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) 43619 (Completion Date 07/03/2024) and 38592 (Completion Date 04/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/03/2024 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-3090-1-a, WAC 388-78A-3090-1-d, WAC 388-78A-2610-1, WAC 388-78A-2610-2-c, WAC 388-78A-2610-2-e

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

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

Sincerely,

Cory Cisneros

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

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 # 38592
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 6	Licensee: Lacey Special Care Community LLC	04/05/2024

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 03/20/2024 and 04/05/2024 of:
The Cottages at Lacey
8570 Martin Way E
Lacey, WA 98516

This document references the following SOD dated: 04/05/2024

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

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor

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

04/11/2024
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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Residential Care Services _____ Date _____

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Statement of Deficiencies	License #: 2443	Compliance Determination # 38592
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Administrator (or Representative) 4/17/24 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and well-maintained environment for 2 of 3 areas (Cottage D and Cottage C) of the facility. This failure placed 53 of 53 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's Disclosure of services, undated, under the section titled, "Housekeeping", showed, "All assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition". The facility served residents with dementia (progressive brain disorder that affects ones ability to think, remember, and ability to perform daily tasks) and mental health needs.

Record review of the "Department of Social And Health Services" document, Completion date 01/18/2024, 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-3090] 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 01/31/2024. 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 03/04/2024."

Record review of the facility's untitled document, dated 01/31/2024, showed the Plan of Correction for maintenance, housekeeping, and infection control, was that all staff were in-serviced on the importance of maintaining a clean, safe environment at all times. Cleaning check off sheets were implemented for the bathrooms and resident living areas. All staff were educated on the use and purpose of the cleaning check off sheets. Cleaning check off sheets for the bathrooms were implemented to document routine restocking of bathrooms with essential items for infection control such as toilet paper, hand soap, and paper towels. The resident care coordinator and the director of nursing in-serviced on routine monitoring and completion of cleaning check off sheets.

Administrator (or Representative) Date

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Record review of the facility document titled, "cottage cleaning expectations", undated, showed the nature of the in-service was to set standards and expectation of housekeeping and cleaning of the cottage including and not limited to resident rooms, common area bathrooms, and common areas.

Record review of the facility's document titled, "Day shift daily cleaning sign off", undated, under the section, "bathroom clean up", showed the caregiver was to stock supplies that included soap, toilet paper, and cabinet items.

Record review of the facility's document titled, "Evening shift daily cleaning sign off", undated, under the section, "bathroom clean up", showed the caregiver was to stock supplies that included soap, toilet paper, and cabinet items.

Record review of the facility's document titled, "NOC [night] shift daily cleaning sign off", undated, under the section, "bathroom clean", showed the caregiver was to clean the toilet that included outside and behind the toilet, disinfect the sink and counters, restock supplies, and scrub the floors. The caregivers were to sweep and mop the laundry room's floor and wipe down the washing machine and drying machine.

Record review on 03/20/2024 at 2:30 PM, of the facility's document that was untitled, and undated that was on the back of the door of the public bathroom across from room D-02, showed under the column titled, bathroom checks two times per shift, there were dates 03/19 (no year) at 1800 (6 PM), 03/19 (no year) at 2220 (10:20 PM), and 03/20 (no year documented) at 0430 (4:30 AM) only documented.

In an observation on 03/20/2024 at 2:24 PM, the public shower and bathroom across from room D-12, there was a shower bench in the shower stall. One of the four legs did not have rubber bottom, that made the shower bench to not stand straight and was unstable.

In an observation on 03/20/2024 at 2:26 PM, inside the public shower and bathroom across from room D-06, there was a shower bench in the shower stall that was missing the rubber bottom to one of the four legs. The shower bench was not standing straight and was unstable.

In an observation on 03/20/2024 at 2:33 PM, inside the public bathroom across from D-02, on the front corner of the rectangle porcelain lid of the toilet, there was a smear of brown matter closest to the wall in the front. On the base of the toilet closest to the ground on the front and to the right closest to the wall, there were multiple brown speckled matter. On the wall to the right of the toilet, three yellow tiles up from the blue tiles, there was thick brown matter. In the bathroom there was a strong pungent odor that resembled feces and urine.

In an interview on 03/20/2024 at 2:38 PM, Staff C, Caregiver, stated they used Cottage D's laundry room. Staff C stated on the back of the door of the bathrooms the caregiver were to document on the cleaning logs, when they cleaned the bathroom and that all handwashing and other supplies were stocked. Staff C stated the caregivers were to sign off two times a shift to ensure that the bathrooms were clean and that supplies were readily available.

