread of germs that include ones that were resistance to antibiotics, and reduces the risk of healthcare

personnel from being infected from germs received from the patient. Healthcare workers were to clean their hands before touching a patient, before moving from work from soiled to clean, after touching a patient or patient's surrounding, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Healthcare works were to wash their hands with soap and water when their hands were visibly soiled.

Record review of the Centers for Disease Control (CDC) article titled, "G. Laundry and Bedding Guidelines for Environmental Infection Control in Health-Care Facilities", dated 01/08/2024, showed laundry in a health-care facility may include personal clothing, patient apparel, and more. Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids. Disease transmission attributed to health-care laundry has involved contaminated fabrics that were handled inappropriately. Occupational Safety Health Administration that defines contaminated laundry as "laundry which has been soiled with blood or other potentially infectious materials or may contain sharps". The laundry process starts with the removal of used or contaminated textiles, fabrics, and/or clothing from the areas where such contamination occurred. Contaminated textiles and fabrics were to be placed into bags or other appropriate containment. The bags were then securely tied or otherwise closed to prevent leakage. Contaminated textiles and fabrics in bags would be transported or stored in carts.

Record review of the facility untitled, and undated document, showed it was the plan of correction from deficiencies dated 10/14/2024. The document showed infection control policies and procedures were reviewed with all staff and in-services had been provided to staff about the proper handwashing procedure on four separate dates. The department head of Director of Nursing and Resident Care Coordinator were responsible to ensure proper infection control for soiled linens took place during rounds and were in designated areas.

Record review of the facility's policy titled, "Infection Control", undated, showed the recommendations for residents and caregiver section showed hands should be washed before and after touching the resident. Gloves should be worn by any staff member who handled soiled laundry. Gloves should be changed between care for each resident and between performing dirty to clean tasks. Hands should be washed immediately after gloves were removed.

Record review of the "Department of Social And Health Services" document, Completion date 10/14/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2610] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 10/29/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 11/27/2024."

Hand Hygiene

In an observation on 12/10/2024 at 11:11 AM, Staff B, Caregiver, was observed to talk to an unknown female resident about how they needed to use the restroom. The unknown resident sat in their wheelchair and Staff B wheeled the resident into the restroom. When staff B exited the restroom, they had been observed to wear blue gloves on their hands. Staff B touched the bathroom door handle and the bathroom door to prop it open to get the unknown resident and their wheelchair out of the bathroom. Staff B wheeled the resident back into the common area of the facility. Without doffing (taking off) their gloves Staff B touched the back of a chair in the kitchenet area. Staff B verbally said they needed to wash their hands before they separated the tables for lunch.

In an interview and observation on 12/10/2024 at 11:50 AM, Staff F, Caregiver had been observed with blue gloved hands outside of the laundry room in Cottage D. Staff F placed a trash bag on the floor as they retrieved the key to the door from their pocket. An unknown resident walked by and attempted to pick up the trash bag on the floor and Staff F had been observed to try and stop the resident from touching the trash. Staff F entered the laundry room and tied the trash bag before they placed the trash bag on the ground. Without doffing their gloves Staff F then had been observed to open the dryer and take the clothes out of the dryer and put them into a wire basket. Staff F confirmed that clean laundry went into the wired basket. Staff F then opened the washing machine and transferred the wet laundry into the dryer. Once the washing machine had been emptied Staff F started another load of laundry. Staff F then picked up the trash bag and placed it in the garbage can. Staff F put a new liner in the garbage can before they exited the room with the trash bag. With the same pair of blue gloves Staff F had been observed to touch the laundry room doorknob and door. Staff F went to the janitor's closet. Staff F retrieved their keys from their pocket, touched the doorknob, and door frame before they threw away the trash bag. Without performing hand hygiene Staff F doffed their blue gloves, and donned (put on) a new pair of gloves. Staff F then went to the free standing food warmer cart, took out a plate of food, and delivered it to a resident. Staff F then continued to go to the free standing food warmer cart and deliver food to residents.

In an observation on 12/10/2024 at 11:58 AM, Staff D, Caregiver, had been observed to wear a pair of blue gloves, they had a bag of trash in their hands. Staff D had been observed to retrieve their keys out of their pocket. Staff D touched the janitors closet doorknob and door frame before they threw away the trash. Without performing hand hygiene or doffing their gloves Staff D had been observed to go down the hallway.

Cottage C Laundry Room

In an observation on 12/10/2024 at 11:35 AM, inside the laundry room of Cottage C, on the ground in front of the washing machine was a blue blanket that sat on the ground without a bag. On the wall in front of the area that the blanket sat on the ground with a

Statement of Deficiencies	License # 2443	Compliance Determination # 51532
Plan of Correction	The Cottages at Lacey	Completion Date
Page 5 of 17	Licensee: Lacey Special Care Community LLC	12/17/2024

sign that showed "dirty area".

In an observation and interview on 12/10/2024 at 1:19 PM, the Cottage C laundry room showed a blue blanket had been on the ground next to the washing machine. Staff E, Caregiver, saw the blanket on the ground and confirmed laundry was not supposed to be on the ground.

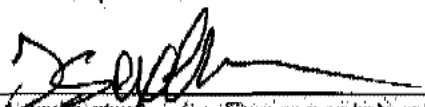
In an interview on 12/10/2024 at 2:31 PM, Staff A, Executive Director, acknowledged a blanket had been found on the ground in the laundry room. Staff A expressed understanding that facility staff did not perform hand hygiene when they should have.

This is an uncorrected and recurring deficiency previously cited on 10/14/2024, 04/05/2024, 01/18/2024, 08/22/2023 and 03/27/2023 for subsections (1)(2)(c)(e).

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 1/31/2025.

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


Administrator (or Representative)

1/3/2025
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(b) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times, and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature had been maintained between 105 and 120 degrees Fahrenheit (F) for 2 of 4 areas (public restroom and Cottage D) reviewed. This failure placed 51 of 51 residents and 31 staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

Record review of the facility untitled, and undated document, showed it was the plan of

sign that showed "dirty area".

In an observation and interview on 12/10/2024 at 1:19 PM, the Cottage C laundry room showed a blue blanket had been on the ground next to the washing machine. Staff E, Caregiver, saw the blanket on the ground and confirmed laundry was not supposed to be on the ground.

In an interview on 12/10/2024 at 2:31 PM, Staff A, Executive Director, acknowledged a blanket had been found on the ground in the laundry room. Staff A expressed understanding that facility staff did not perform hand hygiene when they should have.

This is an uncorrected and recurring deficiency previously cited on 10/14/2024, 04/05/2024, 01/18/2024, 06/22/2023 and 03/27/2023 for subsections (1)(2)(c)(e).

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature had been maintained between 105 and 120 degrees Fahrenheit (F) for 2 of 4 areas (public restroom and Cottage D) reviewed. This failure placed 51 of 51 residents and 31 staff at risk for potential skin burns, discomfort, and decreased quality of life.

Findings included...

Record review of the facility untitled, and undated document, showed it was the plan of

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

correction from deficiencies dated 10/14/2024. The document showed the water temperature guidelines had been reviewed by Staff G, Maintenance Director, and the water temperature heaters had been adjusted per the Washington Administrative Code (WAC) requirements.

Record review of the "Department of Social And Health Services" document, Completion date 10/14/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2950] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 10/29/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 11/27/2024."

Record review of the facility provided document titled, "Monthly Water Temperature Logs", dated "December 2024", showed the required range according to state or provincial regulation water temperature range was 105-120 degrees for resident accessible areas.

In an interview on 12/10/2024 at 11:19 AM, Staff C, Caregiver, said the caregivers at the facility had a hard time getting the facility water warm.

In an observation on 12/10/2024 at 11:43 AM, Cottage D bathroom located across from room D6 showed after five minutes the water temperature had been 103.4 degrees.

In an observation on 12/10/2024 at 11:47 AM, inside Cottage D's kitchenette resident accessible sink the hot water temperature was noted to be cold. At 11:55 AM, after the hot water continuously ran, the hot water temperature was 88.5 degrees F.

In an interview on 12/10/2024 at 11:49 AM, Staff D, Caregiver, stated the hot water in Cottage D's sink has been colder the last few days. Staff D stated they had not told maintenance that day 12/10/2024. Staff D stated the water just gets lukewarm at times and just not getting hot.

In an interview on 12/10/2024 at 12:37 PM, Staff G said when they completed their monthly water temperature audits, they had been aware the facility water struggled to reach the minimum water temperature regulation of 105 degrees. Staff G said the facility pipes had been affected by the cold weather temperatures. Staff G said they had to turn up the water temperature on the water heaters over the regulation to 125 degrees F and 130 degrees F to reach the 105 degrees F minimum. Staff G recognized the water temperature at the facility had not reached the 105 degrees F minimum. Staff G stated the minimum temperature the hot water temperature was to

Statement of Deficiencies	License # 2443	Compliance Determination # 51032
Plan of Correction	The Cottages at Lacey	Completion Date
Page 7 of 17	Licensee: Lacey Special Care Community LLC	12/17/2024

be at was 105 degrees F.

In an observation on 12/10/2024 at 1:13 PM, the common bathroom in the main lobby had a water temperature of 124.7 degrees F.

In an interview on 12/10/2024 at 1:16 PM, Staff H, Business Office Manager, said residents and resident family members used the common bathroom in the main lobby.

In an observation on 12/10/2024 at 1:53 PM, inside the Cottage D resident accessible shower/bathroom across from room D02 the hot water temperature was cool to touch. At 1:59 PM, the hot water temperature was 73.6 degrees F after the hot water had been running for five minutes.

In an observation on 12/10/2024 at 1:59 PM, inside the resident accessible and used shower/bathroom, the hot water temperature was cold. At 2:04 PM, the hot water temperature was 64.6 degrees F after the hot water had been running for five minutes.

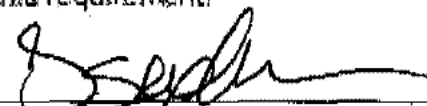
In an interview on 12/10/2024 at 2:31 PM, Staff A, Executive Director, said to their knowledge the facility had not had any concerns with their water temperatures. Staff A acknowledged that Staff G admitted the facility water temperatures struggled to reach the 105 degrees F minimum. Staff A acknowledged that to compensate for the cold water Staff G had turned their water tank's heater temperature up over the regulation to 125 degrees F to 130 degrees F. Staff A stated Staff G was responsible to ensure that all hot water temperatures were always within the required temperatures.

This is an uncorrected deficiency previously cited on 10/14/2024.

Plan/Attestation Statement

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


Administrator (or Representative)

1/3/2025
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and

be at was 105 degrees F.

In an observation on 12/10/2024 at 1:13 PM, the common bathroom in the main lobby had a water temperature of 124.7 degrees F.

In an interview on 12/10/2024 at 1:16 PM, Staff H, Business Office Manager, said residents and resident family members used the common bathroom in the main lobby.

In an observation on 12/10/2024 at 1:53 PM, inside the Cottage D resident accessible shower/bathroom across from room D02 the hot water temperature was cool to touch. At 1:58 PM, the hot water temperature was 73.6 degrees F after the hot water had been running for five minutes.

In an observation on 12/10/2024 at 1:59 PM, inside the resident accessible and used shower/bathroom, the hot water temperature was cold. At 2:04 PM, the hot water temperature was 54.6 degrees F after the hot water had been running for five minutes.

In an interview on 12/10/2024 at 2:31 PM, Staff A, Executive Director, said to their knowledge the facility had not had any concerns with their water temperatures. Staff A acknowledged that Staff G, admitted the facility water temperatures struggled to reach the 105 degrees F minimum. Staff A acknowledged that to compensate for the cold-water Staff G had turned their water tank's heater temperature up over the regulation to 125 degrees F to 130 degrees F. Staff A stated Staff G was responsible to ensure that all hot water temperatures were always within the required temperatures.

This is an uncorrected deficiency previously cited on 10/14/2024.

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Administrator (or Representative)

Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and

cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;
- (3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and
- (4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, record review, and interview the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 3 locations within the facility (Cottage C and Cottage D). This failure placed 51 of 51 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 10/14/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-3100] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 10/29/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 11/27/2024."

Record review of the facility untitled, and undated document, showed it was the plan of correction from deficiencies dated 10/14/2024. The document showed the department head of Director of Nursing and Resident Care Coordinator had been responsible for completed rounds to ensure cabinets were locked. The housekeeping department made sure items were in safe areas away from residents.

Record review of the facility's policy titled, "Handling and Storing Supplies and Equipment Used for Resident Services", dated 02/01/2015, showed the policy indicated the awareness of maintaining a safe and health working environment that included training with the appropriate use and application. All chemicals, supplies, and equipment were stored in designated areas by the department.

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster

and Sample Selection", undated, showed 49 of 51 residents were marked as having a diagnosis of [REDACTED] or [REDACTED]. The characteristic roster showed 25 of 51 residents were marked as being exit seekers or wanderers.

Record review of the Alzheimer's Association document, titled, "Home Safety", undated, showed as the Alzheimer dementia disease progresses, the person's abilities would change. Under the section titled, "how dementia affects safety", showed Alzheimer's disease caused a number of changes in the brain and body that would affect the person's safety that included forgetting how to use household items, becoming easily confused, and experiencing changes in vision. Under the section titled, "home safety tips", showed keep all cleaning products such as bleach out of sight, secured and in the original storage containers to discourage someone from eating or touching harmful chemicals.

Record review of the Poison Control National Capital Poison Center article titled, "mouthwash: swish and spit", undated, showed mouth wash and mouth rinse were liquid products with both antiseptic and disinfectant properties. Sometimes mouthwashes contain alcohol and fluoride. If someone swallowed large quantities of mouth wash, a person may experience toxicity from alcohol, fluoride, and antimicrobial ingredients. The symptoms could include nausea, vomiting, slow breathing, coma (a condition when a person is unconscious for a prolong period caused by injury or illness), and affect the heart and kidneys. Mouthwash could get a person drunk with the alcohol content.

In an observation on 12/10/2024 at 11:19 AM, Resident 1's (R1) room had equate extra whitening toothpaste in a clear bucket on their bed. Inside of R1's opened purse on their bed had a bottle of lotion remedy nourishing cream. Resident 2's side of the room on their dresser had a container of Aveeno lotion and soothe and cool cleanse shampoo and body wash.

In an observation on 12/10/2024 at 11:21 AM, inside the unattended Cottage C kitchenette area, under the sink were two cabinet doors with the right cabinet unlocked. Inside the unlocked cabinet door was a bottle of equate sunscreen sport 100 sun protection factor. The label showed the product had the following ingredients avobenzone (an oil soluble chemical), homosalate (a chemical that is non-mineral to help prevent ultraviolet damage to the skin), oxybenzone (a chemical that blocks the absorption of sun's ultraviolet rays), octisalate (a colorless floral odor oily liquid), octocrylene (a clear, thick, oily liquid that absorbs ultra violet rays). The label showed the product was to be kept out of people's eyes, avoid breathing in the spray, and if the product was swallowed, medical attention was required right away. There was a bottle that was three quarter full of clear liquid that had a label that showed perineal wash. There was a one-gallon jug of clear liquid inside that had a label that showed it was a hand and surface sanitizer solution. The label showed it was 80 percent alcohol. There were warnings listed on the label that showed to keep the product out of eyes, ears, and mouth. If the product was swallowed, the person was to get medical help or contact

a poison control center right away.

