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) 27800 (Completion Date 08/08/2023) and 25727 (Completion Date 06/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/08/2023 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-3030-7-d, WAC 388-78A-3030-7-f

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

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 #: 25727
Intake ID: 85263
Investigator: Phan Pham
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 06/22/2023 through 06/22/2023
Complainant Contact Date(s): 06/15/2023

Allegation(s):

1) Resident abuse - Residents were being handled roughly.
2) Quality of care - the building allegedly was in poor condition, railings were not being cleaned and bathrooms did not have toilet paper.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 5 Closed records sample size: 1
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, infection control practice, and safety measures.
Interviews:	Named resident, residents, and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:

An on-site investigation was conducted, and the concerns related to 1) Resident abuse, there were insufficient evidence to support failed facility practice. 2) Quality of care - The facility failed to ensure infection control standards of practice was being followed and failed to provide toilet paper and disposable towels in the common-use bathrooms. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2443	Compliance Determination # 25727
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 4	Licensee: Lacey Special Care Community LLC	06/22/2023

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 06/22/2023, 06/22/2023 and 06/22/2023 of:

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

This document references the following complaint number(s): 85263, 84976

The following sample was selected for review during the unannounced on-site visit: 5 of 51 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

06/30/2023
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) 7/18/23 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.

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure 2 of 3 staff members (Caregiver D and Caregiver E) changed gloves consistent with infection control standards to prevent the spread of infection. This failure placed the residents and staff at risk for contracting diseases and the spread of infection.

Findings included...

Review of the Center's for Disease Control and Prevention (CDC) website, dated 11/29/2022, under the page titled, "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery In All Settings", showed under the Core practices table., "Risk Assessment with Appropriate Use of Personal Protective Equipment... Remove and discard disposable gloves upon completion of a task or when soiled during the process of care."

An observation on 06/22/2023 at 12:30 PM, showed Staff D, Caregiver, put on gloves and assist Resident 2 (R2) with incontinent care. Staff D wiped the resident's buttocks, put on the incontinent products, and pulled up the resident's pants. Staff D grabbed the resident's wheelchair handles and pulled the wheelchair toward R2. Staff D placed her hands on the resident's waist and assisted positioned R2 into the wheelchair. Staff D wore the same pair of gloves during the entire process.

In an interview at 12:40 PM, Staff D said she had been in-serviced on infection control practices and glove changing. Staff D stated she was trained to remove the gloves after she had finished providing care for the resident.

An observation on 06/22/2023 at 1:01 PM, showed Staff E, Caregiver, put on gloves and assist R3 with incontinent care. Staff E wiped R3's personal areas, put on the incontinent products and pulled up the resident's pants. Staff E grabbed the resident's wheelchair handle and pulled the wheelchair toward R3. Staff E had her hands on the resident's arm and assisted lowering R3 into the wheelchair. Staff E wore the same pair of gloves during the entire process.

In an interview at 1:06 PM, Staff E said she had been in-serviced to remove gloves when she had finished providing care.

In an interview on 06/22/2023 at 2:20 PM, Staff A, Director of Nursing Services, said staff

members had been trained on infection control practices and gloves change when they were hired. Staff A stated the assisted living facility did not have a visual audit system in place and staff members were not routinely observed to ensure infection control standards were being followed.

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) 8/16/23.

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

Administrator (or Representative) — Date: 7/18/23.

WAC 388-78A-3030 Toilet rooms and bathrooms.

(7) When providing common-use toilet rooms and bathrooms, the assisted living facility must:

(d) Provide a handwashing sink with soap and single use or disposable towels, blower or equivalent hand-drying device in each toilet room;

(f) Provide and ensure toilet paper is available at each common-use toilet.

This requirement was not met as evidenced by:

Based on observation and interview, the assisted living facility failed to provide disposable towels and/or toilet paper for 8 of 8 common-use bathrooms. These failures placed one of two sampled (Resident 1) at risk for spreading of infection, not having necessary toileting supplies, and decreased quality of life.

Findings included...

Review of Resident 1's (R1) face sheet showed the resident was admitted to the facility on [redacted]2023 with diagnoses including [redacted]

Review of R1's resident negotiated care plan, dated 03/14/2023, documented R1 was independent with transfers and ambulation, was able to communicate her needs, and continence of bowel and bladder. The desired outcome was to ensure R1 remained independent with toileting. R1 occasionally had incontinent episodes and required assistance with care typically once to twice a week.

In an interview and observation on 06/22/2023 at 11:45 AM, R1 was observed sitting on

her bed and neatly groomed and dressed. R1 said she did not have a private bathroom and had used the common bathrooms in the hallway. R1 stated the bathrooms frequently ran out of toilet paper and paper towels. R1 said sometimes she was "just dirty" when there was no toilet paper.

Observation from 12:04 PM to 12:29 PM on 06/22/2023 revealed the assisted living facility had three separate cottages B, C and D, and each cottage had three common-use bathrooms. At 12:04 PM the bathroom across from room C-12 had no toilet paper. At 12:06 PM the bathroom across from C-02 had no disposable towels. At 12:07 PM the bathroom across from room C-06 had not toilet paper and disposable towels. At 12:11 PM the bathroom across from room D-02 had no disposable towels. At 12:12 PM the bathroom across from room D-06 had no disposable towels. At 12:15 PM the bathroom across from room B-06 had no toilet paper and disposable towels. At 12:16 PM the bathroom across from room B-02 had no toilet paper and disposable towels. At 12:29 PM the bathroom across from room B-12 had no toilet paper and disposable towels.

On 06/22/2023 at 12:23 PM, Staff B, Medication Tech, was asked to observe the bathroom across from room C-06. Staff B said there were no toilet paper and disposable towels in that bathroom. Staff B stated staff members were responsible for equipping toilet paper and disposable towels in the bathrooms.

At 12:27 PM, Staff C, Caregiver, was asked to observe the bathroom across from room B-06. Staff C said the bathroom did not have toilet paper and disposable towels. Staff C stated staff members were supposed to check the bathrooms and refill the bathrooms with toilet paper and disposable towels at the end of the shift.

In an interview on 06/22/2023 at 2:20 PM, Staff A, Director of Nursing Services, said the assisted living facility provided toilet paper and disposable towels for residents. Staff A stated staff members were responsible for ensuring the bathrooms had toilet paper and disposable towels for residents.

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) — 7/18/23 Date