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) 25474 (Completion Date 06/16/2023) and 21079 (Completion Date 03/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/16/2023 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-2610-1, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-f, WAC 388-78A-2160

The Department staff who did the on-site verification:
Celeste Vashey, ALF LTC Licensor

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

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages at Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2443
Compliance Determination #: 21079
Intake ID: 69693
Investigator: Celeste Vashey
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/22/2023 through 03/27/2023
Complainant Contact Date(s):

Allegation(s):

1) Concern the facility was not conducting regular showers for the resident.
2) Staffing concerns within the buiding.
3) Missing items protocol.
4) Standard of what is allowed in residents rooms/cleanliness of resident rooms.
5) Inquire if resident is on counseling services.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Resident rooms Identified resident
Interviews:	Family members Nursing staff
Record Reviews:	Facility policies Staff patterns

Investigation Summary:

1) Based on interview and record review failed practice found. The facility failed to conduct twice weekly showers as agreed upon in the Negotiated Service Agreement.
2) Based on interview and record review no failed practice found regarding staffing concerns within the facility.
3) Based on interiew and record review no failed practice found regarding the facility missing item protocal.
4) Based on interview and record review no failed practice found regarding cleanliess of resident rooms.
5) Based on interview and record review the resident was not on counseling services therefor the counselor would not know of residents history.

Conclusion / Action:

[X]

Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages at Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2443
Compliance Determination #: 21079
Intake ID: 71227
Investigator: Celeste Vashey
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/22/2023 through 03/27/2023
Complainant Contact Date(s):

Allegation(s):
1) Facility reported concern regarding the death of a resident.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 3 Closed records sample size: 1
Observations:	Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members
Record Reviews:	Incident investigation Facility policies Medical records

Investigation Summary:
1) Based on record review and interview no failed practice found regarding the death of the resident.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages at Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2443
Compliance Determination #: 21079
Intake ID: 73099
Investigator: Celeste Vashey
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/22/2023 through 03/27/2023
Complainant Contact Date(s):

Allegation(s):
1) Concern the facility was not conducting regular showers for the resident.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Resident rooms
Interviews:	Nursing staff Family members
Record Reviews:	Facility policies

Investigation Summary:
1) Failed practice found based on interview, observation, and record review. The facility failed to conduct twice weekly showers as agreed upon in the Negotiated Service Agreement.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

RECEIVED
APR 20 2023
DSHS RCS REGION 3
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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2443	Compliance Determination # 21079
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 11	Licensee: Lacey Special Care Community LLC	03/27/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 03/22/2023 and 03/27/2023 of:

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

This document references the following complaint number(s): 69693, 71227, 73099

The following sample was selected for review during the unannounced on-site visit: 3 of 40 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave, Suite 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

04/06/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) 4/18/23 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;

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure required infection control measures were being followed to prevent communicable diseases and failed to ensure they documented and tracked fit testing and medical clearances for 3 of 5 sampled staff (Staff E, Staff F, and Staff G. These failures placed 40 of 40 residents, staff and visitors at risk for being infected and spreading communicable diseases.

Findings included...

Review of WAC 296-842 Respirators, under WAC 296-842-10200, showed, "Scope and application. (1) Respirators are required whenever respiratory hazards (including oxygen-deficient conditions) are present... (2)This chapter applies whenever respirators are used at work."

Review of WAC 296-842-12010, showed, "Keep respirator program records. (1) A written copy of the current respirator program must be kept by the employer.
(2) Keep each employee's current fit test record, if fit testing is conducted, until the next fit test is administered. Fit test records must include:
(a) Employee name;
(b) Test date;
(c) Type of fit-test performed;
(d) Description (type, manufacturer, model, style, and size) of the respirator tested;
(e) Results of fit tests, for example, for quantitative fit tests include the overall fit factor AND a print out, or other recording of the test.
(3) Keep training records that include employees' names and the dates trained.
(4) Keep written recommendations from the LHCP.
(5) You must allow affected employees and their representatives to examine and copy records required by this section."