In an observation on 12/10/2024 at 11:25 AM, in Cottage C's unattended kitchenette area on the upper cabinets to the right of the sink, was a sign that was posted on the cabinet door that showed "cabinets are to be kept locked when staff is not using them".

In an observation on 12/10/2024 at 11:27 AM, in Cottage C's unattended kitchenette area inside the lower unlocked cabinet doors that was to the left of the refrigerator, there was an open bottle of intensive skin therapy phosphocleanse no rinse foam cleanser. There was a 33.5 fluid ounce bottle full of blue liquid with a label that showed restoring anticavity fluoride mouthwash refreshing mint. On the back of the label showed to keep out of reach of children and if the liquid was swallowed, the person was to get medical attention or call poison control center right away.

In an observation on 12/10/2024 at 11:27 AM, in Cottage C's unattended kitchenette area under the island countertop was a silver rolling rack cart. On the left side of the rolling rack hanging off the side was a white spray bottle with a label that showed it was "xpress" detergent disinfectant. The label showed "precautionary statements HAZARDS TO HUMANS AND DOMESTIC ANIMALS".

In an interview on 12/10/2024 at 11:28 AM, Staff C, Caregiver, said all resident shampoos, toothpastes, and body lotions were kept in individual shower caddies in the locked linen closet.

In an observation on 12/10/2024 at 11:36 AM, the Cottage B public bathroom located across from room B6 had an unlocked cabinet that contained a bottle of 28 fluid ounces of equate moisture rich shampoo.

In an interview on 12/10/2024 at 11:39 AM, Staff C stated all the cabinets in the kitchenette areas were to be kept locked if the kitchenette area was unattended by staff. At 11:42 AM, Staff C observed the white spray bottle of "xpress" that continued to hang on the silver rolling rack cart and stated the spray bottle was not to be stored there. Staff C left the spray bottle hanging on the silver rolling rack cart when they left the kitchenette area.

In an observation on 12/10/2024 at 11:54 AM, inside Cottage D's unattended kitchenette area under the counter to the right of the sink, all the drawers were unlocked. Inside the top drawer was a red eight fluid ounce bottle that had a label that showed it was candy apple fine fragrance mist. The labeled showed the bottle had multiple ingredients that included alcohol dent (an undrinkable poisonous grain alcohol) and ethylhexyl (a clear colorless chemical that is often found in plastic). Inside the second unlocked drawer there was a seven fluid ounce bottle of williams lectic shave electric razor pre-shave liquid. There was still no staff present in the area of the kitchenette, or the dining room observed.

Statement of Deficiencies	License #: 2443	Compliance Determination # 61532
Plan of Correction	The Cottages at Lacey	Completion Date
Page 11 of 17	Licensee: Lacey Special Care Community LLC	12/17/2024

In an interview on 12/10/2024 at 11:59 AM, Staff F, Caregiver, stated all the drawers and cabinets in the kitchenette areas were to be kept locked at all times when the area was unattended by staff.

In an interview on 12/10/2024 at 2:31 PM, Staff A, Executive Director, acknowledged multiple areas within the facility had unsecured chemicals.

This is an uncorrected and recurring deficiency previously cited on 10/14/2024 and 01/18/2024.

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>1/3/2025</u> _____ Date

WAC 358-72A-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure facility staff had the required nurse delegation training and credentials for 2 of 3 staff (Staff I and Staff J) reviewed. The facility also failed to maintain and provide current nurse delegation documents for 3 of 3 residents (Resident 3 [R3], Resident 4 [R4], and Resident 5 [R5]). These failures resulted in 3 residents receiving medications from unqualified caregivers and placed them at risk for unmet medical care needs.

Findings included...

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

In an interview on 12/10/2024 at 11:59 AM, Staff F, Caregiver, stated all the drawers and cabinets in the kitchenette areas were to be kept locked at all times when the area was unattended by staff.

In an interview on 12/10/2024 at 2:31 PM, Staff A, Executive Director, acknowledged multiple areas within the facility had unsecured chemicals.

This is an uncorrected and recurring deficiency previously cited on 10/14/2024 and 01/18/2024.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure facility staff had the required nurse delegation training and credentials for 2 of 3 staff (Staff I and Staff J) reviewed. The facility also failed to maintain and provide current nurse delegation documents for 3 of 3 residents (Resident 3[R3], Resident 4 [R4], and Resident 5 [R5]). These failures resulted in 3 residents receiving medications from unqualified caregivers and placed them at risk for unmet medical care needs.

Findings included...

Washington Administrative Code (WAC) 246-840-930

"Criteria for delegation.

ASSESS

(8) Verify that the nursing assistant or home care aide:

- (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;
- (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task;
- (c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training;
- (d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and
- (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.

(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

PLAN

(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:

- (a) The rationale for delegating the nursing task;
- (b) The delegated nursing task is specific to one patient and is not transferable to another patient;
- (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;
- (d) The nature of the condition requiring treatment and purpose of the delegated nursing task;
- (e) A clear description of the procedure or steps to follow to perform the task;
- (f) The predictable outcomes of the nursing task and how to effectively deal with them;
- (g) The risks of the treatment;
- (h) The interactions of prescribed medications;
- (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
- (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
 - (i) How to notify the registered nurse delegator of the change;
 - (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and
 - (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
- (k) How to document the task in the patient's record;
- (l) Document teaching done and a return demonstration, or other method for verification of competency; and
- (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent.

IMPLEMENT

(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.

(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).

EVALUATE

(16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.

(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

(18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.

(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

Record review of the facility untitled, and undated document, showed it was the plan of correction from deficiencies dated 10/14/2024. The Registered Nurse (RN) would review the resident characteristic roster quarterly to ensure delegation was adequate. An audit of the medication technician's employee files were to be completed to ensure compliance with delegation requirements were met. Review of the nurse delegation requirement was completed by the facility licensed nurse to ensure delegation needs were communicated to the RN appropriately.

Record review of the facility's policy titled, "Nurse Delegation", undated, showed the licensed Registered Nurse (RN) would become familiar with specific facility policies, procedures, and available supplies, staff, rules, and regulations governing delegation and nursing care in assisted living. The RN would assess the nursing care needs of the residents. The nursing assistants may be delegated to perform nursing care services beyond their usual and customary roles under the direction and supervision of licensed nurses.

Record review of the "Department of Social And Health Services" document, Completion date 10/14/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2320] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 10/29/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 11/27/2024."

Record review of the Washington State Department of Social and Health Services document, titled, "Community nurse delegation orientation 2024", undated, showed all long-term care workers must have either an active home care aide certified, active nursing assistance certified, or an active nursing assistant registered within Washington state Department of Health. All long-term care workers must have an active credential with the Washington state Department of Health to be delegated. Evaluations occur ongoing for all the resident and nursing visit must be completed at least every 90 days that include the assessment, evaluation, and the competency that would be documented. All the RN delegation forms must be left where the resident resides for compliance with the facility and rules.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed there were five residents documented they had nurse delegation nursing services.

Staff Records

Record review on 12/10/2024 at 11:05 AM, in the nurse delegation staff credential binder showed that Staff J, Activities Director, had a nursing assistant certificate license that had expired on 12/06/2024.

Record review of the Washington state Department of Health Credential Verification website on 12/10/2024 at 11:10 AM, showed Staff J's nursing assistant certification was expired.

Record review on 12/10/2024 at 11:05 AM, in the nurse delegation staff credential binder showed Staff I, Caregiver, did not have any credential license for review.

Record review of the Nurse Delegation Credentials and Training Verification, dated 10/22/2024, showed Staff I had a home care aide license that expired on 08/01/2024.

Record review of the Washington State Department of Health Credential Verification website on 12/10/2024 at 11:10 AM, showed Staff I's nursing assistance certification was expired. Staff I had a nursing assistant registration licensed that was also expired for review.

Resident Records

R3

Record review of R3's Move In Record, dated 09/30/2024, showed R3 moved into the facility on [REDACTED] 2018 with multiple medical diagnoses that included [REDACTED]

Record review on 12/10/2024 at 1:30 PM, of the nurse delegation binder showed R3 was RN delegated for oral medications and topical medication and treatment tasks.

Review of R3's Nurse Delegation Nursing: Visit document, dated 02/26/2024, showed that was the most recent RN visit form available in the binder for review. The document did not list Staff I or Staff J as qualified and delegated long term care worker to administer R3's delegated tasks.

Record review of R3's Medication Administration Record (MAR), dated 11/01/2024 through 11/30/2024, showed Staff I administered R3's medication in the evening on 11/27/2024 and 11/28/2024 with expired credentials after the facility alleged back in compliance of the regulation on 11/27/2024.

Record review of R3's MAR, dated 12/01/2024 through 12/31/2024, showed Staff J had administered R3's delegated medication tasks in the evening on 12/09/2024 with expired credentials.

R4

Record review of R4's Move In Record, dated 09/30/2024, showed R4 moved into the facility on [REDACTED] 2022 with multiple medical diagnoses that included [REDACTED]

Record review on 12/10/2024 at 1:30 PM, the nurse delegation binder showed R4 was delegated for oral medication and topical medications and treatments.

Record review of R4's Nurse Delegation: Nursing Visit document, dated 04/21/2024, showed that was the most recent RN visit form available in the binder for review. The document did not list Staff I or Staff J as qualified and delegated long term care worker to administer R4's delegated tasks.

Record review of R4's MAR, dated 11/01/2024 through 11/30/2024, showed Staff I administered R4's medication in the evening on 11/27/2024 and 11/28/2024 with expired credentials after the facility alleged back in compliance of the regulation on 11/27/2024.

Record review of R4's MAR, dated 12/01/2024 through 12/31/2024, showed Staff J had administered R4's delegated medication tasks in the evening on 12/09/2024 with expired credentials.

R5

Record review of R5's Move In Record, dated 09/30/2024, showed R5 moved into the facility on [REDACTED]/2019 with multiple medical diagnoses that included [REDACTED].

Record review on 12/10/2024 at 1:30 PM, the nurse delegation binder showed R5 was delegated for oral medication and topical medications and treatments.

Record review of R5's Nurse Delegation: Nursing Visit document, dated 04/21/2024, showed that was the most recent RN visit form available in the binder for review. The document did not list Staff I or Staff J as qualified and delegated long term care worker to administer R5's delegated tasks.

Record review of R5's MAR, dated 11/01/2024 through 11/30/2024, showed Staff I administered R5's medication in the evening on 11/27/2024 and 11/28/2024 with expired credentials after the facility alleged back in compliance of the regulation on 11/27/2024.

Record review of R5's MAR, dated 12/01/2024 through 12/31/2024, showed Staff J had administered R5's delegated medication tasks in the evening on 12/09/2024 with expired credentials.

In an interview on 12/17/2024 at 1:19 PM, Staff K, Registered Nurse Delegator, stated they were at the facility every two weeks. Staff K stated they completed all of the residents nursing visit's electronically on their computer. Staff K stated they were unable to print the RN delegation forms and acknowledged the most updated documents were not at the facility in the RN delegation binder for review. Staff K was unaware that Staff I and Staff J were administering RN delegated tasks to RN delegated residents with expired credentials. Staff K stated they expected the administrative staff to ensure that all long-term care workers delegated to administered RN delegated tasks had active and updated credentials. Staff K stated they did not verify or review the delegated long term care workers credentials when they were in the facility every two weeks.

This is an uncorrected deficiency previously cited on 10/14/2024.

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

Statement of Deficiencies	License # 2443	Compliance Determination # 51532
Plan of Correction	The Cottages at Lacey	Completion Date
Page 17 of 17	Licensed: Lacey Special Care Community LLC	12/17/2024

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 1/31/2025

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



Administrator (or Representative)

1/3/2025

Date

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, The Cottages at Lacey 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



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

10/28/2024

Licensee: Lacey Special Care Community LLC
The Cottages at Lacey
8570 Martin Way E
Lacey, WA 98516

RE: The Cottages at Lacey License # 2443

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 10/14/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
 - o Mail the Plan/Attestation Statement and report with original signatures to:

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

Lacey Special Care Community LLC
The Cottages at Lacey #2443
10/14/2024
Page 2 of 55

Cory Cisneros, Field Manager
Residential Care Services
Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
 - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

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



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2443	Compliance Determination #47738
Plan of Correction	The Cottages at Lacey	Completion Date
Page 3 of 55	Licensee: Lacey Special Care Community LLC	10/14/2024

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 the unannounced on-site full inspection and complaint investigation on 09/25/2024 and 09/27/2024 of:

The Cottages at Lacey
8570 Martin Way E
Lacey, WA 98516

This document references the following complaint numbers: 146541.

The following sample was selected for review during the unannounced on-site visit: 7 of 53 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensors
Emily Boniface, Community Program Nurse Licensors
Celeste Vashey, ALF LTC Licensors

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros

Residential Care Services

10/28/2024

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.

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2610 Infection control.

- (1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.
- (2) The assisted living facility must:
- (c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;
- (d) Provide all resident care and services according to current acceptable standards for infection control;
- (e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the facility staff members washed their hands per the acceptable standards for 2 of 3 staff members (Staff L, Staff N) reviewed. The facility failed to ensure infection control supplies were available for 2 of 4 utility rooms reviewed (Cottage D and Cottage C Utility Rooms). The facility failed to ensure 2 of 3 laundry rooms (Cottage B and Cottage D Laundry room) had appropriate infection control for soiled linens. These failures resulted in staff not having necessary infection control supplies and placed 53 of 53 residents and 37 staff at risk of contracting and spreading communicable diseases.

Findings included...

Record review of the facility's policy titled, "Infection Control", revised 02/01/2015, showed hand washing was the single most important measure to prevent the spread of infection and disease. All staff were responsible to carry out the hand washing policy. Staff were to wash hands after handling soiled laundry or items with body fluids and housekeeping tasks, before and after helping a resident with personal care tasks of daily living, before handling food, and whenever they changed from doing a dirty task to a clean task. The use of gloves did not replace hand hygiene.

Record review of the facility's policy titled, "infection Control Hand Washing", revise date 02/01/2015, showed handwashing was the single most important measure for preventing the spread of infection and disease. All staff would be responsible for carrying out the hand washing policy. Staff would wash their hands after handling soiled laundry or items with body fluids and housekeeping tasks, when there was a change from doing a "dirty" task to a "clean" task, and whenever hands were obviously soiled. The use of gloves do not replace hand hygiene. Under the section titled, "washing procedure", showed staff were to use cool or lukewarm water, once hand were completely wet, they were to apply soap. Staff were to bring hands together to form a

heavy lather, rinse with water, dry hands with paper towels, and then turn the water off with a paper towel and discard.

Record review of the facility's policy titled, "Infection Control Policies and Procedures", revised 02/01/2015, under the laundry and handling of soiled and clean linens section showed contaminated laundry should be handled as little as possible. The contaminated item should be placed in a leak proof container and clearly labeled or put in red plastic bag and taken directly to the laundry in covered carts or baskets. Protective gloves and other personal protective equipment needed would be worn by the employees in order to maintain a barrier when handling the contaminated laundry. Under the section F titled, "hand washing", showed staff were to wash their hands a minimum of one minute. Hand washing was to be performed between client contact, removing gloves, and before and after returning from breaks or use of the toilet. Hand washing facilities with hot water, soap, and single use towels were available wherever client contact occurred that included but not limited to kitchen, public restrooms, medication room, and resident apartments. Under the section O, titled, "waterless cleaner", showed the facility policy was to not replace the use of soap and water with waterless cleaners. It was recognized that there were times when soap and water would not be available and the cleansing of hands was appropriate with waterless cleaner.