In an observation and interview on 03/20/2024 at 2:51 PM in the laundry room of Cottage C inside the washing machine was full of resident clothing. On the inside of the opening of

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In an observation and interview on 03/20/2024 at 2:51 PM in the laundry room of Cottage C inside the washing machine was full of resident clothing. On the inside of the opening of

the washing machine was a gray rubber barrier that lined the entire opening to make a tight seal when the washing machine door was shut. The gray rubber barrier had large amounts of black speckled, dotted, and raised substance. The black substance was all the way around the gray rubber area. At 2:54 PM, Staff A, Executive Director, looked at the gray rubber barrier on the washing machine. Staff A stated it was stained from the washing machine chemicals and pointed to the pink solution that hung on the wall and had a tube that connected to the washing machine. Staff A was observed to wipe the black substance with a white paper towel. The white paper towel had black and brown substance on it that was removed. Staff A stated all three Cottages laundry rooms were accessible to all caregivers. Staff A stated the caregivers were to double check the bathrooms and all areas in the Cottages to ensure they had hand washing supplies and replace if needed. Staff A stated Staff D, Director of Nursing, the resident care coordinator, and themselves would routinely make rounds of each Cottage first thing in the morning, at shift change (6 AM, 2 PM, and 10 PM) and every evening before leaving the facility to ensure that supplies were stocked, the areas were clean, and overall state of the Cottage. Staff A stated if a shower bench was missing any rubber part to the legs, the shower bench would need to be replaced. Staff A stated the person that noted the shower bench would report it to the executive director or director of nursing and fill out a maintenance request form. Staff A stated the shower benches were not safe to use without all the rubber pieces on the legs.

This is an uncorrected deficiency previously cited on 01/18/2024.

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) 5/26/2024 .

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

Administrator (or Representative) Date 4/17/24

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;

(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:

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Statement of Deficiencies	License #: 2443	Compliance Determination # 38592
Plan of Correction	The Cottages at Lacey	Completion Date
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Based on observations, interviews, and record reviews, the facility failed to ensure that all necessary hand washing supplies were available in 2 of 3 memory care building laundry room's (Cottage B and Cottage D) for staff to use. This failure placed 53 of 53 residents and staff at risk for spread of infectious disease.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 01/18/2024, 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 01/31/2024. 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 03/04/2024."

Record review of the facility's document titled, "Infection control hand washing", undated, showed all staff were responsible for carrying out the hand washing policy. Staff were to wash their hands after handling soiled laundry or items with body fluids and housekeeping tasks. Whenever anyone changes from doing a "dirty" task to a "clean" task. Under the section titled, "Washing Procedure", showed staff were to wash hands with water, soap, and dry the hands well with paper towels.

In an observation and interview on 03/20/2024 at 2:14 PM, in Cottage B's laundry room, the soap dispenser by the sink was empty. The soap dispenser lever was pressed without any soap expressed. The paper towel dispenser was empty with no other paper towels available for use. There was a large pile of soiled resident clothing and linens that were sitting on the ground next to the washing machine unbagged. Staff B, Caregiver, stated the caregivers were responsible to provide housekeeping services for the assigned cottages. Staff B stated the caregivers were required to restock handwashing supplies. Staff B stated the paper towel dispenser was broken in the laundry room and there weren't any paper towels for use. Staff B stated the washing machine had been broken for two weeks and that laundry room was not being used as much. Staff B was observed to put on gloves and bagged the soiled linens. Staff B then removed a disposable glove from one hand and tie the bag up. Staff B stated they would need to wash their hands out in the kitchen area, opened the laundry room door with their ungloved hand and exited the room without the use of hand sanitizer or washing their hands.

In an observation and interview on 03/20/2024 at 2:35 PM, inside the laundry room of Cottage D, the paper towel dispenser was empty that was by the only sink in the room. At 2:38 PM, Staff C, Caregiver, stated they used Cottage D's laundry room. Staff C stated on the back of the door of the bathrooms the caregiver were to document on the cleaning logs when they cleaned the bathroom and that all handwashing and other supplies were stocked. Staff C stated the caregivers were to sign off two times a shift to ensure that the bathrooms were clean and supplies were readily available.

In an interview on 03/20/2024 at 2:55 PM, Staff A, Executive Director, stated all the Cottage's laundry rooms were accessible to all caregivers. Staff A stated the caregivers were to double check the bathrooms and all areas in the Cottages to ensure they had hand

Based on observations, interviews, and record reviews, the facility failed to ensure that all necessary hand washing supplies were available in 2 of 3 memory care building laundry room's (Cottage B and Cottage D) for staff to use. This failure placed 53 of 53 residents and staff at risk for spread of infectious disease.