Review of the CDC website titled, "Healthcare Respiratory Protection Resources: Fit Testing," last reviewed on 02/04/2021, had an infographic titled, "Summary of Respiration Fit Test Requirements." This infographic explained that "all employees required to wear tight-fitting respirators, including N95 filtering facepiece respirators" were required to be fit tested before a respirator can be worn. A fit test ensured a proper seal between the respirator facepiece and the wearer's face. A proper fit decreased the risk of the wearer contracting the disease. Fit tests must be done "yearly, and after any physical changes that may affect the fit (weight gain/loss, dental work, etc." The infographic also stated that fit testing records must be kept on file until the next annual test is performed.

Record review of "Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings, updated 10/31/2022, under the "Personal Protective Equipment (PPE) and Transmission-based Precautions (TBP)" section showed "When caring for patients in TBP for confirmed or suspected COVID-19 [Corona Virus Disease 2019, a respiratory illness], HCP [Health Care Personal] must wear appropriate PPE including: National Institute of Occupational Health and Safety (NIOSH) approved respirator, gloves, gown, eye protection (for example, googles or a face shield that covers the front and sides of the face and protects from splash and spray)."

N95 Fit Testing and Medical Clearances

Record review of the facility policy, titled, "Respiratory Protection Program for use by health care providers during the COVID-19 Pandemic", undated, showed under the "Medical Evaluations" section that "Every employee of this company who must wear a respirator will be provided with a medical evaluation before they are allowed to use an FFR [Filtering Facepiece Respirator]. Our first step is to give the attached medical questionnaire to those employees. Employees are required to fill out the questionnaire in private and send or give them to the assigned RN [Registered Nurse] nurse delegator or other designated medical provider." Under the "Respirator Fit Testing" section showed "All employees designated to use the FFR's will be fit-tested before using their respirator..."

Record review of Employee list with start dates, undated, showed Staff E, Caregiver, was employed on 07/26/2021.

Record review of Staff E, Caregiver, Respiratory Training Record showed the document was incomplete. The instructor was not listed on the document, the signature of the instructor was not present, the date of when the fit test record was completed was not listed, the respirator model and approval number was not present, the pass or fail section of the document was not filled out, the clean shaven section of the document was not filled out, and the medical evaluation section of the document was not filled out.

Record review of Staff E, Caregiver, showed there was not a Respirator Medical Evaluation Questionnaire document to review.

Record review of Employee list with start dates, undated, showed Staff F, Caregiver, was employed on 01/31/2022.

Record review of Staff F, Caregiver, Respiratory Training Record showed the document was incomplete. The instructor was not listed on the document, the signature of the instructor was not present, the clean shaven section of the document was not filled out, and the medical evaluation section of the document was not filled out.

Record review of Staff F, Caregiver, Respirator Medical Evaluation Questionnaire showed the document was incomplete. The document stated, "Please submit this form along with medical questionnaire directly to Regional Nurse Delegator RN [Registered Nurse] for evaluation." The section the RN was supposed to sign was blank. The section where the RN was supposed to say whether Staff F was approved for the use of a KN95 or N95 respirator or not approved was blank. The document was not dated.

Record review of Employee list with start dates, undated, showed Staff G, Caregiver, was employed on 10/06/2021.

Record review of Staff G, Caregiver, Respiratory Training Record showed the document was incomplete. The instructor was not listed on the document, the signature of the instructor was not present, and the document was not dated.

Record review of Staff G, Caregiver, Respirator Medical Evaluation Questionnaire showed the document was incomplete. The document stated, "Please submit this form along with medical questionnaire directly to Regional Nurse Delegator RN [Registered Nurse] for evaluation." The section where the RN was supposed to sign was blank. The section where the RN was supposed to say whether Staff G was approved for the use of a KN95 or N95 respirator or not approved was blank. The document was not dated.

In an interview on 03/22/2023 at 11:53 AM, Staff A, Executive Director, stated Staff A and Staff B, Director of Nursing Services were the ones who completed the N95 fit testing for the facility staff. Staff A acknowledged Staff E, Staff F, and Staff G's Respirator Training Record and Respirator Medical Evaluation Questionnaire were incomplete. Staff A stated the facility conducted a mass fit testing and Staff A and Staff B may have missed signing and dating some of the staff records. Staff A stated they will look for Staff E's Medical Evaluation Questionnaire in their employee file.

