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) 29035 (Completion Date 09/06/2023) and 21875 (Completion Date 05/03/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/06/2023 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2630, WAC 388-78A-2630-1, WAC 388-78A-2630-1-a

The Department staff who did the off-site verification:
Paul Aube, ALF NCI
Celeste Vashey, ALF LTC Licensor

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, 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 #: 21875
Intake ID: 76121
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/30/2023 through 05/03/2023
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Abuse: Public allegation of physical and mental abuse to a resident, from a staff member.
2. Restraints/Seclusion: Public allegation of staff member using medication to chemically restrain residents for convenience.
3. Death - General: Public allegation of staff member using medication to chemically restrain residents for convenience.

Investigation Methods:

Sample:
Total residents: 41
Resident sample size: 6
Closed records sample size: 3

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Residents
Management

Record Reviews:
Personnel files
Facility policies
Medical records
Medication Administration Records
Progress Notes
Care Plans

Investigation Summary:

1. Resident/Patient/Client Abuse: Facility failed to follow policy and conduct an investigation of physical, verbal, abuse from staff and notify the department when an allegation of abuse was made. Failed practice identified.
2. Restraints/Seclusion: Facility investigated allegation of use of chemical restraints by a staff member. Facility failed to notify the department of the allegation of abuse.

3. Death - General: Facility investigated allegation of use of chemical restraints by a staff member. Facility failed to notify the department of the allegation of abuse.

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 #: 21875
Intake ID: 73391
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/30/2023 through 05/03/2023
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Facility report of physical and mental abuse to a resident, from a staff member.
2. Resident/Patient/Client Rights: Facility report of physical and mental abuse to a resident, from a staff member.

Investigation Methods:

Sample:	Total residents: 41 Resident sample size: 6 Closed records sample size: 3
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Management
Record Reviews:	Personnel files Facility policies Medical records Medication Administration Records Progress Notes Care Plans

Investigation Summary:

1. Quality of Care/Treatment: Facility failed to follow policy and conduct an investigation of physical, verbal, abuse from staff and notify the department when an allegation of abuse was made. Failed practice identified.
2. Resident/Patient/Client Rights: Facility failed to follow policy and conduct an investigation of physical, verbal, abuse from staff and notify the department when an allegation of abuse was made. Failed practice identified.

Conclusion / Action:

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

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 # 21875
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 6	Licensee: Lacey Special Care Community LLC	05/03/2023

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 03/30/2023 and 03/30/2023 of:

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

This document references the following complaint number(s): 76121, 73391

The following sample was selected for review during the unannounced on-site visit: 6 of 41 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

05/11/2023
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) — Date: 5/26/23

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

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

(2) Determine the circumstances of the event;

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

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

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to investigate and document investigative actions and findings after they became aware of an allegation of abuse from a staff member to a resident for one of two incidents reviewed. This failure placed all residents who receive assistance with care at risk for further abuse.

Findings included...

Review of WAC 388-78A-2020, "Definitions," last reviewed on 02/20/2023, showed "Abuse means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Improper Use of Restraint means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline."

Review of the facility policy, titled, "Abuse-Neglect-Exploitation," last reviewed on 09/28/2020, under the "Incident Report" category it stated, "An incident report will be prepared for any suspected/allegation of abuse, neglect or exploitation to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations."

Review of a witness statement on 03/30/2023, reportedly given to facility management on 03/28/2023 from an anonymous staff member, stated "[Staff D, a Medication Technician] is aggressive with the residents. [Staff D] yells at them or grabs them to force them to sit down. [Staff D] also abuses the PRN's ("as needed" medications) and uses too much just to

knock them out."

During an interview with Staff E, a caregiver, on 03/30/2023 at 11:38AM, when asked if they were aware of the allegation of verbal, mental, or physical abuse from Staff D toward residents in the community, Staff E stated that they had witnessed Staff D mistreating residents. When asked to clarify what they witnessed, Staff E stated that they witnessed Staff D administering medications to a resident without crushing them. They stated that Staff D put the medications into the resident's mouth roughly and was yelling at the resident to "chew it right!" On another occasion, Staff E stated they witnessed Staff D grabbing a resident's arm and pushing them down onto the couch, stating "You need to sit the fuck down!" Staff E stated that the resident got up again, and they witnessed Staff D pushing the resident down again in their chair stating, "You need to sit down for 5 fucking minutes!" When asked if Staff E reported this to anyone, they stated that they reported it to Staff C, the Assistant Director of Nursing.

During an interview with Staff A, the Executive Director, on 03/30/2023 at 9:53AM, when asked if they were aware of the allegation of verbal, mental, or physical abuse from Staff D toward residents in the community, Staff A stated that they were not aware of the allegation of abuse. Staff A stated they were only aware that Staff D was alleged to "overuse" PRN (as needed) medications to ensure that they had an easier shift.

During an interview with Staff C, the Assistant Director of Nursing, on 03/30/2023 at 9:57AM, when asked if they were aware of any allegations of verbal, mental, or physical abuse from Staff D toward residents in the community, Staff C stated that they were aware of the allegations made against Staff D. When asked to clarify what the allegations were, Staff C stated that Staff D was alleged to yell at residents, push them down into their chair when they were trying to stand up, and overuse PRN medications for their convenience.