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This is an uncorrected deficiency previously cited on 01/18/2024 and recurring deficiency previously cited on 06/22/2023 for subsection (1) and 03/27/2023 for subsection (1)(2)(c).

Plan/Attestation Statement

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Administrator (or Representative) 4/17/24 Date

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Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottages at Lacey
Provider Type: Assisted Living Facility
License/Cert.#: 2443
Compliance Determination #: 33402
Intake ID: 107475
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 12/07/2023 through 01/18/2024
Complainant Contact Date(s): 01/18/2024, 01/19/2024

Allegation(s):

1) bathrooms were not cleaned
2) bathrooms were not stocked with essential items needed for care and services for residents & visitors
3) bathroom and shower room equipment had feces and were not cleaned
4) bathroom cabinets were not locked and accessible to residents
5) flu shots were administered without proof of the vaccination record
6) staff not have the required credentials for job duty
7) food was served with seasoning that residents were unable to eat
8) residents charged for laundry and toiletry supplies that were not provided.

Investigation Methods:

Sample:
Total residents: 50
Resident sample size: 3
Closed records sample size: 1

Observations:
Residents
Dining
Resident care equipment
Laundry rooms
Bathrooms & shower rooms
Resident rooms
Staff to resident interactions

Interviews:
Nursing staff
Residents
Family members
Administrative Staff

Record Reviews:
Medical records
Facility policies
Grievance log
Staff training records

Investigation Summary:

1) after observation the facility failed to keep the bathrooms in a clean, safe, and sanitary condition- failed practice identified

2) after observation the facility failed to have hand washing supplies and toilet paper in bathrooms through out all 3 cottages. - Failed practice identified.
3) after observation of the bathrooms and shower rooms shower benches, walls, grab bars, and other surfaces in all three cottages had feces present and were not in clean, safe, and sanitary condition- failed practice identified.
4) After observation of cabinets in the bathroom all were locked. There was cabinets in the kitchen area that were not locked and accessible to residents that had chemicals.- Failed practice identified.
5) flu shot vaccination records were provided to show what residents received, consents, and the lot number of the vaccination vial- no failed practice identified.
6) after record review of sampled employee files, all staff had the required credentials for their job duty- no failed practice identified
7) after observation and record review the food served was appropriate for the residents. Residents didn't have any complaints and were observed to eat their meal with not concerns- no failed practice
8) after observation and interview the staff are providing care and services as residents service agreement. The facility had adequate supplies of toiletry items. the facility did not have a system in place for housekeeping services- failed practice identified for the housekeeping system, no failed practice identified for lack of supplies available.

Conclusion / Action:

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

STATE OF WASHINGTON
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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 12/07/2023 and 01/18/2024 of:

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

This document references the following complaint number(s): 107475

The following sample was selected for review during the unannounced on-site visit: 3 of 50 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF Complaint Investigator
Anissa Bearden, Licensor

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

01/29/2024
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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

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As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

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

Administrator (or Representative) 1/31/24 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 areas (Cottage B, Cottage C, and Cottage D). This failure placed 50 of 50 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included...

Record review of the facility's Disclosure of services, undated, under the section titled, "Housekeeping", showed, "All assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition". The facility served residents with dementia (progressive brain disorder that affects ones ability to think, remember, and ability to perform daily tasks) and mental health.

Record review of the facility's document titled, "what is expected of you daily on your shift", undated, showed housekeeping was to be completed on the residents' shower days. The caregivers were to allow, if capable, to have the residents help with sweeping, mopping, and putting clothes away.

Record review of the facility's document titled, "what does housekeeping look like", undated, showed they were to change the linens and blankets for the residents as needed if soiled. When the resident was scheduled for housekeeping the resident's entire bed would be changed and washed that includes the sheets, pillowcases, blankets, and comforters. Caregivers were to move the residents' bed and sweep and mop underneath, check between bed and wall for any fallen items, and then sweep and mop the rest of the room. They were to wipe down and dust the dressers and nightstands. The blinds were to be wiped with the sweefer (facility's version of a dry mop). Resident's closets were to be tidied up and made sure they had their own belongings in the closet. Trash would be taken out. For every soiled brief or depends that were changed or discarded in the room, they were to be taken out every time.

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 3 of 3 areas (Cottage B, Cottage C, and Cottage D). This failure placed 50 of 50 residents at risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included…

Record review of the facility's Disclosure of services, undated, under the section titled, "Housekeeping", showed, "All assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition". The facility served residents with dementia (progressive brain disorder that affects ones ability to think, remember, and ability to perform daily tasks) and mental health.