Record review of the Centers for Disease Control (CDC) article titled, "G. Laundry and Bedding Guidelines for Environmental Infection Control in Health-Care Facilities", dated 01/08/2024, showed laundry in a health-care facility may include personal clothing, patient apparel, and more. Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids. Disease transmission attributed to health-care laundry has involved contaminated fabrics that were handled inappropriately. Occupational Safety Health Administration that defines contaminated laundry as "laundry which has been soiled with blood or other potentially infectious materials or may contain sharps". The laundry process starts with the removal of used or contaminated textiles, fabrics, and/or clothing from the areas where such contamination occurred. Contaminated textiles and fabrics were to be placed into bags or other appropriate containment. The bags were then securely tied or otherwise closed to prevent leakage. Contaminated textiles and fabrics in bags would be transported or stored in carts.

Hand Hygiene/Utility Room Supplies

In an observation on 09/25/2024 at 12:25 PM, in Cottage D's soiled utility room, at the handwashing sink there were no paper towels or single use towels available for use. There were no hand sanitizer dispensing machines in the utility room observed.

In an observation on 09/25/2024 at 12:45 PM, inside Cottage C's soiled utility room, at the handwashing sink there were no paper towels or single use towels available for use. There were no hand sanitizer dispensing machines in the utility room observed.

Cottage C

In an observation on 09/27/2024 at 10:53 AM, Staff L, Caregiver entered the bathroom in Cottage C located across from room C06 with Resident 16 [R16]. When Staff L exited the bathroom, they had gloves on. Staff L had been observed to open the door handle with their gloved hand and hold open the door for R16 with another gloved hand. Staff L

had carried a clear plastic bag with them and went towards the back of the hallway. Staff L had taken off their gloves when they walked through the hallway. Staff L had been observed to retrieve a key out of their pocket and opened the Cottage C soiled utility room. Staff L had gone into the room and when they returned to the hallway, they no longer had the clear plastic bag with them. Staff L then went into the kitchenette area and performed hand hygiene.

Cottage B

In an observation on 09/27/2024 at 11:56 AM, Staff N, Caregiver, was wearing gloves. Staff N then touched Resident 17 [R17]'s shirt on their chest and their wheelchair handlebars. Staff N took off the gloves they wore. At 12:04 PM, Staff N did not perform hand hygiene before they put on another pair of gloves. Staff N then passed out napkins and silverware to Cottage B residents. At 12:09 PM, Staff N then began to serve drinks to Cottage B residents. At 12:14 PM, Staff N started the process of serving Cottage B residents their lunch. At 12:16 PM, Staff N took off their gloves. At 12:17 PM Staff N opened the door and physically left the building. Staff N returned to the kitchenette area, and opened the refrigerator door. Without performing hand hygiene Staff N then put on a new pair of gloves and opened the cart to where the food was stored and took a resident their food. Staff N then went and got a resident a drink and brought it to them. At 12:20 PM, Staff N started to assist Resident 13 [R13] in Cottage B eat their meal. Staff N touched R13's wheelchair handlebars. Staff N then picked up silverware and started to help R13 eat their meal.

In an interview on 09/25/2024 at 2:27 PM, Staff I, Cook, said the facility staff members were to perform hand hygiene when they started different tasks. Staff I said if facility staff used gloves, they were supposed to perform hand hygiene before they donned (put on) the gloves and when they doffed (took off) the gloves.

Laundry Rooms

In an observation on 09/25/2024 at 12:17 PM, inside the laundry room in Cottage B, on the ground in front of the washing machine there was soiled resident blue pants and white and gray socks that were unbagged on the ground.

In an observation on 09/25/2024 at 12:34 PM, inside the laundry room in Cottage D, on the ground in front of the washing machine was a bag of soiled resident's clothing that was bagged and untied that sat on the ground. There was a pink, peach, and purple colored shirt that was sitting unbagged on the ground in front of the washing machine and next to the open and untied bagged soiled linens.

This is a recurring deficiency previously cited on 04/05/2024, 01/18/2024, 06/22/2023 and 03/27/2023 for subsections (1)(2)(c)(e).

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

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure medications were stored properly and secured for 1 of 7 sampled resident's (Resident 3[R3]) room. This failure placed 53 of 53 memory care assisted living residents at risk to ingest non prescribed medications in error.

Findings included...

Record review of the facility's policy titled, "Security and Storage of Medications", undated, showed it was the facility policy to ensure that all medications were stored in such a way that promoted safety, security, and proper environment. The facility policy referenced WAC 388 78A 2260. The procedure section showed all medications should be stored in locked cabinets or rooms and should only be accessible to the authorized resident and personnel.

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed 51 of 53 residents were marked as having a diagnosis of [REDACTED]

or [REDACTED]

[REDACTED]. The characteristic roster showed 25 of 53 residents were marked as being exit seekers or wanderers.

Record review of R3's, "Resident Information", dated 09/25/2024, showed R3 moved into the facility on [REDACTED]/2024. R3 had diagnoses of [REDACTED] and [REDACTED].

Record review of R3's, untitled document, date initiated 08/13/2024, that the facility had provided was R3's negotiated service agreement, showed under the medication section that the facility staff were to order and maintain all of R3's medications and treatments per their physician orders.

In an observation on 09/26/2024 at 10:34 AM, R3's bedroom door had been unlocked and R3 had not been observed to be inside their room. On top of R3's dresser showed a bottle of Bayer genuine aspirin (a medication that can treat pain, fever, and inflammation) 325 mg (milligrams) and a bottle of Tylenol rapid release (a medication that can treat minor aches, pains, and can reduce fever) 500 mg 24 tablets.

Record review of R3's, untitled document, dated 09/01/2024 – 09/25/2024, that the facility had provided was R3's Medication Administration Record, showed there were no physician orders for R3 to receive 325 mg of aspirin or 500 mg of Tylenol.

In an interview and observation on 09/26/2024 at 11:02 AM, Staff C, Caregiver, said the facility provided R3 their medications. Staff C said R3 did not have medications they took on their own. Staff C confirmed on top of R3's dresser were two bottles of Aspirin and Tylenol. Staff C said to follow up with Staff A, Executive Director or Staff B, Director of Nursing. Staff C exited the room without retrieving R3's unsecured medications.

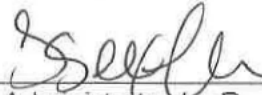
In an interview on 09/26/2024 at 11:28 AM, Staff A confirmed the facility staff provided R3 their medications. Staff A had been unaware R3 had aspirin and Tylenol inside of their room.

In an interview on 09/27/2024 at 10:34 AM, Staff L, Caregiver confirmed that the facility staff provided R3 with their medications.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure the facility's hot water temperature had been maintained between 105 and 120 degrees Fahrenheit (F). This failure placed 53 of 53 residents and 37 staff at risk for potential skin burns.

Findings included...

Record review of the facility provided document titled, "Monthly Water Temperature Logs", dated "August 2024", showed the required water temperature range according to state regulation was 105-120 degrees.

In an observation and interview on 09/25/2024 at 12:49 PM, the bathroom in cottage C located across from room C12 showed the water temperature was 121.9 degrees. Staff B, Director of Nursing had been unaware of what the water temperature guidelines should be. After staff B had been educated on the water temperature guidelines, they acknowledged the bathroom temperature had a reading over 120 degrees.

In an observation on 09/26/2024 at 10:34 AM, the bathroom in cottage C located across from room C12 showed the water temperature reached 121.9 degrees.

In an observation on 09/26/2024 at 12:23 PM, the bathroom in cottage C located across from room C12 showed the water temperature was 120.4 degrees.

In an interview on 09/26/2024 at 12:36 PM, Staff A, Executive Director, acknowledged that the bathroom in cottage C located across from room C12 hot water temperature had exceeded 120 degrees. Staff A stated that Staff G, Maintenance Director, would be present at the facility tomorrow 09/27/2024 to discuss the water temperature guidelines further.

In an interview on 09/27/2024 at 10:18 AM, Staff G said they turned down the water heaters in the cottages. Staff G said all the water heaters were set to 125 degrees. Staff G said when they were hired the person who trained them informed them the water temperatures were supposed to be set between 120-125 degrees. Staff G said they documented their monthly water temperature checks.

Record review of an email sent to the Department on 10/01/2024 at 10:34 AM, showed that Staff A said the facility did not have a water temperature policy to review.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident records for 2 of 3 resident cottages medication carts (Cottage B and Cottage C). This failure placed 53 of 53 residents at risk for exposure of confidential records.

Findings included...

Record review of the Centers of Disease Control (CDC) document, titled "Health Insurance Portability and Accountability Act of 1996 (HIPAA)", dated 09/10/2024, showed "The Health Insurance Portability and Accountability Act (HIPAA) of 1996 establishes federal standards protecting sensitive health information from disclosure without patient's consent. The US Department of Health and Human Services issued the HIPAA Privacy Rule to implement HIPAA requirements. The HIPAA Security Rule protects specific information cover the Privacy Rule."

Record review of the facility's policy titled, "Confidentiality of Resident Records", dated 04/01/2020, showed it was the policy for the facility to hold all resident information in the strictest confidence and make such information accessible only to authorized staff, the resident, authorized authorities and individuals with resident's approval in accordance with applicable state and federal law. All resident's medical records were to be kept in a secure location and/or electronic medical record system and shall only be accessible to authorized staff members.

In an observation on 09/25/2024 at 12:06 PM, in Cottage B on the unattended medication cart on the side sitting on top of the plastic sharps container, were four empty bubble packs that had prescription labels. The four bubble package prescription labels were facing upward and easily to review, read, and displayed the residents first name, last name, and their medication name. Review of two of the prescription's labels, showed it was for Resident 11 (R11) for their divalproex (prescribed medication to help treat seizures or a mental health disorder to help stabilize mood) medication. There was a prescription bubble package with a prescription label for Resident 12 (R12) for their medication acetaminophen (medication to help relieve pain, fever, and discomfort). The other prescription bubble package with a prescription label for Resident 13 (R13) for their medication lacosamide (prescribed medication to help treat seizures a condition when the body involuntary and uncontrollably jerks).

In an observation on 09/25/2024 at 12:42 PM, in Cottage C on the side of the medication cart, on top of the plastic sharp container's, were three empty bubble cardboard package that had a prescription label on the top of the package that were faced upwards, that displayed three residents first and last name and the name of the medication the package was for. One of the bubble package prescription labels showed it was for Resident 8 with their medication trazadone (prescribed medication to help treat sad moods or inability to sleep) listed. One of the bubble package prescription

labels showed Resident 9's name with their medication lisinopril (prescribed medication to help treat high blood pressure or heart failure conditions) listed. The bubble package with prescription label that showed Resident 10's name and their medication alendronate (prescribed medication to help treat or prevent bone loss or bone thinning).

In an observation on 09/25/2024 at 2:42 PM, in Cottage B on the unattended medication cart on the side sitting on top of the plastic sharps container, remained the four empty bubble packs that had prescription labels and names showed upward for R11, R12, R13 as previously seen prior that day.

In an observation on 09/26/2024 at 10:33 AM, in Cottage B, R11's two empty bubble packages with the prescription labels for divalproex, R12's empty bubble packages with the prescription labels for acetaminophen, and R13's empty bubble packages with the prescription labels for lacosamide remained on top of the plastic sharps container facing upward to review.

In an observation on 09/26/2024 at 10:45 AM, an untitled and undated document, showed the first and last names of 17 resident names, posted to the wall above the medication cart near the entryway and visible to other residents and visitors in the Birch Cottage. In an interview on 09/26/2024 at 4:18 PM, Staff H, Registered Nurse Delegator, stated all the empty bubble package that had prescription labels with resident's name and medication listed were to be shredded and kept confidential per HIPPA.

In an interview on 09/27/2024 at 2:29 PM, Staff K, Medication Technician, stated they were to keep the prescription labels that had the residents first and last name and their medication that were attached to the empty medication bubble packages, in the top drawer locked up, of the medications cart until the medication technician was able to dispose them into the shredding box.

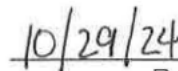
Plan/Attestation Statement

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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



Administrator (or Representative)



Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure all staff received their food handlers training for 2 of 7 sampled staff (Staff A and Staff D) reviewed. The facility failed to follow and implement safe storing practice for 1 of 1 kitchen reviewed. These failures placed 53 of 53 residents at risk for receiving food handled by unqualified staff and receiving ice that was at risk for exposure to contamination.

Findings included...

WAC 246-217-015 (1)

"(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

WAC 246-217-025 (1)(8)(9)

"(1) In order to qualify for issuance of an initial or renewal food worker card, an applicant must demonstrate his/her knowledge of safe food handling practices by satisfactorily completing an examination conducted by the local health officer or designee.

(8) Copies of food worker cards for all employed food service workers must be kept on file by the employer or kept by the employee on his or her person and open for inspection at all times by authorized public health officials."

WAC 246-217-035 (1) (5)(c)

"(1) All initial cards are valid for two years from the date of issuance.

(5) The card shall be approximately three inches by five inches in size and contain the following information: (c) Printed (or typed written) name and signature of the food service worker

WAC 246-215-04605

"Objective—Equipment food-contact surfaces and utensils (FDA Food Code 4-602.11). (1) EQUIPMENT, FOOD-CONTACT SURFACES, and UTENSILS must be cleaned: (5) Except when dry cleaning methods are used as specified under WAC 246-215-04620, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD must be cleaned: (a) At any time when contamination might have occurred; (d) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (i) At a frequency specified by the manufacturer; or (ii) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold."

Food Handlers Cards

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed

Statement of Deficiencies	License # 2443	Compliance Determination # 47738
Plan of Correction	The Cottages at Lacey	Completion Date
Page 13 of 55	Licensee: Lacey Special Care Community LLC	10/14/2024

Staff A, Executive Director, was hired on 08/16/2021.

Record review of Staff A's, Washington State Food Worker Card, dated 07/08/2022 - 07/09/2024, showed it was expired.

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff D, Caregiver was hired on 08/12/2024.

There was no Washington State Food Worker Card provided for Staff D to review.

On 09/27/2024 at 10:27 AM, the Department requested Staff D and Staff A's Washington state food worker cards for review.

In an interview on 09/25/2024 at 12:56 PM, Staff B, Director of Nursing, stated that caregivers and medication technicians served food to residents.

In an interview on 09/27/2024 at 11:45 AM, Staff A stated the facility did not have any other Washington stated food worker cards for Staff A and Staff D dated prior to 09/27/2024 for review.

In an interview on 09/26/2024 at 2:16 PM, Staff A said Staff J, Business Office Manager, had been responsible for the upkeep of the facility staff files which included food handler's cards.

In an interview on 09/27/2024 at 11:46 AM, Staff J said they had been responsible for facility staff's completed onboarding paperwork when they were hired. Staff J said Staff A had an excel spread sheet of the facility staff's food handler's cards to keep track of when they would be expired. Staff J said Staff A notified them when the food handlers cards needed to re-done.

In an observation on 09/25/2024 at 2:20 PM, in the facility kitchen there was a large ice making machine. Inside the top door in the back of the ice machine was a white plastic splash plate that had black and brown speckled substance across the lip and the corners of the white plastic splash plate. Below the white plastic splash plate was a mound of formed ice.