During an interview with Staff B, Director of Nursing, and Staff C, on 03/30/2023 at 10:04AM, when asked if they were aware of any allegations of verbal, mental, or physical abuse from Staff D toward residents in the community, Staff B stated they were not aware of any allegations of abuse. Staff B stated that they were aware of the allegation of excessive PRN use for Staff D's convenience but was not aware of the allegations of physical and verbal abuse. Staff B stated that they audited Medication Administration Records (MARs) for the named residents but was not able to substantiate those claims. Staff C corrected Staff A, referencing a witness statement they received regarding the allegations against Staff D. Staff B replied that they did not read the statement correctly and focused only on the excessive PRN usage.

During an interview with Staff B on 03/30/23 at 12:57PM, when asked if they categorized chemical restraints as a form of abuse, Staff B responded, "Yes." When asked why there was no incident report generated Staff B stated, "I just have not done that. With this, we usually do an investigation and go from there. For an abuse allegation, we do not do incident reports. I don't know to do incident reports for that."

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) 6/17/2023

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

Administrator (or Representative) — Date: 5/31/23

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

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

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

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to make a report to the Department's Complaint Resolution Unit when they had reasonable cause to believe that abuse of a resident occurred for one of two incidents reviewed. This failure resulted in the Department not being able to investigate the alleged abuse and the facility policies and procedures which placed all residents who receive assistance with care at risk for further abuse.

Findings included...

Review of WAC 388-78A-2020, "Definitions," last reviewed on 02/20/2023, showed that "Abuse means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Improper Use of Restraint means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline."

Review of the facility policy, titled, "Abuse-Neglect-Exploitation," last reviewed on 09/28/2020, under the "Reporting/Notifications: Staff Responsibilities" category it stated, "Any staff member to witness, receive report, suspect, or become aware of abuse, neglect, abandonment, exploitation, sexual, or physical assault of a resident is responsible for

notifying Director of Nursing as well as reporting directly to the State Hotline as soon as possible once they have ensured that all residents are safe but no later than the end of shift."

Review of a witness statement, reportedly given to facility management on 03/28/2023 from an anonymous staff member, stated "[Staff D, a Medication Technician] is aggressive with the residents. [Staff D] yells at them or grabs them to force them to sit down. [Staff D] also abuses the PRN's ("as needed" medications) and uses too much just to knock them out."

During an interview with Staff A, the Executive Director, on 03/30/2023 at 9:53AM, when asked if they were aware of the allegation of verbal, mental, or physical abuse from Staff D toward residents in the community, Staff A stated that they were not aware of the allegation of abuse. Staff A stated they were only aware that Staff D was alleged to "overuse" PRN (as needed) medications to ensure that they had an easier shift.

During an interview with Staff E, a caregiver, on 03/30/2023 at 11:38AM, when asked if they were aware of any issues regarding abuse from a staff member to a resident, Staff E stated that they had witnessed Staff D mistreating residents. When asked to clarify what they witnessed, Staff E stated that they witnessed Staff D administering medications to a resident without crushing them. They stated that Staff D put the medications into the resident's mouth roughly and was yelling at the resident to "chew it right!" On another occasion, Staff E stated they witnessed Staff D grabbing a resident's arm and pushing them down onto the couch, stating "You need to sit the fuck down!" Staff E stated that the resident got up again, and they witnessed Staff D pushing the resident down again in their chair stating, "You need to sit down for 5 fucking minutes!" When asked if Staff E reported this to anyone, they stated that they reported it to Staff C, the Assistant Director of Nursing.

During an interview with Staff C, the Assistant Director of Nursing, on 03/30/2023 at 9:57AM, when asked if they were aware of any allegations of verbal, mental, or physical abuse from Staff D toward residents in the community, Staff C stated that they were aware of the allegations made against Staff D. When asked to clarify what the allegations were, Staff C stated that Staff D was alleged to yell at residents, push them down into their chair when they were trying to stand up, and overuse PRN medications for their convenience.

During an interview with Staff B, Director of Nursing, and Staff C, on 03/30/2023 at 10:04AM, when asked if they were aware of any allegations of verbal, mental, or physical abuse from Staff D toward residents in the community, Staff B stated they were not aware of any allegations of abuse. Staff B stated that they were aware of the allegation of excessive PRN use for Staff D's convenience but was not aware of the allegations of physical and verbal abuse. Staff B stated that they audited Medication Administration Records (MARs) for the named residents but was not able to substantiate those claims. Staff C corrected Staff A, referencing a witness statement they received regarding the allegations against Staff D. Staff B replied that they did not read the statement correctly and focused only on the excessive PRN usage. When asked when they were notified of the alleged abuse from Staff D, Staff B stated that they became aware of the allegation on

Tuesday, 03/28/2023.

Review of Department records on 03/30/2023 showed no reports submitted by the facility of an allegation of abuse from Staff D.

During an interview with Staff B on 03/30/23 at 12:57PM, when asked if they categorized chemical restraints as a form of abuse, Staff B responded, "Yes." When asked why this was not reported to the Department, Staff B stated they wanted to conduct their investigation first, so they had all of the information before reporting it to the Department.

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) 6/17/23 .

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

Administrator (or Representative) — Date: 5/31/23