In an interview on 03/22/2023 at 12:05 PM, with Anonymous Staff H, Direct Care Staff, stated they had not been N95 fit tested during their time working for the facility.

In an interview on 03/22/2023 at 12:35 PM, Staff K, Medication Technician, stated they had not been N95 fit tested during their time working for the facility.

In an interview on 03/22/2023 at 1:00 PM, Staff A, Executive Director stated they could not locate Staff E's Respirator Medical Evaluation Questionnaire.

COVID19 Testing

Record review of "Public Health and Social Services Department" letter sent by Thurston County Health Officer, dated 02/21/2023, under "Testing" section showed, "All staff and residents on the exposed units should follow post exposure testing guidance. Test all exposed resident and staff immediately..."

In an interview on 03/22/2023 at 9:57 AM, Staff A, Executive Director, stated the facility staff and residents tested for COVID19 on the first, third, fifth, and seventh day after the February 2023 COVID19 outbreak occurred.

Record review of February 2023 staff schedule showed Anonymous Staff H, Direct Care Staff, was scheduled for 5 of 28 days in February. The schedule did not indicate which cottage Anonymous Staff H was assigned to.

In an interview on 03/22/2023 at 12:05 PM, with Anonymous Staff H, Direct Care Staff, stated they regularly worked in Cottage C and Cottage C was one of the Cottages that were affected with COVID-19 in February 2023. Staff H stated they were not tested for COVID19 during the outbreak. Staff H inquired to stay anonymous due to fear of retaliation from the facility administration.

Record review of residents and staff members who were tested for COVID19 during the February 2023 outbreak showed Anonymous Staff H, Direct Care Staff, was not tested for COVID19.

Record review of February 2023 staff schedule showed staff J, Caregiver/Medication Technician, was scheduled for 15 of 28 days in February. The schedule did not indicate which cottage staff J was assigned to.

In an interview on 03/22/2023 at 12:25 PM, Staff J stated they regularly worked in Cottage D and Cottage D was one of the Cottages that were affected with COVID-19 in February 2023. Staff J stated they were not tested for COVID-19 during the outbreak that took place in February 2023.

Record review of residents and staff members who were tested for COVID19 during the February 2023 outbreak showed staff J was not tested for COVID-19.

In an interview on 03/23/2023 at 5:40 PM, Staff B, Director of Nursing Services, confirmed not all employees were tested for COVID19 during the February 2023 outbreak. Staff B stated the facility tested staff that worked in the cottages with outbreaks.

In an interview on 03/24/2023 at 11:03 AM, Collateral Contact 3 (CC3), Outbreak Investigator for the Local Health jurisdiction (LHJ), stated the facility was advised to test all residents and staff inside of Cottage C and Cottage D buildings due to the COVID-19 outbreak.

PPE Use During COVID-19 Outbreak

Record review of "Public Health and Social Services Department", letter sent by Thurston County Health Officer, dated 02/21/2023, showed "At this time, please use full personal protective equipment (PPE), when caring for those patients known to be positive to COVID-19, to include appropriate respiratory protection, eye protection, gown, and gloves."

Record review of a facility policy, titled, "Suspected or Confirmed COVID Outbreak Protocol", undated, showed, "[the] Community will use PPE in accordance with CDC [Center for Disease Control and Prevention] recommendations for droplet precautions in all buildings."

Record review of a facility policy, titled "Respiratory Protection Program for use by health care providers during the COVID-19 Pandemic", undated, showed a facility sign from the Washington State Department of Health "Aerosol Contact Precautions" , last revised on 10/09/2000, "Everyone Must: including visitors, doctors, & Staff clean hands when entering or leaving room. Use a NIOSH-approved N95 or equivalent or higher-level respirator especially during aerosolizing procedures. Face mask is acceptable if respirator is not available and for visitors. Wear eye protection (face shield or goggles). Gown and glove at the door."