In an interview on 09/25/2024 at 2:27 PM, Staff I, Cook said the ice machine was cleaned every six months by an outside company who came and serviced the machine. Staff I could not remember the date of when the ice machine was last serviced. Staff I said they thought the ice machine had been cleaned recently. Staff I said maybe Staff J, Business Office Manager, kept track of the invoice for review. Staff I said the kitchen staff did not have any specific cleaning guidelines or schedules of when they were supposed to clean specific areas within the kitchen. Staff I said if the kitchen staff noticed something needed to be cleaned, they would clean it.

In an interview and observation on 09/25/2024 at 2:52 PM, Staff I looked inside of the ice machine. Without performing hand hygiene Staff I reached inside of the machine and wiped the black speckled substance. As Staff I wiped the black substance it came off. Staff I said the facility kitchen staff would wipe the ice machine in between the scheduled cleaning services. Staff I acknowledged the facility kitchen staff needed to clean the ice machine.

In an interview on 09/25/2024 at 2:53 PM, Staff J stated they were unsure when the ice machine had been last serviced.

In an interview on 09/27/2024 at 2:47 PM, Staff A, Executive Director, acknowledged that during the annual full inspection the kitchen's ice machine had been observed to have a black substance inside of it. Staff A acknowledged the kitchen staff did not have a system in place of when they were supposed to clean the ice machine other than when the ice machine was serviced every six months.

Plan/Attestation Statement

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to obtain prescribed medications in a correct and timely manner for 2 of 7 sampled residents (Resident 6 [R6] and Resident 7 [R7]). This failure placed R6 and R7 at risk of untreated medical conditions due to medications not being given as prescribed.

Findings included...

On 09/25/2024 at 11:30 AM, the department requested resident records for the sample, including records for R6 and R7. Requested records included resident assessments, negotiated service agreements, progress notes medication administration record, physician notifications and fax transmittals, and incident reports.

Review of the facility policy, "Medication Unavailable," with last review date 06/22/2021 (otherwise undated), detailed the facility policy and procedure for staff to order/reorder medications for residents receiving medication services. The policy stated, "In the instance where a medication is not available, facility staff will work with resident/responsible party, pharmacy, and physician to obtain medications." The procedure stated "If medications are determined to be unavailable, facility staff will work to determine cause for unavailability (waiting on new physician prescription,

resident needs to be seen by provider, deliver pharmacy, delivery from family, etc.) and take steps in attempt to obtain needed medications including repeated contact with physician/pharmacy. Unavailability of medication and efforts made to obtain medication will be documented in resident record, and resident/responsible part and physician will be notified. Dispensing pharmacy will be contacted 5-7 days prior to last dose for ongoing routine and PRN medications (due to insurance reimbursement requirements, medications cannot be ordered too early, or the insurance will not cover the cost of the medications). Residents will be monitored for ill effects of missed medication doses and appropriate action taken as needed."

In an observation on 09/25/2024 at 10:38 AM, an undated document titled, "Medication Ordering," was posted in Cottage B above the medication cart with instructions for ordering resident medications. The document showed, "Medication Ordering: For New Patients "Send new orders and face sheet with billing information to the pharmacy. New Orders: Please send the original physicians order as soon as it is written. First doses may be available from the Ekit or RxNow cabinet but require a call to the pharmacy for controlled substances. Refills, please order refills according to the refill after date on the label. Refill orders received before 1200PM will be deliver the next pharmacy business day. Emergency or STAT orders Please call and fax any STAT orders directly to the pharmacy Please call the pharmacy for any emergency requests outside of scheduled deliveries. Control Drug Orders Control drug orders can only be delivered upon receipt of a valid script from the prescriber."

R7

Review of R7's progress notes, dated 06/20/2024 through 09/23/2024, showed that R7 admitted to the facility on [REDACTED] 2024 with a diagnosis of [REDACTED].

Review of R7's Service Agreement, dated 06/19/2024, showed medication assistance as a service area and showed the "Resident Specific Details" as " Staff to order all medicine. Staff to also ensure that [R7] is receiving the right medication at the right dosage, via the right route at the right time to maintain therapeutic levels. Staff to notify DNS [Director of Nursing Services] if [R7] is refusing to take medications."

Review of R7's MAR from 06/20/2024 through 09/23/2024, showed an order for Pantoprazole (a medication used to reduce stomach acid and protect the stomach lining) with a start date of 06/21/2024. Instructions read "Give 1 tablet orally in the morning for acid reflux." The MAR showed 16 missed doses for the following dates: 07/20/2024 through 07/24/2024, 08/04/2024, 08/11/2024, 08/23/2024, 08/26/2024, and 09/03/2024 through 09/09/2024. For 07/28/2024, the record showed a blank (no documentation nor initial from staff to show acknowledgement of the medication for that shift). All other dates showed a NA, indicating "Medication Not Available," as it listed in the Staff Administration Legend on the MAR.

Review of R7's alert charting, dated 06/20/2024 through 09/26/2024, showed the following note entries regarding Pantoprazole:

Review of R7's alert charting, notes dated 07/21/2024, 08/04/2024, 09/07/2024,

09/08/2024, showed "med na on order."

Review of R7's alert charting, notes dated 07/22/2024, 07/23/2024, 07/24/2024, 09/05/2024, and 09/09/2024 showed "Medication not on cart."

Review of R7's alert charting from 08/23/2024 showed "Medication not on cart, reorder coming per [Pharmerica Staff]. New script requested by pharmacy."

Review of R7's alert charting from 08/26/2024 showed "Called Pharmerica today and spoke to [Pharmerica Staff] to inquire of status of reorder of Pantoprazole. They said that it was accidentally put on profile. They changed it in there system. It will be sent out on there next delivery run." Alert charting for 08/26/2024 reflected R7 refused lunch.

Review of R7's alert charting, note dated 09/03/2024, showed "Medication not available, waiting for pharmacy delivery."

Review of R7's alert charting, note dated 09/04/2024, showed "medications not here."

Review of R7's alert charting, an additional note from 09/09/2024 showed "Called Pharmerica and spoke to [Pharmerica Staff] to reorder Pantoprazole."

No other documentation was reflected in the documentation provided regarding Pantoprazole.

Review of R7's MAR, 06/20/2024 to 09/23/2024, showed an order for Quetiapine (a medication to help decrease agitation for individuals with dementia) with instructions to "Give 1 tablet orally one time a day related to Dementia..." Start date on the order showed 06/20/2024 at 1317 (1:17 PM).

Review of R7's MAR dated 06/20/2024 to 09/23/2024 showed R7 missed the scheduled dose of Quetiapine on the following 6 dates: 08/24/2024, 08/26/2024, 08/31/2024, 09/02/2024, 09/03/2024, and 09/08/2024.

On 08/24/2024, the 8PM dose showed a blank (no documentation nor initial from staff to show acknowledgement of the medication for that shift and did not indicate the medication was given).

On 08/26/2024, the MAR reflected RS meaning resident sleeping as the reason for the missed dose.

On 08/31/2024, 09/02/2024, and 09/03/2024, the MAR listed NA, meaning "Medication Not Available." On 09/08/2024, the MAR listed "O" meaning "Other."

Review of R7's alert charting, note dated 09/02/2024, showed "Medications not available, waiting for pharmacy delivery."

Review of R7's alert charting, note dated 09/08/2024, showed "Held, due to PRN given previously."

Record review of R7's progress notes, dated 08/24/2024-09/08/2024 showed no documentation of what steps the facility took to ensure R7's medication availability.

Review of R7's medication administration record (MAR), dated 06/20/2024 to 09/23/2024, alert charting date range 06/20/2024 to 09/26/2024, and service agreement dated 06/19/2024 showed no documentation of attempts to obtain the medication Quetiapine (a medication to help decrease agitation for individuals with dementia).

Review of R7's MAR, dated 06/20/2024 to 09/23/2024, showed an order for Amlodipine

Statement of Deficiencies	License # 2443	Compliance Determination # 47738
Plan of Correction	The Cottages at Lacey	Completion Date
Page 17 of 55	Licensee: Lacey Special Care Community LLC	10/14/2024

(a medication to treat heart conditions and lower high blood pressure) with instructions to "Give 1 tablet orally one time a day for Hypertension." Start date was 06/21/2024 at 8AM. The MAR reflected one missed dose on 08/31/2024. The MAR was blank (no documentation nor initial from staff to show acknowledgement of the medication for that shift and did not indicate the medication was given). There was no progress note regarding this missed medication.

Record review of R7's progress notes, dated 08/24/2024-09/08/2024 showed no documentation of what steps the facility took to ensure R7's medication availability.

Review of R7's medication administration record (MAR), dated 06/20/2024 to 09/23/2024, alert charting date range 06/20/2024 to 09/26/2024, and service agreement dated 06/19/2024 showed no documentation of attempts to obtain the medication Amlodipine (a medication to treat heart conditions and lower high blood pressure).

Review of R7's MAR, dated 06/20/2024 to 09/23/2024, showed an order for Cholestyramine (a medication used to lower cholesterol levels in the blood) with instructions to "Give 1 packet orally one time a day for high cholesterol." Order start date was 06/21/2024 at 8AM. The MAR reflected one missed dose on 08/30/2024 with a notation of NA meaning "Medication Not Available."

Review of R7's alert charting, dated 06/25/2024 to 09/26/2024, showed alert charting note "Medication not on cart," for 08/30/2024.

Record review of R7's progress notes, dated 08/24/2024-09/08/2024 showed no documentation of what steps the facility took to ensure R7's medication availability.

Review of R7's medication administration record (MAR), dated 06/20/2024 to 09/23/2024, alert charting date range 06/20/2024 to 09/26/2024, and service agreement dated 06/19/2024 showed no documentation of attempts to obtain the medication Cholestyramine (a medication used to lower cholesterol levels in the blood).

Review of R7's MAR, dated 06/20/2024 to 09/23/2024, showed an order for Cyclosporine (a medication used to decrease the body's immune response to eye cells and prevent inflammation) with instructions to "Instill 1 drop in both eyes two times a day for Eye drops." Medication start date was 06/20/2024 at 5PM. The MAR showed 3 missed doses due to non-availability of medication. The missed doses were on 07/02/2024, 8AM dose, on 08/31/2024 at 8AM, and 09/06/2024 at 5PM.

Review of R7's alert charting, dated 06/20/2024 to 09/26/2024, showed a note for 08/31/2024 at 10:34 AM "Medication drops not found on cart."

Record review of R7's progress notes, dated 08/24/2024-09/08/2024 showed no documentation of what steps the facility took to ensure R7's medication availability.

Record review of R7's progress notes, dated 08/24/2024-09/08/2024 showed no documentation of what steps the facility took to ensure R7's medication availability.

Review of R7's medication administration record (MAR), dated 06/20/2024 to 09/23/2024, alert charting date range 06/20/2024 to 09/26/2024, and service agreement dated 06/19/2024 showed no documentation of attempts to obtain the medication Cyclosporine (a medication used to decrease the body's immune response to eye cells and prevent inflammation).

R6

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R6 moved into the facility on [REDACTED]/2024.

Review of R6's Service Agreement, dated 09/23/2024, showed medication assistance as a service area added on 03/08/2024 and showed "Resident Specific Details: Staff to order all medicine. Staff to also ensure that [R6] is receiving the right medication at the right dosage, via the right route at the right time to maintain therapeutic levels. Staff to notify DNS if [R6] is refusing to take medications."

Review of R6's medication administration record (MAR), date range 03/01/2024 through 09/25/2024, showed orders for Abilify (a medication used to treat disordered thinking), and metoprolol (a medication used to treat high blood pressure). Review of the MAR legend showed NA meant medication was not available.

Record review of R6's MAR, dated 04/14/2024-09/03/2024, showed for medication Abilify (a medication used to treat disordered thinking), was documented was NA for 04/014/2024 through 04/17/2024, 09/02/2024 and 09/03/2024. The MAR showed the medication Metoprolol was documented as NA for 04/23/2024 AM and PM, 04/24/2024 AM and PM, 06/23/2024 AM, and 09/03/2024 AM.

Record review of R6's progress notes, dated 03/12/2024 through 09/23/2024, showed no notes documented between the dates of 03/12/2024 and 04/06/2024. No documentation for any of R6's missed medication was provided for review. There were no notes that indicated the reason for medication unavailability nor to show what was done by staff to obtain medication.

In an interview on 09/26/2024 at 10:48 AM, Staff B, Director of Nursing, said medication technicians were responsible for re-ordering medications and documenting those attempts in the resident chart.

In an interview on 09/27/2024 at 2:30 PM, Staff A, Executive Director, confirmed that it was the responsibility of the medication technician to monitor quantity and re-order medications for residents.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

(h) Provide staff orientation and appropriate training for expected duties, including:

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

(C) Cardiopulmonary resuscitation;

(D) First aid; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure all staff were properly trained on how to report allegations of abuse and neglect as a mandated reporter for 3 of 4 sampled Staff (Staff L, Staff J, and Staff N). The facility failed to ensure that 2 of 2 sampled staff (Staff M and Staff N) were educated on how to review residents negotiated service agreements (NSA). The facility failed to ensure 3 of 6

sampled staff (Staff A, Staff F, and Staff E) had the required CPR (cardiopulmonary resuscitation) and/or First Aide training. The facility failed to ensure at least one caregiver who had their CPR and First Aide training had been present to assist residents at all times in 2 of 2 cottages reviewed (Cottage B and Cottage C). The facility failed to ensure that 1 of 2 sampled staff (Staff E) completed their continued education units (CEU). These failures placed all 53 of 53 residents at risk of staff not identifying and reporting potential abuse and neglect to help protect the residents and placed all residents at risk of receiving care and services from untrained and unqualified staff.

Findings included...

Record review of the Department of Social and Health Services book, "Assisted Living Guidebook", dated February 2018, showed facilities were required to report 24 hours a day, seven days a week to the Department's CRU (Complaint Resolution Unit) hotline via phone or online for any reasonable cause to believe violations that possibly involved abuse, neglect, or misappropriation.

Record review of the facility's policy titled, "Abuse-Neglect-Exploitation", undated, showed it was the facility policy to recognize and protect residents against all abuse, neglect, and exploitation. The facility utilized the information in the Assisted Living Facility Guidebook by Washington State Department of Social and Health Services as a guideline for identifying, defining, and reporting any possible instances of abuse, neglect, or exploitation. All facility staff were considered to be a mandatory reporter. Under staff responsibilities section showed it was the responsibility of each staff member to immediately contact the hotline directly regarding suspected or alleged abuse, neglect, or exploitation.

Record review of the facility's policy titled, "Negotiated Service Agreements", undated, showed each NSA would be based on the assessed needs and wishes of each resident. The initial NSA would provide direction to the facility staff on the resident's capabilities, needs, and preferences. Each NSA would be reviewed and updated as necessary with ongoing and change of condition assessments or when the NSA no longer met the needs and desires of the resident.

Record review of the provider letter sent by the Department, dated 09/22/2022 amended date 10/07/2022, showed CPR and first aid training no longer had emergency rules in place. All facilities were to be back in compliance by 10/27/2022.

WAC 388-112A-0720 (2)(a)(b)

"(2) Assisted living facilities. (a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire. (b) Licensed nurses working in assisted living facility must have and maintain a valid CPR card or certificate within thirty days of their date of hire."