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Statement of Deficiencies	License #: 2443	Compliance Determination #:33402
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Record review of the facility's policy, "Cleaning resident rooms and furnishings", undated, showed "it will be the responsibility of the housekeeping department to maintain each resident room and furnishing in a clean manner daily. In buildings without dedicated housekeeping staff, the responsibility will fall on the care staff." Under the section "procedure" showed a thorough cleaning would be done one time a week or more often as necessary. Deep cleaning included disinfecting toilets, bathing fixtures, floors and doorknobs. Residents that required and or desire more frequent housekeeping services would receive as listed on their negotiated service agreement.

In an interview on 12/06/2023 at 10:48 AM, Staff A, Executive Director, stated the facility did not have housekeeping staff. Staff A stated that the caregivers perform all of the housekeeping job tasks.

In an observation on 12/06/2023 at 11:10 AM, in Cottage B's first public bathroom was a teal shower mat on the ground with smeared brown matter.

In an observation on 12/06/2023 at 11:13 AM, in Cottage B's second public bathroom was a walk-in shower with yellow wall tiles. On the yellow tiles were multiple splattered light and dark brown matter that resembled feces.

In an observation on 12/06/2023 at 11:17 AM, in Cottage B's third public bathroom on top of the white toilet paper dispenser were smears of brown matter on the top that resembled feces. On the yellow wall tiles above the toilet paper dispenser was smeared brown matter. There was smeared streaks of brown matter on the call light box, the paper towel holder, the vertical grab bar on the wall, and on the tiles next to the toilet bowel cleaner brush. On the paper towel dispenser that was hanging on the wall over the trash can, there was large amounts of brown matter that was near the clean white paper towels. Inside the trash can bag was a soiled brief that was dark yellow and had a pungent odor that resembled urine. Next to the sink two yellow tiles up on the wall was a smear of brown matter.

In an interview on 12/06/2023 at 11:25 AM, Staff B, Caregiver, stated they did not have a task sheet for their cleaning tasks. Staff B stated they had 14 residents to care after on their shift. Staff B stated they were to provide a few residents showers, meals, cleaning, and provide care to the 14 residents they were assigned to. Staff B stated if the residents had more behaviors on certain days, then they would not be able to get the cleaning tasks completed. Staff B stated they documented the cleaning that they completed on the electronic records. Review of the cleaning task showed they were to preform daily shift housekeeping services that included daily trash removal, make the bed, remove food and dishes, and once a week a deep cleaning that included laundry services. Staff B stated the deep cleaning included sweeping and mopping under the resident's bed and "the way you would clean your own home". Staff B stated night shift caregivers were responsible to clean the shower rooms every night. Staff B stated the shower benches and shower rooms were to be disinfected after they were used. Staff B showed the Department a white bottle with pink liquid inside that was unlabeled. Staff B stated they used that chemical to clean the tabletops, counters, and in the bathrooms.

Record review of the facility's policy, "Cleaning resident rooms and furnishings", undated, showed "it will be the responsibility of the housekeeping department to maintain each resident room and furnishing in a clean manner daily. In buildings without dedicated housekeeping staff, the responsibility will fall on the care staff." Under the section "procedure" showed a thorough cleaning would be done one time a week or more often as necessary. Deep cleaning included disinfecting toilets, bathing fixtures, floors and doorknobs. Residents that required and or desire more frequent housekeeping services would receive as listed on their negotiated service agreement.

In an interview on 12/06/2023 at 10:49 AM, Staff A, Executive Director, stated the facility did not have housekeeping staff. Staff A stated that the caregivers perform all of the housekeeping job tasks.

In an observation on 12/06/2023 at 11:10 AM, in Cottage B's first public bathroom was a teal shower mat on the ground with smeared brown matter.

In an observation on 12/06/2023 at 11:13 AM, in Cottage B's second public bathroom was a walk-in shower with yellow wall tiles. On the yellow tiles were multiple splattered light and dark brown matter that resembled feces.

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In an interview on 12/06/2023 at 11:25 AM, Staff B, Caregiver, stated they did not have a task sheet for their cleaning tasks. Staff B stated they had 14 residents to care after on their shift. Staff B stated they were to provide a few residents showers, meals, cleaning, and provide care to the 14 residents they were assigned to. Staff B stated if the residents had more behaviors on certain days, then they would not be able to get the cleaning tasks completed. Staff B stated they documented the cleaning that they completed on the electronic records. Review of the cleaning task showed they were to preform daily shift housekeeping services that included daily trash removal, make the bed, remove food and dishes, and once a week a deep cleaning that included laundry services. Staff B stated the deep cleaning included sweeping and mopping under the resident's bed and "the way you would clean your own home". Staff B stated night shift caregivers were responsible to clean the shower rooms every night. Staff B stated the shower benches and shower rooms were to be disinfected after they were used. Staff B showed the Department a white bottle with pink liquid inside that was unlabeled. Staff B stated they used that chemical to clean the tabletops, counters, and in the bathrooms.