In an interview on 03/22/2023 at 9:57 AM, Staff A, Executive Director, stated the facility had a two-week supply of PPE which included COVID-19 testing for residents and staff, surgical face masks, N95 respirators, face shields, gowns, and gloves. Staff A stated the LHJ provided the facility with PPE and could deliver the PPE the same day. Staff A stated when the facility had visitors during the COVID19 outbreak, they were instructed to wear additional PPE such as a face mask and gown.

Observation on 03/22/2023 at 11:05 AM, showed the facility PPE storage had one box of medical gloves, one box of face shields, and two boxes of 100 count gowns for staff to utilize.

In an interview on 03/22/2023 at 12:05 PM, with Anonymous Staff H, Direct Care Staff, for Cottage C, stated during the February 2023 COVID-19 outbreak they were not instructed to wear additional PPE. Anonymous Staff H stated they wore a surgical face mask during

the outbreak. Anonymous Staff H stated they did not wear eye googles or a face shield, gown, or gloves when they were in direct contact with the residents. Anonymous Staff H stated during visitation the families were only required to wear a surgical face mask during the COVID-19 outbreak.

In an interview on 03/22/2023 at 12:20 PM, Staff I, Caregiver for Cottage C, stated during the COVID-19 outbreak in February 2023 the staff had the option if they wanted to wear eye googles or a face shield while working. Staff I stated they did not wear eye googles or a face shield during the February 2023 outbreak.

In an interview on 03/23/2023 at 3:11 PM, with Collateral Contact 1 (CC1), Resident 2's representative, stated the facility staff never instructed them to wear additional PPE during the February 2023 outbreak. CC1 stated they visited Resident 2 in Cottage C who was COVID-19 positive, three to four times a week, on a weekly basis. CC1 stated they wore a surgical face mask during the visitation.

In an interview on 03/23/2023 at 3:30 PM, with Collateral Contact 2 (CC2), Resident 1's representative, stated they were never informed the facility experienced a COVID-19 outbreak in February 2023. CC2 stated themselves and other visitors visited Resident 1 in Cottage B multiple times throughout the month of February. CC2 stated the facility staff never instructed them to wear additional PPE during February. CC2 stated if they knew the facility was in outbreak status, they would have suspended their visitation with Resident 1.

In an interview on 03/24/2023 at 11:03 AM, Colleterial Contact 3 (CC3), Outbreak Investigator for the LHJ, stated the community supply of PPE they were able to provide to facilities had dwindled. CC3 stated facilities should use their own source to obtain PPE for the facility.

Reporting COVID-19 Outbreak

Record review of a facility policy, titled, "Suspected or Confirmed COVID Outbreak Protocol", undated, showed, "The Executive Director will then notify all appropriate state agencies including DSHS [Department of Social and Health Services], LHJ [Local Health Jurisdiction] (Thurston County DOH [Department of Health]) and follow their guidance on next steps including universal testing for all staff and residents if directed to do so."

Record review of "Public Health and Social Services Department", letter sent by Thurston County Health Officer, dated 02/21/2023, under "Identification of a positive case" showed "Notify your licensor immediately, Notify all HCW [Health Care Workers], Residents, and their families of the outbreak within 12 hours per Centers for Medicare & Medicaid Services (CMS) Guidance."

In an interview on 03/22/2023 at 9:57 AM, Staff A, Executive Director, stated they notified CRU (Complaint Resolution Unit) of the February 2023 COVID19 outbreak that took place within the facility.

Review of Department records showed as of 03/22/2023, the Department had not received notification from the facility that the facility experienced a COVID-19 outbreak in February 2023.

In an interview on 03/24/2023 at 11:03 AM, Colleterial Contact 3 (CC3), Outbreak Investigator for the LHJ, stated they provided the facility with a declaration letter that instructed the facility to notify the state licensor, health care staff, residents, families, and facility workers within 12 hours of knowledge of the COVID19 outbreak.

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) 5/11/2023 .