WAC 388-112A-0611 "Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year: (i) A certified home care aide; (ii) A long-term care worker who is exempt from the 70-hour home care aide basic

training under WAC 388-112A-0090 (1) and (2); (iii) A certified nursing assistant"

WAC 388-110-220 "Enhanced adult residential care service standards. (3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must: (d) Ensure that each staff who works directly with residents has at least six hours of continuing education per year related to dementia, including Alzheimer's disease. This six hours of continuing education may be part of the ten hours of continuing education required by WAC 388-112[A]..."

Abuse and neglect

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff L, Caregiver, was hired on 05/18/2021.

In an interview on 09/27/2024 10:34 AM, Staff L said they had worked for the facility for around four years. Staff L said if they were concerned a resident had been abused or neglected, they would report it to their supervisor. Staff L said if needed they would contact 911.

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff N, Caregiver was hired at the facility on 07/13/2023.

In an interview on 09/27/2024 at 11:29 AM, Staff N stated they were unaware what a mandated reporter was. Staff N stated they would "report anything from A to Z to their med tech [Medication Technician], unless it was an emergency then report to 911", when Staff N was asked when they were to report to the state hotline number. Staff N stated the med tech was responsible to make the reports. Staff N was unable to provide examples of abuse and neglect incidents that would be required to be reported to the Department.

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff J, Business Office Manager, was hired on 12/12/2022.

In an interview on 09/27/2024 at 11:46 AM, Staff J said if they had been concerned a resident had been abused or neglected, they would report it to Staff A, Executive Director. Staff J said if they needed to report the concern to anyone else, they would report it to Staff B, Director of Nursing. Staff A said if all else failed they would report it to the corporate regional representative as a last resort.

NSA's Education of Facility Staff

Record review of Resident 5's (R5) Move In Record, dated 09/25/2024, showed R5 moved into the facility on [REDACTED] /2023, with multiple medical diagnoses that included [REDACTED]

and [REDACTED]

Record review of R5's untitled, and undated document that was provided as R5's

service plan, under the section titled, "falls", showed R5 was to use a personal alarm to alert staff when trying to transfer without assistance. Staff were to ensure the alarm was on and working each shift. The staff were to notify the licensed nurse if the alarm was not working properly. The alarm was recently added to R5's service plan on 08/26/2024.

In an interview on 09/27/2024 at 11:29 AM, Staff N, Caregiver, stated R5 did not use an alarm on their wheelchair or when they were in bed. Staff N stated they worked as needed. Staff N stated they were to check the residents service plans all the time for any updates to the resident's care needs.

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff M, Caregiver, was hired on 01/23/2023.

In an interview on 09/27/2024 at 1:26 PM, Staff M stated R5 did not use an alarm when they were up or in bed. Staff M stated they were to check the residents service plans every day for any changes to the resident's care needs.

CPR & First Aid

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff A was hired on 08/16/2021.

Record review of Staff A's American Red Cross Certificate of completion adult, child, and baby first aid/CPR/AED, dated 01/20/2022, showed it expired on 01/20/2024.

Record review of the facility provided document, untitled and undated document, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff F, Medication Technician, was hired on 01/13/2022.

Record review of the facility provided document titled, "NationalCPRFoundation", dated 09/20/2022, showed Staff F's CPR card expired on 09/20/2024.

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff E, Caregiver, was hired on 06/13/2022

Record review of the facility provided document titled, "Heartsaver First Aid CPR AID", dated 08/10/2022, showed Staff E's First Aid and CPR card was expired and was to be renewed "08/2024".

In an interview on 09/26/2024 at 2:16 PM, Staff A, said Staff E had been in school and they were scheduled to complete their first aid and CPR card in two weeks. Staff A acknowledged that Staff F's CPR card had recently expired. Staff A said C did not have a current first aid and CPR card to review. Staff A said Staff J had been responsible for the upkeep of the facility staff files.

In an interview on 09/27/2024 at 11:46 AM, Staff J said they had been responsible for facility staff's completed onboarding paperwork when they were hired. Staff J said Staff A had an excel spread sheet of the facility staff's first aid and CPR cards to keep track of

when they would be expired. Staff J said Staff A notified them when first aid and CPR cards needed to re-done.

Unsupervised Cottages

Cottage C

In an observation on 09/27/2024 at 11:41 AM, in Cottage C, Staff C, Caregiver, was working in the cottage assisting residents to the dining room to get ready for lunch. At 11:44 AM Staff C left the cottage with an unknown male resident and escorted them back to Cottage B. Staff C returned back to Cottage C at 11:46 AM. During the time that Staff C was not in Cottage C there were no other facility staff members available.

Cottage B

In an observation on 09/27/2024 at 11:55 AM, Cottage B, showed Staff N had been the only facility staff member inside of Cottage B. Staff N had distributed 15 residents their drinks and food for lunch. The residents had been observed to start eating their food. At 12:17 PM, Staff N had been observed to physically leave Cottage B, leaving the residents unattended and unsupervised. Within a minute Staff N returned to Cottage B.

In an interview on 10/14/2024 at 10:45 AM, Staff A, Executive Director, stated the staff were not to leave the cottages unattended. Staff A stated it was the expectation that the staff member that had to leave the cottage to get another caregiver or any other staff member to be in the cottage to cover. Staff A stated it was the staff's expectation to be in the dining room watching the residents during mealtimes.

Record review of an email sent to the Department on 10/01/2024 at 10:34 AM, showed that Staff A said the facility did not have a dining room services and supervision expectations of the caregivers during dining services to review.

CEU's

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff E was hired on 06/13/2022. The document showed Staff E's date of birth was October 13th.

Record review of Staff E's "Relias Official Transcript", undated, showed Staff E participated in course "Assisting with Bathing" on 07/13/2023 for 0.25 hours. Staff E participated in course "Washington Orientation Training" on 07/13/2023 for 2.00 hours. Staff E participated in course "Washington Safety Training" on 07/13/2023 for 3.00 hours. The three courses totaled 5.25 hours total which did not meet the minimum 12-hour expectation. Review of Staff E's transcript CEU's showed there was no completed dementia or Alzheimer's courses for 10/13/2022 through 10/13/2023 for review.

In an interview on 09/26/2024 at 2:16 PM, Staff A said the expectation was for the facility staff members to have 12 completed CEU's every year. Staff A said Staff J had been responsible for the upkeep of employee files which included employee CEU's.

In an interview on 09/27/2024 at 11:46 AM, Staff J said they had been responsible for

facility staff's completed onboarding paperwork when they were hired. Staff J said Staff A had an excel spread sheet of the facility staff's CEU's and notified them when employee staff CEU's were due.

The Department requested additional CEU's for Staff E on 09/26/2024 at 10:27 AM.

As of 10/08/2024 the Department did not receive any further CEU's for Staff E to review.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;
- (3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and
- (4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to secure potentially hazardous supplies accessible to memory care residents for 4 of 4 locations within the facility (Cottage B, Cottage C, Cottage D, Resident 3 [R3]'s room). This failure placed 53 of 53 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility policy, titled, "Safe Storage and Handling of Supplies and

Equipment", dated 09/01/2024, showed the facility would ensure that all supplies and equipment were stored in a safe manner, protecting residents from exposure and risk. When considering safe storage of supplies and equipment the administrator would consider the assessed needs of the residents and the functional and cognitive abilities to determine what supplies would be accessible to residents.

Record review of the Alzheimer's Association document, titled, "Home Safety", undated, showed as the Alzheimer dementia disease progresses, the person's abilities would change. Under the section titled, "how dementia affects safety", showed Alzheimer's disease caused a number of changes in the brain and body that would affect the person's safety that included forgetting how to use household items, becoming easily confused, and experiencing changes in vision. Under the section titled, "home safety tips", showed keep all cleaning products such as bleach out of sight, secured and in the original storage containers to discourage someone from eating or touching harmful chemicals.

Record review of the Poison Control National Capital Poison Center article titled, "mouthwash: swish and spit", undated, showed mouth wash and mouth rinse were liquid products with both antiseptic and disinfectant properties. Sometimes mouthwashes contain alcohol and fluoride. If someone swallowed large quantities of mouth wash, a person may experience toxicity from alcohol, fluoride, and antimicrobial ingredients. The symptoms could include nausea, vomiting, slow breathing, coma (a condition when a person is unconscious for a prolong period caused by injury or illness), and affect the heart and kidneys. Mouthwash could get a person drunk with the alcohol content.

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed 51 of 53 residents were marked as having a diagnosis of [REDACTED]

or [REDACTED]

[REDACTED]. The characteristic roster showed 25 of 53 residents were marked as being exit seekers or wanderers.

Cottage B

In an observation and interview on 09/25/2024 at 12:09 PM, The Cottage B bathroom across from room B2 had been unlocked. Staff B, Director of Nursing, said the bathroom had been a communal bathroom that residents used. Inside of the bathroom showed a cabinet with a typed sign attached to the outside of it that read "Please lock for safety, thank you." The cabinet was unlocked and there was a container of Listerine cool mint antiseptic with Resident 14's initials handwritten on it. There was a container of Pantene 501 conditioner, a bottle of rice water Himalayan shampoo, a container of no rinse foam phytoplex cleanser (cleanser used for the hair, face, and body), and a yellow bottle with no label that had a clear liquid substance inside of it.

Cottage D

In an observation and interview on 09/25/2024 at 12:24 PM, the Cottage D bathroom across from room D2 was unlocked. Inside the bathroom showed a cabinet with a typed sign attached to the outside of it that read "cabinets are to be kept locked when staff is

not using them." The left side of the cabinet was unlocked and there was a container of soothe and all cleanse, three individual packages of premoistened washcloths, a container of sooth and cool total body cleanser keratin smoothing conditioner, and a bottle of remedy moisturize body lotion. At 12:27 PM Resident 15 entered the bathroom. Staff B confirmed Resident 15 had been the individual who entered the bathroom.

In an observation on 09/25/2024 at 12:28 PM, the Cottage D bathroom across from room D6 was unlocked. Inside the bathroom showed an unlocked cabinet that had a bottle of anti-perspirant and container of soft soap.

In an observation on 09/25/2024 at 12:36 PM, the Cottage D kitchenet area showed there was a bottle of hand sanitizer with aloe sitting on a shelf. There were multiple residents observed to be within the common area living room and kitchenet area. Observed in the second drawer from the top in the kitchenette cabinet was Remedy brand Cleanse shampoo and body wash, leave-in conditioner, electric razor pre-shave, and three boxes of fluoride toothpaste. Observed in the drawer below this was nail supplies including three bottles of nail polish.

In an interview on 09/25/2024 at 12:38, Staff B, Director of Nursing, stated all the cabinets should have been locked.

In an observation and interview on 09/25/2024 at 12:37 PM, in Cottage D's kitchenette, under the sink in the unlocked cabinets were a bin of various small bottles of multiple colors of paint that were labeled "outdoor acrylic [a water-based substance with tiny particles of plastic resin and pigment] paint". There was an open bottle of lavender lotion under the sink inside the unlocked cabinet. The Department showed the bin of multiple paint bottles to Staff B and Staff B stated the paints were to be locked up. Staff B stated all chemicals and supplies that were not edible were to be locked up.

Cottage C

In an observation on 09/25/2024 at 12:43 PM, the Cottage C bathroom across from room C2 had been unlocked. Inside the bathroom showed the bottom right cabinet was unlocked with a container of remedy moisture skin cream, two bottles of intensive skin therapy rinse foam cleanser, and a container of Cetaphil (facial cleanser that can could be harmful if ingested causing nausea, vomiting, loose stools, and stomach pain).

In an interview on 09/25/2024 at 12:45 PM, Staff B confirmed when the bathroom cabinets had a sign that indicated they needed to be locked they were supposed to be locked.

R3's Room

In an observation on 09/26/2024 at 10:34 AM, R3's room door was unlocked. On R3's nightstand next to their bed showed a container of crest hum detoxify (toothpaste), a container of dove mends clean comfort odor protection (deodorant), and Colgate total 24-hour whitening toothpaste. On R3's dresser showed a container of perineal wash (cleans the area between the anus and genitals) and a container of dawn mist premium baby powder.

In an interview on 09/26/2024 at 11:28 AM, Staff A, Executive Director stated items such as body wash would typically be stored in a holding caddy and locked inside of a

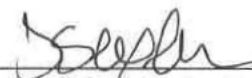
cabinet.

In an interview on 09/27/2024 at 10:34 AM, Staff L, Caregiver said this was a memory care facility and they had to keep an eye on all the residents because they eat inedible items. Staff L said anything inedible should be locked up. Staff L said items such as lotions and shampoos should be locked to prevent residents from eating them.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/21/24.

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


Administrator (or Representative)

10/29/24
Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure 3 of 7 sampled staff (Staff A, Staff E, and Staff F) had submitted a new Washington state name and background check every two years. This failure placed 53 of 53 residents at risk for being cared for by a staff member with a potentially disqualifying history.

Findings included...

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff A, Executive Director, was hired on 08/16/2021.

Record review of Staff A's initial Washington State Name and Date of Birth background check, dated 08/03/2021 showed that it had been completed.

Record review of Staff A's, 2-year Washington State Name and Date of Birth background check, dated 12/14/2023 showed that it had been completed four months late.

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff E, Caregiver, was hired on 06/13/2022.

Record review of Staff E's initial Washington State Name and Date of Birth background check, dated 03/09/2022 showed that it had been completed.

There was no record provided to review that Staff E had a completed 2-year Washington State Name and Date of Birth background check.

Record review of the facility provided document, untitled and undated, showed a list of employee names, titles, hire dates, birthdates, and department information showed Staff F, Medication Technician, was hired on 01/13/2022.

Record review of Staff F's initial Washington State Name and Date of Birth background check, dated 01/03/2022 showed that it had been completed.

Record review of Staff F's 2-year Washington State Name and Date of Birth background check, dated 03/27/2024, showed that it had been completed two months late.

In an interview on 09/26/2024 at 2:16 PM, Staff A said Staff J, Business Office Manager, had been responsible for the upkeep of the facility staff files. Staff A said when a 2-year background check needed to be completed, they used the date on the initial Washington State Name and Date of Birth Background Check.

In an interview on 09/27/2024 at 11:46 AM, Staff J said they had been responsible for the upkeep of the facility staff's files. Staff J said they checked the facility staff paper background checks monthly.

Plan/Attestation Statement

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Administrator (or Representative)

10/29/24
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

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

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available

information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment within 14 days of the resident's move-in date for 4 of 4 sampled residents (Resident 1 [R1], Resident 3 [R3], Resident 6 [R6], and Resident 7 [R7]). This failure placed R1, R3, R6, and R7 at risk for their care needs and services not being met.

Findings included...

Record review of the facility policy titled, "Assessments-Pre-Admission", dated "10.1.20", showed that each resident would have a completed assessment prior to their admission into the facility to ensure that services and care needs could be met. The policy did not reference the facility need for a completed 14-day assessment.

Record review of the facility policy titled, "Assessments-Full Assessments", dated "10.1.20", showed WAC (Washington Administrative Code)'s references to WAC 388 78A 2090 and 388 78A 2110. The full assessment section showed residents would be reassessed approximately 30 days after their admission into the community to evaluate if there were any changes needed in the resident's care or services. Full assessments would be complete every six months or if a change of condition occurred. The policy did not reference the facility need for a completed 14-day assessment.

Record review of the facility policy titled, "Assessments-Ongoing Focused Assessment", dated "10.1.20", showed that ongoing assessments occurred when a resident had a change in their physical, emotional, or mental functioning that was a departure from their previously assessed functioning. If a resident had a change of condition, an accident, acute illness, or exacerbation of chronic condition that required intervention from the physician, or when the negotiated service agreement no longer addressed the residents needs and preferences. The policy did not reference the facility need for a completed 14-day assessment.