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In an observation on 12/06/2023 at 11:40 AM, in Resident 1's (R1) room was large amounts of dust and dirt in the corners of their room and under their bed. R1 stated that staff didn't move any items or furniture when they clean. R1 stated staff don't empty the garbage can in their room; so they will empty their garbage can in the public bathroom trash can because that one does get emptied. The garbage can in R1's room was empty without a trash bag inside.

In an observation on 12/06/2023 at 11:47 AM, in Resident 2's room was large amounts of dust particles on the ground, in the corners of their room, and under the bed.

In an observation on 12/06/2023 at 11:51 AM, in Cottage C's first bathroom in the shower area was a white shower bench with brown matter on the ground that resembled feces. There was a urine collection hat on the ground next to the shower bench.

In an observation on 12/06/2023 at 11:54 AM, under the bed of Resident 3's room were crumpled tissues, a white plastic spoon, and spilled substance that was dried on the floor.

In an observation on 12/06/2023 at 11:58 AM, in Cottage C's second bathroom on the silver paper towel and trash holder that hung on the wall was a large amount of raised brown substance and smeared streaks of brown substance that was resembled feces that was near the paper towel dispensing opening. Next to the keyhole of the garbage and paper towel holder, were large amounts of brown smeared substance that was dried. On the silver grab bar on the wall next to the left side of the toilet and above the toilet paper dispenser was a brown smear that resembled feces. On the front of the white toilet bowl between the opening part of the seat was a pea size, raised brown matter. The bathroom had a pungent odor that resembled ammonia (a gas with a sharp suffocating smell) and urine. The white shower curtain that was hanging up had multiple brown splattered areas halfway up from the ground on both sides. There was a thick wad of hair that sat on the shower drain

In an observation on 12/06/2023 at 12:03 PM, in the third bathroom in Cottage C in the shower room was a shower seat. Under the shower seat was a two inch long and half an inch thick brown substance that resembled feces that sat on the ground. There was a second shower bench that was sitting up against the wall of the shower area, was sitting sideways. One of the four legs of the shower bench was missing a rubber stopper. In the trash can that was attached to the paper towel dispenser was a brown soiled brief. The bathroom had a pungent odor that resembled feces and urine.

In an interview on 12/06/2023 at 12:10 PM, Staff C, Medication Technician/Caregiver, stated they used bathroom 3 shower stall at 9:30 AM today (12/06/2023) to give a resident a shower. Staff C stated they just rinse the shower chair and the shower stall with water and that night caregivers will deep clean and disinfect. Staff C stated they do not disinfect the shower area after a shower. Staff C stated they used the blue liquid that was labeled "glass and surface cleaner" to clean with on the tables and counter tops. Staff C stated they were to deep clean the resident's rooms according to their shower schedule.

In an observation on 12/06/2023 at 11:40 AM, in Resident 1's (R1) room was large amounts of dust and dirt in the corners of their room and under their bed. R1 stated that staff didn't move any items or furniture when they clean. R1 stated staff don't empty the garbage can in their room, so they will empty their garbage can in the public bathroom trash can because that one does get emptied. The garbage can in R1's room was empty without a trash bag inside.

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In an observation on 12/06/2023 at 12:03 PM, in the third bathroom in Cottage C in the shower room was a shower seat. Under the shower seat was a two inch long and half an inch thick brown substance that resembled feces that sat on the ground. There was a second shower bench that was sitting up against the wall of the shower area, was sitting sideways. One of the four legs of the shower bench was missing a rubber stopper. In the trash can that was attached to the paper towel dispenser was a brown soiled brief. The bathroom had a pungent odor that resembled feces and urine.

In an interview on 12/06/2023 at 12:10 PM, Staff C, Medication Technician/Caregiver, stated they used bathroom 3 shower stall at 9:30 AM today (12/06/2023) to give a resident a shower. Staff C stated they just rinse the shower chair and the shower stall with water and that night caregivers will deep clean and disinfect. Staff C stated they do not disinfect the shower area after a shower. Staff C stated they used the blue liquid that was labeled "glass and surface cleaner" to clean with on the tables and counter tops. Staff C stated they were to deep clean the resident's rooms according to their shower schedule.

In an observation and interview on 12/06/2023 at 12:30 PM, Staff C, Medication Technician/Caregiver, stated they gave Resident 5 (R5) a shower on 12/05/2023. Staff C stated they were unable to sweep or mop R5's room as they did not have time. The floor in R5's room was noted to have dried brown matter beside the bed to the right. There was dust and debris on the ground and under the beds.