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

Administrator (or Representative) — Date: 4/18/23

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 document and provide services agreed upon in the Negotiated Service Agreement for 2 of 2 sampled residents (Resident 1 and Resident 2). This failure placed both residents at risk for unmet care needs.

Findings included...

Record review of the facility policy, titled, "Negotiated Service Agreements", undated, showed, "The Comprehensive Negotiated Service Agreement contents will include: The care and services necessary to meet the resident's needs including risk to resident health/safety, plan to provide assistance with facility assisted ADL's (Activities of Daily Living), plan to provide necessary intermittent nursing services, plan to provide necessary health support services, resident's preferences for how services will be provided. Clearly defined respective roles and responsibilities of the resident, the facility staff, and resident's family or other outside providers. Times the services will be delivered including frequency

and approximate time of day as appropriate..."

In an interview on 03/22/2023 at 9:34 AM, Staff C, Caregiver, stated residents were showered twice weekly. If a resident refused a shower, then it would be entered into the Point Click Care [medical record software] system as a refusal. If a resident refused to shower, Staff C stated they would attempt again later.

In an interview on 03/22/2023 at 9:40 AM, Staff D, Caregiver, stated residents were showered twice weekly. If a resident refused a shower, then it would be entered into the Point Click Care system as a refusal. If a resident refused to shower, Staff D stated they would attempt again later.

In an interview on 03/22/2023 at 10:49 AM, Staff A, Executive Director, stated the shower schedule was in the Negotiated Service Agreement for each resident. Showers were to take place twice weekly depending on the resident's preference. Staff A stated residents could have PRN (as necessary) showers as needed. Staff A stated if a resident refused a shower, facility staff were to attempt again later, try to give the resident a bed bath, or a sponge bath. Staff A stated it would be documented if a resident accepted or declined a shower. If a resident continue to refuse showering, then it would be discussed with the resident's family and changes to the care plan would be made.

In an interview on 03/22/2023 at 12:05 PM, Anonymous Staff H, Direct Care Staff, stated residents were showered twice weekly by the caregivers. If a resident refused a shower, it would be documented in the caregivers' charting notes.

In an interview on 03/22/2023 at 12:20 PM, Staff I, Caregiver, stated if any residents refused to be showered it would be documented. Staff I stated staff would attempt again later. Staff I stated if day shift was unable to get the shower completed, they would pass the information along onto the next shift, so the next shift could attempt as well.

In an interview on 03/22/2023 at 12:25 PM with Staff J, Caregiver/Medication Technician, stated they utilize Point Click Care to determine which resident needed to be showered for the day. If a resident refused a shower, they would document it.

Resident 1 (R1)

Record review of R1's Face sheet, showed R1 admitted to the facility on [redacted] 2022. R1 had multiple diagnoses which included [redacted], and [redacted], or [redacted].

Record review of R1's Care plan, undated, under the bathing section initiated on

01/11/2022, showed R1 preferred to be bathed in the morning, and were scheduled for two showers a week. R1 required one staff member assistance with set up, stand by, and cueing to complete bathing tasks.

In an interview on 03/23/2023 at 4:30 PM, Collateral Contact 2 (CC2), POA (Power of Attorney) for R1, stated the month of February was when they expressed concern regarding R1's showering. CC2 stated every time they visited R1 they appeared visibly dirty with black substances on their cheeks and greasy hair. CC2 stated they had a meeting with Staff B, Director Nursing Services, to go over their showering concerns and review R1's care plan. CC2 stated prior to the meeting none of the facility staff reached out regarding R1 not showering. CC2 stated they would have attempted to help R1 shower if needed.

Record review of "Documentation Survey Report", for February 2023, showed R1 received one shower on February 26, 2023. The document did not provide an explanation as to why R1 only received one shower for the month of February 2023.

Record review of R1's February 2023 Progress Notes, showed no documentation of R1 showers provided or refused for the month of February 2023.

In an interview on 03/22/2023 at 9:40 AM, with Staff D, Caregiver, Staff D stated R1 was not resistive to showering and was compliant with all hygiene tasks.

In an interview on 03/22/2023 at 10:49 AM, with Staff A, Executive Director, Staff A stated they were unaware of R1 having any issues surrounding showering.