R1

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R1 moved into the facility on [REDACTED]/2024.

There was no 14-day assessment provided for R1 for review.

R3

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R3 moved into the facility on [REDACTED] 2024. There was no 14-day assessment provided for R3 for review.

R6

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R6 moved into the facility on [REDACTED]/2024. There was no 14-day assessment provided for R6 for review.

R7

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R7 moved into the facility on [REDACTED]/2024.

There was no 14-day assessment provided for R7 for review.

In an interview on 09/26/2024 at 11:14 AM, Staff A, Executive Director said assessments were completed at preadmission, 30 days, and every 6 months or if there is a change in resident condition. Staff A confirmed they were the facility staff completing assessments of residents.

In an interview on 09/26/2024 at 1:37 PM, Staff A said they were the facility staff member who completed assessments for the residents. Staff A said they completed a pre-admission assessment prior to the resident moving into the facility, then the next assessment would be a 30-day assessment, every 6 months, or if a resident had a change of condition.

In an interview on 09/26/2024 at 2:25 PM, Staff A acknowledged they had not been aware they were required to complete 14-day assessments for the residents.

Plan/Attestation Statement

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Administrator (or Representative)

10/29/24
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure facility staff had the required nurse delegation training and credentials for 2 of 3 staff (Staff O and Staff P) reviewed. The facility failed to maintain and provide current nurse delegation documents for 4 of 4 residents (Resident 5[R5], Resident 3 [R3], Resident 2 [R2] and Resident 7 [R7]). These failures placed all delegated residents at risk for receiving care from an unqualified caregivers and unmet medical care needs.

Findings included...

WAC 246-840-930

"Criteria for delegation.

(1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN,

IMPLEMENT, EVALUATE.

ASSESS

(2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii).

(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.

(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.

(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.

(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.

(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.

(8) Verify that the nursing assistant or home care aide:

(a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;

(b) Has completed both the basic caregiver training and core delegation training before performing any delegated task;

(c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training;

(d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and

(e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.

(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

PLAN

(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:

(a) The rationale for delegating the nursing task;

(b) The delegated nursing task is specific to one patient and is not transferable to another patient;

(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;

(d) The nature of the condition requiring treatment and purpose of the delegated nursing task;

(e) A clear description of the procedure or steps to follow to perform the task;

(f) The predictable outcomes of the nursing task and how to effectively deal with them;

(g) The risks of the treatment;

(h) The interactions of prescribed medications;

- (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
 - (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
 - (i) How to notify the registered nurse delegator of the change;
 - (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and
 - (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
 - (k) How to document the task in the patient's record;
 - (l) Document teaching done and a return demonstration, or other method for verification of competency; and
 - (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks, and may be more frequent.
- (13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.

IMPLEMENT

- (14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.
- (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).

EVALUATE

- (16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.
- (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.
- (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.
- (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

Record review of the facility policy, titled, "Delegation of Nursing Tasks", dated 04/01/2021, showed the registered nurse (RN) transferred the performance of selected nursing tasks to competent nursing assistants in selected situations. The RN delegating the tasks retains the responsibility and accountability for the nursing care of the

resident. The RN was responsible for evaluating the nursing needs of residents, and the ability of current staff to perform the tasks within the realm of nurse delegation. The RN would identify staff members who qualify to perform delegation. The qualification included a registered or certified nursing assistant or licensed home care aide in Washington State, successful completion of the nurse delegation certification courses. Delegation would be in accordance with current nurse delegation regulations, assisted living regulations, and the nurse practice act of Washington State.

Record review of the Washington State Department of Social and Health Services document, titled, "Community nurse delegation orientation 2024", showed all long-term care workers must have nurse delegation core training certificate or transcript, the nurse delegation special focus on diabetes certificate or transcript if administering insulin, and have either an active home care aide certified, active nursing assistance certified, or an active nursing assistant registered within Washington state Department of Health. All long-term care workers must have an active credential with the Washington state Department of Health to be delegated. Evaluations occur ongoing for all the resident and nursing visit must be completed at least every 90 days that include the assessment, evaluation, and the competency that would be documented. All the RN delegation forms must be left where the resident resides for compliance with the facility and rules.

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed there were 23 residents documented they had nurse delegation nursing services.

Staff Records

Record review on 09/26/2024 at 11:35 AM, in the nurse delegation staff credential binder showed that Staff O, Medication Technician (Med Tech), did not have a core nurse delegation certificate for review.

Record review on 09/26/2024 at 11:35 AM, in the nurse delegation staff credential binder showed that Staff P, Med Tech, had a Washington State Department of Health Credential Verification, dated 05/01/2024 that showed Staff P's nursing assistant certification was "pending".

Record review on 09/27/2024 of the Washington State Department of Health Credential Verification website, showed Staff P's nursing assistant certification was pending and there were no other credentials listed active for Staff P.

Resident Records

R5

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R5 received nurse delegation nursing services.

Record review of R5's Move In Record, dated 09/25/2024, showed R5 moved into the facility on [REDACTED] /2023 with multiple medical diagnoses that included [REDACTED] and [REDACTED]

[REDACTED]

Record review on 09/26/2024 at 12:22 PM, the nurse delegation binder showed there were no RN delegation documents for R5 for review.

Record review of R5's Medication Administration Record (MAR), dated 07/01/2024 through 07/31/2024, showed R5 had an order to have their blood sugar checked every day and as needed. The MAR showed that Staff P had checked R5's blood sugar seven of 31 times for the month. The MAR showed Staff O administered R5's blood sugar checks 18 of 31 days.

Record review of R5's MAR, dated 08/01/2024 through 08/31/2024, showed R5 had an order to have their blood sugar checked every day and as needed. The MAR showed that Staff P had checked R5's blood sugar seven of 31 times for the month. The administrations showed Staff O administered R5's blood sugar checks 22 of 31 days.

Record review of R5's MAR, dated 09/01/2024 through 09/25/2024, showed R5 had an order to have their blood sugar checked every day and as needed. The MAR showed that Staff P had checked R5's blood sugar four of 25 times. The administrations showed Staff O administered R5's blood sugar checks 16 of 25 days.

R3

Record review of R3's Move In Record, dated 09/25/2024, showed R3 moved into the facility on [REDACTED] /2024 with multiple medical diagnoses that included [REDACTED].

Record review on 09/26/2024 at 12:22 PM, the nurse delegation binder showed there were no RN delegation documents for R3 for review.

Record review of R3's MAR, dated 08/23/2024 through 08/31/2024, showed R3 had an order to have their blood sugar checked three times every day and have lispro insulin (prescribed injectable medication to help lower high blood sugars quickly to a more therapeutic range) injected three times daily with meals. The MAR showed that Staff P had checked R3's blood sugar and injected R3's lispro insulin three of nine days. The MAR showed Staff O administered R3's blood sugar and injected R3's lispro insulin five of nine days. R3 had an order for lantus insulin (prescribed injectable medications that worked over a period of time to help maintain blood sugar level in more therapeutic range) to inject every evening. Staff P had administered R3's lantus three of 9 administrations.

Record review of R3's MAR, dated 09/01/2024 through 09/25/2024, showed R3 had an order to have their blood sugar checked three times every day and have humalog (prescribed injection that helps lower high blood sugar levels quickly) insulin injected three times daily with meals. R3 had an order to have their blood sugar checked three times every day and have lispro insulin injected three times daily with meals. The MAR showed that Staff O had checked R3's blood sugar and injected R3's lispro insulin one of 2 days of administration. The MAR showed that Staff O had checked R3's blood sugar and injected R3's humalog insulin 15 of 25 days. The MAR showed Staff P administered R3's blood sugar and injected R3's Humalog insulin four of 25 days. R3 had an order for

lantus insulin to inject every evening. Staff P had administered R3's lantus two of 24 days.

R2

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R2 received nurse delegation nursing services.

Record review of R2's Move In Record, dated 09/25/2024, showed R2 moved into the facility on [REDACTED]/2020 with multiple medical diagnoses that included [REDACTED].

Record review on 09/26/2024 at 12:25 PM, of the nurse delegation binder showed that R2 had a nurse delegation: instructions for nursing task document, dated 09/13/2023, and showed R2 was delegated for "oral medications crushed and/or administered; and topical treatments". There was no nursing visit documents or any documentation to show when R2 was last reviewed by the RN delegator and who was delegated to administer R2's delegated tasks.

Record review of R2's MAR, dated 07/01/2024 through 07/31/2024, showed R2 had an orders for atorvastatin (prescribed medication to help reduce the production of fat build up in the blood) take by mouth daily, aripirazole (prescribed medication to help reduce irritability and behaviors related to mental health or dementia) take by mouth daily, boudreaux butt paste (a zinc paste that helps treat and prevent skin break down) applied to heel ulcer two times daily, and lisinopril (prescribed medication to help reduce high blood pressure) take by mouth daily. Review of the administrations showed Staff P administered R2's oral and topical medications seven of 31 days. Review of the administrations showed Staff O administered R2's oral and topical medications 18 of 31 days.

Record review of R2's MAR, dated 08/01/2024 through 08/31/2024, showed R2 had an order atorvastatin take by mouth daily, aripirazole take by mouth daily, boudreaux butt paste applied to heel ulcer two times daily, and lisinopril take by mouth daily. Review of the administrations showed Staff P administered R2's oral and topical medications eight of 31 days. Review of the administrations showed Staff O administered R2's oral and topical medications 22 of 31 days.

Record review of R2's MAR, dated 09/01/2024 through 09/25/2024, showed R2 had an order atorvastatin take by mouth daily, aripirazole take by mouth daily, boudreaux butt paste applied to heel ulcer two times daily, and lisinopril take by mouth daily. Review of the administrations showed Staff P administered R2's oral and topical medications four of 25 days. Review of the administrations showed Staff O administered R2's oral and topical medications 16 of 25 days.

R7

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R7 received nurse delegation nursing services.

Record review of R7's Move In Record, dated 09/25/2024, showed R7 moved into the facility on [REDACTED]/2024 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review on 09/26/2024 at 12:22 PM, the nurse delegation binder showed there were no RN delegation documents for R7 for review.

Record review of R7's MAR, dated 07/01/2024 through 07/31/2024, showed R7 had an orders for amlodipine (a prescribed medication to help lower high blood pressure) daily, cholestyramine powder (prescribed medicated powder to help lower fat levels in the blood) mixed with liquid daily, cyclosporine (prescribed eye drops to help increase tear production) eye drops two times daily, pantoprazole (prescribed medication to help reduce stomach acid and protect the stomach wall lining) daily, and quetiapine (prescribed medication to help treat mental health conditions and behaviors as seen with dementia) daily. Review of the administrations showed Staff P administered R7's eye drops and oral medications seven of 31 days. Review of the administrations showed Staff O administered R7's eye drops and oral medications 18 of 31 days.

Record review of R7's MAR, dated 08/01/2024 through 08/31/2024, showed R7 had an order for amlodipine daily, cholestyramine powder mixed with liquid daily, cyclosporine eye drops two times daily, pantoprazole daily, and quetiapine daily. Review of the administrations showed Staff P administered R7's eye drops and oral medications seven of 31 days. Review of the administrations showed Staff O administered R7's eye drops and oral medications 22 of 31 days.

Record review of R7's MAR, dated 09/01/2024 through 09/25/2024, showed R7 had an order for amlodipine daily, cholestyramine powder mixed with liquid daily, cyclosporine eye drops two times daily, pantoprazole daily, ciprofloxacin (prescribed medication to clear an infection), mupirocin ointment (prescribed ointment to help clear or prevent topical infection) and quetiapine daily. Review of the administrations showed Staff P administered R7's eye drops and oral medications four of 25 days. Review of the administrations showed Staff O administered R7's eye drops and oral medications 16 of 25 days.

In an interview on 09/25/2024 at 11:58 AM, Staff A, Executive Director, stated all of the current RN delegation documents were stored in the binders that were provided to the Department on 09/25/2024.

In an interview on 09/25/2024 at 12:15 PM, Staff O stated they poke and check R3's blood sugar and inject R3's insulin to them daily as prescribed on the MAR. Staff O stated the current RN delegator was Staff H, RN Nurse Delegator (ND).

In an interview on 09/25/2024 at 12:35 PM, Staff A stated they were not aware of any other RN delegation binders other than the binders the Department reviewed that only had RN delegation documents dated January 2024 and prior to that date.

In an observation on 09/27/2024 at 11:53 AM, Staff O cleansed and pierced R3's finger with the blood sugar needle and check R3's blood sugar reading. Staff O stated they almost always have to give R3 their insulin when they check R3's blood sugar. Staff O stated they were the ones to check R5's blood sugar every day.

In an interview on 09/26/2024 at 4:18 PM, Staff H stated they were the facility's RN ND. Staff H stated all the current RN delegation documentation was stored on their computer and not at the facility. Staff H was not aware the RN delegation documents

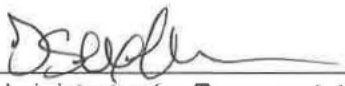
were required to be onsite at the facility. Staff H stated they assumed RN delegation in February 2024. Staff H stated upon starting they had completed an audit of the staff credentials and certificates and had identified that there were some staff that needed to complete their certificates and credentials. Staff H stated they did not have all the documentation for Staff P to be qualified for administering RN delegated tasks to the RN delegated residents. Staff H stated if the certificates or the credentials for the facility staff were not in the staff verification binder, they did not have the documents.

As of 09/30/2024 at 5 PM, the Department did not receive any additional RN delegation documents for staff or residents to review.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide care agreed upon in the negotiated service agreement (NSA) for 2 of 7 sampled residents (Resident 4 [R4] and Resident 5 [R5]). This failure placed R4 and R5 at risk for decreased quality of life by not having their care needs provided with consideration to their preferences.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreements [NSA]", dated 10/01/2020, showed it was the facility's policy to develop an NSA for each resident upon admission. NSA's were based on the assessed needs and wishes for each resident and would be developed with the input, participation and agreement of the resident, responsible parties, facility staff and others as appropriate and to the extent possible.

Record review of the facility's policy titled, "supervising and monitoring residents", undated, showed it was the facility's policy to observe and monitor each resident consistent with their assessed needs and NSA.

R4

Record review of R4's "Move in Record", dated 09/25/2024, showed R4 moved into the facility on [REDACTED] /2024. R4 had multiple diagnoses including [REDACTED] and [REDACTED].

Record review of R4's Negotiated Service Agreement, dated 09/26/2024 under the sleep/wake patterns section initiated on 03/03/2023, showed R4 preferred to go to bed around 11:00 PM and rise around 10:00 AM. Under the medication section showed that the facility staff were to order and maintain all R4's medications.

Record review of R4's Medication Administration Record (MAR) dated 07/01/2024 – 07/31/2024, showed R4 had a house supplement they took three times a day related to R4's abnormal weight loss. R4 missed 21 of 31 dosages at 7:00 AM due to resident sleeping.

Record review of R4's, MAR, dated 08/01/2024 – 08/31/2024, showed R4 missed one of 31 dosages of their house supplement at 7:00 AM due to resident sleeping.

Record review of R4's "Progress Notes", dated 06/27/2024, showed Staff O, Medication Technician wrote "Resident slept in as [R4] usually does..."