In an observation on 12/06/2023 at 12:40 PM, in Cottage D in the bathroom across from Resident 4 on the wall tiles next to the toilet and under the call light box were multiple different sized, shaped, dry brown splattered substance that resembled feces. On the silver wall paper towel and garbage holder, near the opening of the garbage can was thick brown substance. On the yellow wall tiles left of the sink had brown substance. In the shower stall under the grab bar on the wall were dried dripping lines of brown substance that went down to the ground.

In an observation on 12/06/2023 at 12:48 PM, in Cottage D in the hallway across from Resident 5 on the pink handrail on the wall were two brown streaked lines of brown substance that resembled finger imprints.

In an observation on 12/06/2023 at 12:51 PM, under the island counter in the kitchen area of Cottage D, there was a clear bag with yellow soiled multiple briefs inside. There was a strong pungent smell that resembled stale urine.

In an interview and observation on 12/06/2023 at 1:58 PM, Staff A, Executive Director, stated they walked the cottages every day in the main areas and peak into the bathrooms. Staff A stated they had walked through the cottages that morning. The Department showed Staff A the brown substance in Cottage B's third bathroom. Staff A stated the brown substance looked like feces. Staff A stated if soiled briefs were thrown away in the bathroom garbage the staff were to remove the trash bag, take it out to the dumpster, and put a new trash bag in the garbage can. Staff A stated any disinfectant could be used to clean surfaces and the shower/bathroom rooms. Staff A stated there was no specific disinfectant that the staff were to use.

In an interview on 12/06/2023 at 3:24 PM, Staff A stated they had 24-hour caregiver coverage and if a caregiver on their shift was unable to complete their cleaning task it was to be carried out by the next shifts caregiver.

In an interview on 01/18/2024 at 2:28 PM, Collateral Contact 1 (CC1), power of attorney for Resident 7 (R7), stated they had addressed the concerns with management about the feces in the bathrooms, no soap or paper towels to wash their hands, and the cleanliness of the facility and R7's room multiple times without any changes made. CC1 stated they moved R7 out related to the unsafe and uncleanliness of the facility in [redacted] 2023.

Plan/Attestation Statement

In an observation and interview on 12/06/2023 at 12:30 PM, Staff C, Medication Technician/Caregiver, stated they gave Resident 5 (R5) a shower on 12/05/2023. Staff C stated they were unable to sweep or mop R5's room as they did not have time. The floor in R5's room was noted to have dried brown matter beside the bed to the right. There was dust and debris on the ground and under the beds.

In an observation on 12/06/2023 at 12:40 PM, in Cottage D in the bathroom across from Resident 4 on the wall tiles next to the toilet and under the call light box were multiple different sized, shaped, dry brown splattered substance that resembled feces. On the silver wall paper towel and garbage holder, near the opening of the garbage can was thick brown substance. On the yellow wall tiles left of the sink had brown substance. In the shower stall under the grab bar on the wall were dried dripping lines of brown substance that went down to the ground.

In an observation on 12/06/2023 at 12:48 PM, in Cottage D in the hallway across from Resident 5 on the pink handrail on the wall were two brown streaked lines of brown substance that resembled finger imprints.

In an observation on 12/06/2023 at 12:51 PM, under the island counter in the kitchen area of Cottage D, there was a clear bag with yellow soiled multiple briefs inside. There was a strong pungent smell that resembled stale urine.

In an interview and observation on 12/06/2023 at 1:58 PM, Staff A, Executive Director, stated they walked the cottages every day in the main areas and peak into the bathrooms. Staff A stated they had walked through the cottages that morning. The Department showed Staff A the brown substance in Cottage B's third bathroom. Staff A stated the brown substance looked like feces. Staff A stated if soiled briefs were thrown away in the bathroom garbage the staff were to remove the trash bag, take it out to the dumpster, and put a new trash bag in the garbage can. Staff A stated any disinfectant could be used to clean surfaces and the shower/bathroom rooms. Staff A stated there was no specific disinfectant that the staff were to use.

In an interview on 12/06/2023 at 3:24 PM, Staff A stated they had 24-hour caregiver coverage and if a caregiver on their shift was unable to complete their cleaning task it was to be carried out by the next shifts caregiver.

In an interview on 01/18/2024 at 2:26 PM, Collateral Contact 1 (CC1), power of attorney for Resident 7 (R7), stated they had addressed the concerns with management about the feces in the bathrooms, no soap or paper towels to wash their hands, and the cleanliness of the facility and R7's room multiple times without any changes made. CC1 stated they moved R7 out related to the unsafe and uncleanliness of the facility in [redacted] 2023.