Resident 2 (R2)

Record review of R2's face sheet, showed R2 was admitted to the facility on [redacted] 2023. R2 had multiple diagnoses which included [redacted].

Record review of R2's care plan, undated, under the bathing section, initiated on [redacted] 2023, showed R2 preferred to be bathed in the morning and they were scheduled for two showers a week. R2 required partial assistance from one staff member to complete bathing due to physical or cognitive impairment. R2 could wash their arms, legs, trunk, and private areas. Staff were to assist with R2's back, feet, and hair. Staff were to encourage R2 to participation in ADL's as much as possible and assist to complete all bathing tasks.

Record review of "Documentation Survey Report", for February 2023, showed R2 did not

receive a shower from 02/01/2023-02/08/2023, which indicated R2 went 8 days without showering. The document did not provide an explanation as to why R2 did not receive a shower between February 1, 2023 – February 8, 2023.

Record review of R2 February 2023 Progress Notes did not provide an explanation as to why R2 did not receive a shower between 02/01/2023-02/08/2023.

In an interview on 03/22/2023 at 9:34 AM, Staff C, Caregiver, stated R2 refused to shower often. Staff C stated an intervention they utilized was offering R2 a sweet treat such as chocolate to help encourage R2 to shower.

In an interview on 03/23/2023 at 3:11 PM, with Collateral Contact 1 (CC1), R2's Responsible Party, stated they were unsure if R2 was getting showered regularly. CC1 stated the facility requested toiletries such as shampoo, conditioner, and soap. CC1 stated that the supplies requested in January 2023 had barely been utilized.

During an observation on 03/22/2023 at 9:25 AM, showed R2's closet that contained a shower caddy with toiletries. There was shampoo, conditioner, and liquid soap that were all over three-quarters full.

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) 6/11/2023 .

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

Administrator (or Representative) — Date: 4/18/2023

Plan of Correction

Agency Name	**Citation Date**
The Cottages of Lacey	3/27/2023
Submitted by	**Date of POC Submission**
Teresa Sexton	4/18/2023
☐ **Complaint Citation** ☐ **Certification Citation**	

Citation: (list WAC)	
What *initial or immediate actions* were taken to address concerns affecting clients?	WAC388-78A-2610- 1,2,C,F. Audit of respiratory protection plan and staff fit testing records completed and updated per compliance guidelines. Covid testing protocol reviewed and facility is following the most current protocol and policy. Staff in service and training to be provided on infection control protocol and procedures during upcoming all staff meeting. Covid reporting guidelines reviewed and facility is following most current protocol.
How will you apply the correction to all clients you support?	**System or Operational Changes:** Inservice to be completed for staff members during all staff meeting reviewing respiratory protection plan, donning and doffing PPE, covid testing requirements and reporting guidelines. PPE obtained through facility contracted vendor.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Administrator, Director of Nursing Services, Assistant Director of Nursing.
Date by which lasting correction will be achieved	5/11/2023
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Cory Cisneros, Field Manager

Residential Care Services

Region 3, Unit E

800 NE 136th Ave, Suite 200

Vancouver, WA 98684

Plan of Correction

Agency Name	**Citation Date**
The Cottages of Lacey	3/27/2023
Submitted by	**Date of POC Submission**
Teresa Sexton	4/18/2023
☐ **Complaint Citation** ☐ **Certification Citation**	

Citation: (list WAC)	
What *initial or immediate actions* were taken to address concerns affecting clients?	WAC388-78A-2160 Review of Negotiated Service Plan policy and requirements. Facility audit it to be completed and facility is following the most up to date policy.
How will you apply the correction to all clients you support?	**System or Operational Changes:** Bi-monthly auditing of required charting in Point Click Care to maintain accurate and timely documentation.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Administrator, Director of Nursing Services, and Assistant Director of Nursing Services.
Date by which lasting correction will be achieved	5/11/2023
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Cory Cisneros, Field Manager

Residential Care Services

Region 3, Unit E

800 NE 136th Ave, Suite 200

Vancouver, WA 98684