Record review of R4's "Progress Notes", dated 08/02/2024, showed Staff O wrote "Resident woke up with staff assistance at approximately 7:55 AM. Caregivers reported that [R4] was very sleepy and did not want to get up..."

In an interview on 09/27/2024 at 9:46 AM, Collateral Contact 1 (CC1), Representative for R4, stated R4 got restless at night and in their opinion, they thought R4 experienced sundowning behaviors (a state of confusion that occurred in the late afternoon and lasts into the night). CC1 said R4 stayed up late. CC1 said they reviewed R4's most updated person service care plan and noted on the paperwork the facility staff put that R4 liked to go to bed at 11:00 PM and wake up at 10:00 AM. CC1 said they thought at times R4 missed breakfast because they did not like to get up early.

In an interview on 09/27/2024 at 10:34 AM, Staff L, Caregiver stated R4 was not a morning person and liked to sleep through breakfast. Staff L said R4 liked to sleep in.

In an interview on 09/27/2024 at 1:03 PM, Staff A, Executive Director, acknowledged R4 missed 21 of their 31 dosages of their house supplement at "0700" in the month of July. Staff A acknowledged R4's person service care plan indicated R4 liked to be woken up at 10:00 AM but their house supplement was scheduled at 7:00 AM and could possibly contributed to why R4 slept through receiving their house supplement.

R5

Record review of R5's Move In Record, dated 09/25/2024, showed R5 moved into the facility on [REDACTED] /2023 with multiple medical diagnoses that included [REDACTED].

[REDACTED] and [REDACTED]

Record review of R5's progress note, dated 07/15/2024 at 12:21 PM, showed R5 had attempted to lean forward in their wheelchair when R5 fell out of the wheelchair landing face first into the ground. The facility documented for interventions that R5's service plan was reviewed and updated to include R5 had a history of falling to the floor from the seated lying position. If R5 was observed to be bending or leaning forward in their wheelchair, staff were to encourage R5 to lean back in the chair and offer assistance to reach for whatever item was on the ground that R5 was leaning forward to reach.

Record review of R5's progress note, dated 08/26/2024 at 4:13 PM, showed it was an incident investigation from a recent fall that R5 had on 08/22/2024. The progress note showed R5 was attempting to get out of bed without assistance. R5 was forgetful and their diagnosis of [REDACTED] contributed to her forgetting to call for assistance before R5 transfers. The facility implemented intervention to update the service plan to always include a bed/chair alarm.

Record review of R5's Negotiated Services Agreement (NSA), undated, under the section titled, "falls", showed R5 had a history of falling to the floor from a seated/lying position. On 07/15/2024 the NSA was updated to include that if staff was observe to bend or lean forward, staff were to encourage R5 to lean back in their chair and offer to reach for any items that R5 was reaching for. On 08/26/2024 the NSA was updated and showed R5 used a personal alarm to alert staff when R5 tried to transfer without assistance. Staff were to ensure that the alarm was on and working each shift. Staff were to notify the LN (Licensed Nurse) if alarm was not working correctly.

In an observation on 09/27/2024 at 9:57 AM, R5 was sitting in their wheelchair in the dining room outside of the dining room tables. R5 was leaning forwards with their upper body and head over their legs and feet. R5 was observed to not have an alarm on their wheelchair or them self. Staff N, Caregiver, was at the dining room island countertop. Staff N was not observed to approach R5 and encourage them to sit up right to prevent falling.

In an interview on 09/27/2024 at 11:29 AM, Staff N, Caregiver, stated R5 was a high fall risk and had difficulties with transferring. Staff N stated R5 did not use any alarms when they were up in the wheelchair or in bed.

In an observation on 09/27/2024 at 11:39 AM, R5 was sitting upright in the wheelchair out in the hallway of Cottage C. There was no alarm attached or observed on the wheelchair or on R5 observed.

In an interview on 09/27/2024 at 1:03 PM, Staff A, Executive Director, stated that R5 was to have an alarm on when she was up in any kind of chair or in bed to notify the staff if R5 was trying to transfer them self independently. Staff A stated this was updated from the last prior fall and added on the NSA.

In an interview on 09/27/2024 at 1:26 PM, Staff M, Caregiver, stated R5 did not use an

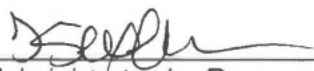
alarm when they were up in the wheelchair or in bed.

This is a recurring deficiency previously cited on 03/27/2023.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents, or their responsible party's signed the negotiated service agreement [NSA] for 3 of 7 sampled residents (Resident 3 [R3], Resident 4 [R4], and Resident 6 [R6]). This failure placed residents or their responsible party's at risk for being denied the opportunity to negotiate and agree to the resident's care needs and services being provided.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreements", revised "10.1.20", showed each NSA would be reviewed and updated as necessary with each ongoing and or focused assessment, change of condition, or when the NSA no longer met the needs and desires of the resident. The NSA would be signed by the resident, resident representative, and facility representative after completion of each ongoing assessment. Signed NSA's would be kept in the resident record.

R3

Statement of Deficiencies	License #: 2443	Compliance Determination #47738
Plan of Correction	The Cottages at Lacey	Completion Date
Page 43 of 55	Licensee: Lacey Special Care Community LLC	10/14/2024

Record review of R3's Assessment, dated 08/13/2024 showed the assessment had been R3's most updated assessment provided to review. The assessment had been completed and signed by Staff A, Executive Director on 08/13/2024.

Record review of R3's facility provided, Negotiated Service Agreement (NSA) document, date initiated 08/13/2024, showed Staff B, Director of Nursing, signed the document on 09/20/2024. Collateral Contact 2 (CC2), R3's Power of Attorney signed and agreed upon the document on 09/25/2024.

In an interview on 09/26/2024 at 11:47 AM, CC2 said the facility staff had electronically sent them R3's NSA to review and sign on 09/25/2024.

R4

Record review of R4's Assessment, dated 07/09/2024 showed the assessment had been R4's most updated assessment provided for review. The assessment had been completed and signed by Staff A on 08/13/2024.

Record review of R4's facility provided, NSA, date initiated 03/03/2023 showed Staff B signed the document on 09/19/2024. Collateral Contact 1 (CC1), R4's Power of Attorney, signed and agreed upon the document on 09/26/2024.

In an interview on 09/27/2024 at 9:46 AM, CC1 said the facility staff had electronically sent them R4's NSA to review and sign on 09/26/2024.

R6

Record review of R6's progress notes, dated 06/20/2024 through 09/23/2024, showed R6 returned from the hospital, post-operatively, on [REDACTED]/2024 with surgical drains and new medications.

Record review of R6's Level of care assessment dated, 09/23/2024, showed R6 was assessed by Staff A, Executive Director, on 09/23/2024.

Record review of R6's facility provided service agreement showed the care plan was updated to reflect post-return orders on 09/23/2024.

In an interview on 09/27/2024 at 12:45 PM, Staff A, Executive Director, said it was the facility protocol to re-assess the resident and update resident service agreements when residents return from the hospital with new orders. Staff A said the updated Negotiated Service Agreement (NSA) was then sent to the guardian or whoever was responsible for signing right away but at least the same day the assessment and NSA were updated.

In an interview on 09/27/2024 at 12:37PM, Staff A acknowledged that upon R6's return from the hospital on [REDACTED]/2024, R6 did have new orders for pain medications, eye drops and Home Health.

In an interview on 09/27/2024 at 1:03 PM, Staff A acknowledged R6 was not re-assessed for change in condition and the care plan was not updated until 09/23/2024.

In an interview on 09/27/2024 at 11:28 AM, Collateral Contact 2 (CC2), R6's guardian, said they received an updated NSA on 09/25/2024 at 3:21 PM from Staff B, Director of

Nursing. CC2 stated that, until 09/25/2024, CC2 had not received any other NSA documents since R6's admission.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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



Administrator (or Representative)

10/29/24

Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

- (1) The care and services necessary to meet the resident's needs, including:
 - (a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:
 - (i) The resident's preadmission assessment;
 - (ii) The resident's full assessments;
 - (iii) On-going assessments of the resident;
 - (b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;
 - (c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

This requirement was not met as evidenced by:

Based on observation, interview, and record review facility failed to provide the care and services needed as agreed upon in their negotiated services agreement (NSA)'s for 4 of 7 sampled residents (Resident 3 [R3], Resident 5 [R5], Resident 7 [R7], and Resident 4 [R5]) This failure placed the residents at risk for unmet care needs and the staff untrained on the services the residents require

Findings included...

R5

Record review of R5's MC LOC (memory care level of care) assessment, dated 06/19/2024, under medications showed, facility staff were to order and maintain all medication and treatments and assist R5 per physician orders and resident preference. Staff were to assist with one to seven routine medication/treatments per day that included blood sugar monitoring once a day. There was nothing in that section that indicated that R5 required nurse delegation for their blood sugar checking. Under the section titled, "ADL [activities of daily living] mobility transfers", showed R5 was independent with changing position in bed without any staff assistance or bed mobility aid. Under the section titled, "recommendations", for side rails, showed "none" was marked for R5. Staff A completed R5's assessment.

Record review of R5's untitled negotiated service agreement, undated, under the section titled, "coordination of care", showed family assist to coordinate care with physicians and outside providers. The information would be relayed to the appropriate facility staff. There was no outside provider or services listed that R5 had any services from a home health provider. Under the section titled, "medications", showed there was no documentation that R5 received nurse delegation for their blood sugar checks. Under the section titled, "medical history: diabetic", showed there was no documentation to show R5's blood sugars were a nurse delegated task.

Record review of the facility's outside provider binder on 09/26/2024, showed R5 had received physical therapy home health services since 01/26/2024 to help address lower extremities strength and balance endurance. R5's most recent visit from home health physical therapy was dated 09/26/2024, that worked with R5 for bilateral lower extremity and postural strengthening.

In an observation on 09/25/2024 at 2:43 PM, on the right side of R5's bed, there was a black half siderail. The frame of the siderail was slid under R5's mattress and strapped to the frame of the bed for stability. R5's left side of the bed and head of the bed were up against the wall.

In an interview on 09/25/2024 at 3:17 PM, R5 was unable to communicate. R5's speech was slurred and mumbled.

In an interview on 09/27/2024 at 11:29 AM, Staff N, Caregiver, stated R5 had a special diet today. Staff N stated R5 was unable to talk full sentences and would point to what they needed or say one or two words. Staff N stated R5 could roll them self in their bed with the use of the side rail that was on R5's bed. Staff N stated without the side rail, R5 had difficulties rolling.

In an interview on 09/27/2024 at 11:53 AM, Staff O, Medication Technician, stated R5 required the medication technicians to poke R5's finger and check their blood sugar every day.

In an interview on 09/27/2024 at 1:26 PM, Staff M, Caregiver, stated R5 typically could answer yes or no questions. Staff M stated it was not often that R5 could speak full sentences. Staff M stated R5 typically said one or two words at a time.

In an interview on 09/27/2024 at 2:29 PM, Staff K, Med Tech, stated R5 required two person staff assistance for all transfers. Staff K stated at times R5 would assist with use of the handrail on the wall for their transfers, but mostly required two staff members. Staff K stated it was rare that R5 could communicate with words unless R5 experienced

a panic attack then R5 typical said more words.

R3

Record review of R3's Move In Record, dated 09/25/2024, showed R3 moved into the facility on [REDACTED]/2024 with multiple medical diagnoses that included [REDACTED]

Record review of R3's Medication Administration Record (MAR), dated 08/23/2024 through 08/31/2024, showed R3 had an order to have their blood sugar checked three times every day and have lispro insulin (prescribed injectable medication to help lower high blood sugars quickly to a more therapeutic range) injected three times daily with meals. The MAR showed that Staff P had checked R3's blood sugar and injected R3's lispro insulin three of nine days. The MAR showed Staff O administered R3's blood sugar and injected R3's lispro insulin five of nine days. R3 had an order for lantus insulin (prescribed injectable medications that worked over a period of time to help maintain blood sugar level in more therapeutic range) to inject every evening. Staff P had administered R3's lantus three of nine administrations.

Record review of R3's MAR, dated 09/01/2024 through 09/25/2024, showed R3 had an order to have their blood sugar checked three times every day and have humalog (prescribed injection that helps lower high blood sugar levels quickly) insulin injected three times daily with meals. R3 had an order to have their blood sugar checked three times every day and have lispro insulin injected three times daily with meals. The MAR showed that Staff O had checked R3's blood sugar and injected R3's lispro insulin one of two days of administration. The MAR showed that Staff O had checked R3's blood sugar and injected R3's humalog insulin 15 of 25 days. The MAR showed Staff P administered R3's blood sugar and injected R3's Humalog insulin four of 25 days. R3 had an order for lantus insulin to inject every evening. Staff P had administered R3's lantus two of 24 days.

Record review of R3's NSA, date initiated 08/13/2024 under the medication section showed that the facility staff were to order and maintain all of R3's medications and treatments per their physician orders. The diabetic section showed the facility staff were to monitor and report any signs of excessive thirst, dizziness, confusion, excessive sweating and shaking. Staff were to monitor R3's blood glucose level changes. R3 was diabetic and required regular snacks throughout the day. R3's treatment section showed staff assisted R3 with monthly vitals and weights. R3's NSA did not address that the facility staff were to check R3's blood sugar three times every day and have lispro insulin injected three times daily with meals.

R4

Record review of R4's Move In Record, dated 09/25/2024, showed R4 moved into the facility on [REDACTED]/2023 with multiple medical diagnoses that included [REDACTED].

Record review of the facility provided document titled, "Assisted Living Facility Resident

Characteristics Roster and Sample Selection", undated showed R4 received nurse delegation services.

Record review of R7's NSA, undated, showed there was no documentation to show that R4 received RN delegated services and what the nurse delegated task were.

R7

Record review of R7's Move In Record, dated 09/25/2024, showed R7 moved into the facility on [REDACTED]/2024 with multiple medical diagnoses that included [REDACTED] and [REDACTED].

Record review of the facility provided document titled, "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated showed R7 received nurse delegation services.

Record review of R7's NSA, undated, showed there was no documentation to show that R7 received (Registered Nurse (RN) delegated services and what the nurse delegated tasks were.

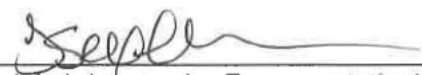
In an interview on 09/26/2024 at 10:45 AM, Staff A, Executive Director, said Staff A and Staff B, Director of Nursing, complete the Negotiated Service Agreements (NSA).

In an interview on 10/14/2024 at 10:45 AM, Staff A, Executive Director, stated Staff A and Staff B updated the residents services agreements. Staff A stated they would add RN delegation or any intermittent nurses services it was documented on the residents assessment.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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


Administrator (or Representative)

10/29/24
Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to

evaluate the significance of the resident not getting his or her medication, and such staff person;

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the physician when 3 of 7 sampled residents (Resident 4[R4], Resident 6[R6], Resident 7[R7]) refused their medication. This failure placed these 3 residents at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included...

Record review of the facility policy, titled, "Medication Refusal by a Resident", undated, showed when a resident who received medication assistance services did not take their medication, the facility would take appropriate action which included notifying the residents health care practitioner of the resident choosing not to take their medication.

R4

Record review of R4's "Move in Record", dated 09/25/2024, showed R4 moved into the facility on [REDACTED] /2024. R4 had multiple diagnoses including [REDACTED] and [REDACTED].