Plan/Attestation Statement

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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) 3/4/24.

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

Administrator (or Representative) 1/31/24 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;

(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, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 3 buildings (Cottage C, and Cottage D). This failure placed 50 of 50 residents at risk for ingesting potentially toxic materials.

Findings included...

Record review of the facility's policy, "Safe Storage and Handling of Supplies and Equipment", undated, showed the community would ensure that all supplies and equipment, dirty and clean, were handled and stored in a safe manner, protecting residents from exposure and risk.

Record review of the facility's policy, "Cleaning resident rooms and furnishings", undated, under the section "procedure", showed all equipment and supplies would be stored in the commercial laundry room. The door would be locked when housekeeper was not on duty. Supplies would always be locked in a separate cabinet and room with commercial laundry room.

In an interview on 12/06/2023 at 11:25 AM, Staff B, Caregiver, stated all cleaning chemicals were locked under the kitchen sink cabinet in the cottages.

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

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;

(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, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 3 buildings (Cottage C, and Cottage D). This failure placed 50 of 50 residents at risk for ingesting potentially toxic materials.

Findings included…

Record review of the facility's policy, "Safe Storage and Handling of Supplies and Equipment", undated, showed the community would ensure that all supplies and equipment, dirty and clean, were handled and stored in a safe manner, protecting residents from exposure and risk.

Record review of the facility's policy, "Cleaning resident rooms and furnishings", undated, under the section "procedure", showed all equipment and supplies would be stored in the commercial laundry room. The door would be locked when housekeeper was not on duty. Supplies would always be locked in a separate cabinet and room with commercial laundry room.

In an interview on 12/06/2023 at 11:25 AM, Staff B, Caregiver, stated all cleaning chemicals were locked under the kitchen sink cabinet in the cottages.

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In an observation on 12/06/2023 at 11:48 AM, in the second public bathroom of Cottage C, in the shower stall on the ground was a one-gallon white jug that was half full of pink liquid with no lid on it. The white jug had a label that showed, 'soothe & cool cleanse shampoo and body wash'. The white jug was unsecured and accessible by all residents.

In an observation on 12/06/2023 at 12:18 PM, the cabinet under the sink of Cottage C was unlocked and able to open. Inside the cabinet was a staff members purse with multiple items inside. There were multiple bottles of chemicals in the cabinet unsecured. There were 13 residents eating at the dining room tables that was in the same area as the cabinet and the caregiver had their back towards the cabinet.

In an observation and interview on 12/06/2023 at 12:30 PM, in Resident 5's room, there was an eight-ounce bottle of cleanse shampoo and body wash that was sitting on the bedside table. Staff C, Medication Technician/Caregiver, stated they were to lock all chemicals, shampoo's, and soaps to ensure residents did not have access to them.

In an observation on 12/06/2023 at 12:51 PM, in Cottage D, the cabinet under the kitchen sink was unlocked. Inside the unlocked cabinet was a spray bottle labeled "xpress detergent disinfectant". There were two unknown residents wandering around the kitchen area without a caregiver visible in the area.

In an observation on 12/06/2023 at 1:48 PM, in Cottage C, in the kitchen under the island countertop was a spray bottle that was labeled "xpress" that was hanging on a four wheeled cart unsecured and accessible to all residents.

In an interview on 01/18/2024 at 11:19 AM, Staff A, Executive Director, stated all chemicals, shampoos, soaps, and cleaners were to be locked up at all times. Staff A stated there were designated closets, cabinets in the bathrooms and the kitchens for all chemicals that have locks.

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) 3/4/24

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

Administrator (or Representative) 1/31/24 Date

In an observation on 12/06/2023 at 11:48 AM, in the second public bathroom of Cottage C, in the shower stall on the ground was a one-gallon white jug that was half full of pink liquid with no lid on it. The white jug had a label that showed, “soothe & cool cleanse shampoo and body wash”. The white jug was unsecured and accessible by all residents.

In an observation on 12/06/2023 at 12:18 PM, the cabinet under the sink of Cottage C was unlocked and able to open. Inside the cabinet was a staff members purse with multiple items inside. There were multiple bottles of chemicals in the cabinet unsecured. There were 13 residents eating at the dining room tables that was in the same area as the cabinet and the caregiver had their back towards the cabinet.

In an observation and interview on 12/06/2023 at 12:30 PM, in Resident 5’s room, there was an eight-ounce bottle of cleanse shampoo and body wash that was sitting on the bedside table. Staff C, Medication Technician/Caregiver, stated they were to lock all chemicals, shampoo’s, and soaps to ensure residents did not have access to them.