Record review of R4's facility provided, Negotiated Services Agreement (NSA) document, 09/26/2024, showed under the medication section that the facility staff were to order and maintain all R4's medications per their health care practitioner's orders.

Record review of R4's Memory Care Level of Care Assessment, dated 07/09/2024, showed R4 had a diagnosis of [REDACTED].

Record review of R4's hospice order, dated 08/24/2023, showed an order to give 12 ounces of house nutritional supplement by mouth three times daily with meals and record the amount accepted.

Record review of R4's Medication Administration Record (MAR) document, dated 07/01/2024 – 07/31/2024, showed R4 had a house supplement they took three times a day related to R4's abnormal weight loss. R4 missed 21 of 31 dosages at 7:00 AM due to resident sleeping.

Record review of R4's MAR, dated 08/01/2024 – 08/31/2024, showed R4 missed one of 31 dosages of their house supplement at 0700 due to resident sleeping. R4 missed two of 31 dosages of their house supplement at 1200 (12:00 PM) due to resident declined their medication. R4 missed four of 31 dosages of their house supplement at 1700 (5:00 PM) due to resident declined and one of 31 dosages due to resident sleeping. R4 missed two of 31 dosages of their house supplement at 2100 (9:00 PM) due to resident declined.

and three of 31 dosages due to resident sleeping.

In an interview on 09/27/2024 at 9:46 AM, Collateral Contact 1 (CC1), R4's Power of Attorney, confirmed R4 had house supplements that they took related to weight loss.

In an interview on 09/27/2024 at 1:03 PM, Staff A, Executive Director, acknowledged that R4 had missed 21 of 31 dosages of their house supplement due to the resident sleeping.

In an interview on 09/27/2024 at 2:25 PM, Staff A said if a resident refused their medication the facility policy was to notify their health care practitioner of the refusal. Staff A said some residents practitioners opted into being notified after three consecutive missed dosages rather than the first missed dosage.

A record request was made on 09/27/2024 at 11:28 AM for all of R4's notifications to their health care practitioner of when R4 declined their house supplement and slept through their house supplement from 07/01/2024 – 08/31/2024.

As of 10/08/2024 there were no records provided to show R4's health care practitioner had been notified of when R4 declined their house supplement and slept through their house supplement from 07/01/2024 – 08/31/2024.

R6

Record review of the facility's "Assisted Living Facility Resident Characteristics Roster and Sample Selection", undated, showed R6 moved into the facility on [REDACTED]/2024.

Review of R6's Service Agreement (NSA), dated 09/23/2024, showed medication assistance as a service area added on 03/08/2024 and showed "Resident Specific Details: Staff to order all medicine. Staff to also ensure that [R6] is receiving the right medication at the right dosage, via the right route at the right time to maintain therapeutic levels. Staff to notify DNS [Director of Nursing Services] if [R6] is refusing to take medications."

Review of R6's MAR, dated 03/01/2024 through 09/25/2024, showed orders for Mirtazapine(a medication used to treat depression), Abilify (a medication used to treat disordered thinking), and metoprolol (a medication used to treat high blood pressure). Review of the MAR legend showed RD meant Resident Refused. The MAR showed for Mirtazapine "RD" was documented for the dates 03/13/2024 through 03/19/2024, 03/23/2024, 04/06/2024. The MAR showed for Abilify "RD" was documented for 03/13/2024 and 03/14/2024. The MAR showed for Metoprolol "RD" was documented for the following doses: 03/12/2024 PM, 03/13/2024 AM and PM, 03/15/2024 PM, 03/16/2024 AM and PM, 03/17/2024 PM, 03/18/2024 PM, 03/19/2024 PM, 03/23/2024 PM, 04/06/2024(PM indicates the afternoon dose, AM indicates the morning dose).

Record review of progress notes dated 03/12/2024 through 09/23/2024 showed no notes reflecting notification of R6's physician nor DNS notification for any of R6's medication refusals.

R7

Review of R7's progress notes. dated 06/20/2024 through 09/23/2024, showed that R7

admitted to the facility on [REDACTED] /2024 with a diagnosis of [REDACTED]

Review of R7's Service Agreement (NSA), dated 06/19/2024, showed medication assistance as a service area and showed the "Resident Specific Details... Staff to order all medicine. Staff to also ensure that [R7] is receiving the right medication at the right dosage, via the right route at the right time to maintain therapeutic levels. Staff to notify DNS if [R7] is refusing to take medications."

Review of R7's MAR, dated 03/12/2024 through 09/23/2024 showed an order for cholestyramine (a medication used to lower cholesterol levels in the blood) with instructions to "Give 1 packet orally one time a day for high cholesterol." Order start date was 06/21/2024 at 8AM. The MAR reflected two missed doses, one dated 07/28/2024 and the second on 08/03/2024; notation marked "RD," meaning resident refused.

Record review of R7's progress notes, dated 06/25/2024 to 09/26/2024, showed no note regarding the refusal nor notification of R7's physician.

In an interview on 09/27/2024 at 2:30 PM, Staff A, Executive Director, said medication technicians were expected to follow the physician's orders and notification policy for missed and refused medications.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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


Administrator (or Representative)

10/29/24
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete a change of condition assessment for 3 of 7 sampled residents (Resident 5 [R5], Resident 4 [R4], and Resident 6 [R6]) when they had a change in condition. This failure placed the residents at risk for unmet care needs and staff not having the most updated and accurate information about the care and services the resident required.

Findings included...

Record review of the facility's policy, titled, "Change of Condition- Monitoring and Reporting", dated 04/01/2023, showed it was the policy of the facility to monitor residents for change in health, baseline function, and cognition and to consult with the resident representative, resident physician, and other individual designated by the resident as soon as possible when there have been significant changes in the resident. Under the section titled, "routine monitoring and reporting", showed in the daily course of interaction with the residents, examples included dining, activities of daily living (ADL's), passive social interaction, staff would monitor and report to the licensed nurse any significant change in resident health, physical abilities, cognition, and/or emotional wellbeing and documentation made in resident record. The licensed nurse would evaluate the resident for change of condition and update the negotiated service agreement as necessary that could include a temporary care plan for increased assistance in circumstances when the resident was expected to return to normal baseline within 14 days.

R5

Record review of R5's Move In Record, dated 09/25/2024, showed R5 moved into the facility on [REDACTED] /2023 with multiple medical diagnoses that included [REDACTED]

and [REDACTED]

Record review of R5's MC LOC (memory care level of care) assessment, dated 06/19/2024, under the section titled, "communication", showed R5 spoke English and was able to speak and/or write clearly to make their needs known independently. Under the section titled, "ADL [activities of daily living] Continence bowel and bladder health", showed R5 was able to complete a stand pivot transfer with the use of the assist rails in the bathroom with one person staff assistance. R5 required minimal staff assistance for safe transfers from a seated position and/or in and out of bed. Staff were to notify the licensed nurse if R5 required an increase in assistance. R5 required minimal assistance for transfers from staff when R5 completed a stand and pivot transfer. Staff were to notify the director of nursing of increased need for assistance. Under the section titled, "ADL bathing preference", showed R5 required partial bathing assistance. R5 only required staff to assist with washing R5's back, feet, and hair. R5 was able to wash their body with no staff assistance.

Record review of R5's untitled Negotiated Service Agreement (NSA) document, undated, under the section titled, "mobility", showed R5 required minimal staff assistance for ambulation and was independent with bed/chair mobility. R5 was able to reposition self at will without assistance. Staff were to notify the licensed nurse if resident needed increased assistance. Under the section titled, "bathing", R5 required partial assistance

from staff to complete bathing. Staff were to only assist with washing R5's back, hair, and feet. Under the section titled, "transfers", showed R5 could stand pivot transfer that required minimal staff assistance. Under the section titled, "dining assistance", showed R5 only required set up, stand by, and being cued by staff. Under the section titled, "communication", showed R5 was independent with communication and able to make needs known.

Record review of R5's incident investigation progress note, dated 07/15/2024 at 12:21 PM, showed R5 had fallen out of their wheelchair by bending forward. R5's fall was reasonable be related to urinary tract infection (infection in the bladder/urine) that exacerbated symptoms of dementia as well as R5's poor safety awareness. Under the section of the progress note "interventions", showed R5 had a history of falling to the floor from seated/lying positions. Staff were to encourage R5 to lean back if R5 was observed to be leaning or bending forward in their chair.

Record review of R5's progress note, dated 09/18/2024 at 5:02 AM, showed R5 ate 45 % of their dinner. R5 showed weakness and was unable to grab the bar and put weight on their foot. R5 required two -person care during transfers.

Record review of R5's progress notes, dated 09/24/2024 at 1:42 PM, showed R5 was sliding down from an upright position in their wheelchair to almost laying onto the seat cushion with their head on the back of the chair. Care staff had to assist R5 multiple times to sit upright. As soon as staff left R5, R5 would return to the unsafe position.

Record review of R5's progress note, dated 09/25/2024 at 5:59 AM, showed R5 was unable to sit up in their wheelchair correct with a safe posture.

In an interview on 09/27/2024 at 11:29 AM, Staff N, Caregiver, stated R5 required staff assistance with all ADL's that included transfers in and out of bed, to the toilet, showers, and at times rolling in bed. Staff N stated R5 required two staff person assist with transfers. Staff N stated R5 could point to things to inform staff they needed something. Staff N stated R5 had difficulty talking in sentences and could say a word or two when communicating.

In an interview on 09/27/2024 at 1:26 PM, Staff M, Caregiver, stated R5 in the last two weeks was not eating as much as they were and required the staff to cut their food up in small bites. Staff M stated R5 required two person staff assistance with all R5's transfers in and out of the bathroom and R5's bed. Staff M stated R5 last week was unable to help pull themselves up with the handrail bar in the bathroom or put weight on their feet to stand.

In an interview on 09/27/2024 at 2:29 PM, Staff K, Med Tech (Medication Technician), stated on 09/18/2024 R5's daughter reported to them that R5 had a difficult time swallowing. Staff K stated R5 did not eat as much for dinner that night.

In an interview on 09/27/2024 at 1:07 PM, Staff A, Executive Director, stated R5's difficulty swallowing would be a change in R5's condition. Staff A stated a change of condition assessment was not completed for R5.

R4

Record review of R4's "Move in Record", dated 09/25/2024, showed R4 moved into the

facility on [REDACTED]/2024. R4 had multiple diagnoses of [REDACTED]

and [REDACTED]

Record review of R4's Memory Care Level of Care Assessment, dated 07/09/2024, showed R4 had a diagnosis of [REDACTED]. Under the activities of daily living dietary section showed R4 had a good appetite.

Record review of R4's Progress Notes, dated 08/11/2024 at 5:17 AM, showed Staff C, Caregiver wrote R4 had been placed on alert for not eating.

Record review of R4's Progress Notes, dated 08/11/2024, showed at 2:37 PM, Staff P, Med Tech wrote that R4 did not eat breakfast or lunch. The facility staff tried to offer R4 liquids, and they refused.

Record review of R4's Progress Notes, dated 08/12/2024, showed at 1:01 PM, Staff O, Med Tech wrote that R4 drank their house supplements with help. R4 ate a small portion of breakfast and refused lunch after several attempts.

Record review of R4's Progress Notes, dated 08/12/2024, showed at 9:05 PM Staff Q, Med Tech, wrote that R4 did not eat their dinner or nutritional shake on their shift.

Record review of R4's Progress Notes, dated 08/13/2024 at 1:49 PM, Staff O wrote that R4 had been placed on alert for decreased appetite and start of hospice services on 08/13/2024.

Record review of R4's Progress Notes, dated 09/10/2024 at 5:59 PM Staff A, Executive Director, wrote R4 had a 17-pound weight loss this past month.

In an interview on 09/27/2024 at 9:46 AM, Collateral Contact 1 (CC1), R4's Power of Attorney, confirmed R4 had recently been readmitted onto hospice services approximately a month and a half ago due to their weight.

In an interview on 09/27/2024 at 1:03 PM, Staff A confirmed R4 had started hospice services. Staff A stated if resident had started hospice services a change of condition assessment should have been completed for R4.

There was no change of condition assessment provided to review for when R4 had admitted to hospice services as of 08/13/2024. The last completed assessment had been completed on 07/09/2024.

R6

Record review of R6's progress notes, dated 06/20/2024 through 09/23/2024, showed R6 returned from the hospital, post-operatively, on [REDACTED]/2024 with surgical drains and new medications.

Record review of R6's Level of Care (LOC) assessment, dated 09/23/2024, showed R6 was assessed by Staff A, Executive Director, on 09/23/2024.

Record review of R6's service agreement, undated, showed the care plan was updated to reflect post-return orders on 09/23/2024.

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

In an interview on 09/27/2024 at 12:45 PM, Staff A, Executive Director, said it is facility protocol to re-assess the resident and update resident service agreements when residents return from the hospital with new orders. Staff A said the updated Negotiated Service Agreement (NSA) was then sent to the guardian or whoever was responsible for signing right away but at least the same day the assessment and NSA were updated.

In an interview on 09/27/2024 at 11:28 AM, Collateral Contact 2 (CC2), R6's guardian, said they received an updated NSA on 09/25/2024 at 3:21 PM from Staff B, Director of Nursing. CC2 stated that, until 09/25/2024, CC2 had not received any other NSA documents since R6's admission.

In an interview on 09/27/2024 at 12:37PM, Staff A acknowledged that upon R6's return from the hospital on [REDACTED]/2024, R6 did have new orders for pain medications, eye drops and Home Health.

In an interview on 09/27/2024 at 1:03 PM, Staff A acknowledged R6 was not re-assessed for change in condition and the care plan was not updated until 09/23/2024.

R7

Record review of R7's progress notes from 06/20/2024 through 09/23/2024, showed that R7 admitted to the facility on [REDACTED]/2024 with a diagnosis of [REDACTED].

Record review of pre-admission assessment, shown as completed 06/11/2024, showed R7 had a history of falls within the last 3 months prior to admission.

Record review of document titled "CPMG: MC LOC Assessment- V 2" showed R7's admission assessment dated 06/19/2024.

Record review of document titled "CPMG-FALL Risk Evaluation" dated [REDACTED]/2024. Assessment showed a result indicating "High Risk for Falling." The assessment said "no," to the question of whether resident had fallen before.

Record review of document titled "CPMG: MC LOC Assessment- V 2" showed R7's 30-day assessment dated 07/18/2024. R7 was categorized as independent with mobility, requiring a walker, and there was a note about R7's non-compliance with use of the walker thereby requiring frequent reminders.

No other assessments were provided for R7.

Record review of the facility undated incident log showed two unwitnessed fall incidents for R7: one dated 07/07/2024 at 3:14PM and the second dated 08/23/2024 at 8:40 AM.

Record review of R7's Progress notes, dated 06/20/2024 through 09/23/2024 showed two incident investigations completed on 07/08/2024 and 08/27/2024, respectively.

Record review of R7's progress notes from 06/20/2024 through 09/23/2024, showed note dated 07/07/2024 at 3:41 PM: "Resident was lying on the ground outside near a wooden pole. Back was against the pole as she was lying on her right side. Lawn chair

was to left of her feet". The next note, dated 07/07/2024 at 7:49 PM, said "resident remained at baseline. No changes to gait noted. No c/o pain or discomfort. WCTM [will continue to monitor]." There was no further documentation of resident assessment after their fall.

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, The Cottages at Lacey is or will be in compliance with this law and / or regulation on (Date) 11/27/24.

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



Administrator (or Representative)

11/7/24

Date