In an observation on 12/06/2023 at 12:51 PM, in Cottage D, the cabinet under the kitchen sink was unlocked. Inside the unlocked cabinet was a spray bottle labeled “xpress detergent disinfectant”. There were two unknown residents wandering around the kitchen area without a caregiver visible in the area.

In an observation on 12/06/2023 at 1:48 PM, in Cottage C, in the kitchen under the island countertop was a spray bottle that was labeled “xpress” that was hanging on a four wheeled cart unsecured and accessible to all residents.

In an interview on 01/18/2024 at 11:10 AM, Staff A, Executive Director, stated all chemicals, shampoos, soaps, and cleaners were to be locked up at all times. Staff A stated there were designated closets, cabinets in the bathrooms and the kitchens for all chemicals that have locks.

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)_____ .

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

_____ _____

Administrator (or Representative) 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;

(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 provide necessary handwashing supplies in 3 of 3 memory care buildings (Cottage B, Cottage C, and Cottage D) for staff and residents to use. This failure placed all 60 of 60 residents, staff, and visitors at risk for spread of infectious disease.

Findings included...

Record review of the facility's policy titled, "Infection control" revised dated 02/01/2015, showed "Hand washing is the single most important measure for preventing the spread of infection and disease. All staff will be responsible for carrying out the hand washing policy". Under the section titled "washing procedure" showed the staff were to use water that was comfortable temperature, soap, dry hands with paper towels and have a trash can available to discard the used paper towels.

Record review of the Center of Disease Control and Prevention (CDC) Hand Hygiene Guidance in Health Care Settings, dated 01/30/2020, showed, "Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations, ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered."

Record review of CDC's fact sheet titled, "Hand Hygiene at Work", undated, showed good hand hygiene means regularly washing hands with soap and water for at least 20 seconds, and then drying them. It also meant using alcohol-based hand sanitizer with at least 60 percent alcohol if soap and water was not readily available. Under the section titled, "Tips for Protecting Employee Health", showed increased access to sinks that was accessible to all employees and in places such as bathrooms, food preparation areas, or in eating areas. Provide soap, water, and a way to dry hands so employees can wash and dry hands properly. Place hand sanitizer dispensers with at least 60% alcohol near frequently touched surfaces, in areas where soap and water were not easily accessible, such as near shared equipment, building entrances and exits and more.

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;

(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 provide necessary handwashing supplies in 3 of 3 memory care buildings (Cottage B, Cottage C, and Cottage D) for staff and residents to use. This failure placed all 50 of 50 residents, staff, and visitors at risk for spread of infectious disease.

Findings included…

Record review of the facility's policy titled, "infection control" revised dated 02/01/2015, showed "hand washing is the single most important measure for preventing the spread of infection and disease. All staff will be responsible for carrying out the hand washing policy". Under the section titled "washing-procedure" showed the staff were to use water that was comfortable temperature, soap, dry hands with paper towels and have a trash can available to discard the used paper towels.

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Record review of the facility's Disclosure of services, undated, under the section titled, "Housekeeping", showed, "All assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition". The facility served residents with dementia (progressive brain disorder that affects ones ability to think, remember, and ability to perform daily tasks) and mental health.

In an observation on 12/06/2023 at 11:10 AM, in the first public bathroom of Cottage B, there were no paper towels available for use.

In an observation on 12/06/2023 at 11:17 AM, in the third public bathroom of Cottage B, the soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed.

In an observation on 12/06/2023 at 12:08 PM, in the third public bathroom of Cottage C, there were no paper towels available for use.

In an observation on 12/06/2023 at 12:43 PM, in the third public bathroom of Cottage D, in the toilet paper holder, there was no toilet paper available for use. The paper towel dispenser was empty. The soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed.

In an observation on 12/06/2023 at 1:52 PM, in the laundry room of Cottage C, the soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed. There were no paper towels or any other item available for use to dry your hands. The trash can did not have a trash bag.

In an observation on 12/06/2023 at 1:55 P, in the third bathroom of Cottage C, the soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed.

In an observation and interview on 12/06/2023 at 1:58 PM, in the third bathroom of Cottage B, there was large amounts of brown matter on the wall near the toilet. Staff A, Executive Director, stated the brown matter looked like feces. Staff A stated they would wash their hands with soap and water when they were asked how to wash their hands. Staff A was unable to wash their hands in the bathroom as there was no soap or paper towels for use.

In an interview on 12/06/2023 at 10:49 AM, Staff A, Executive Director, stated the facility did not have housekeeping staff. Staff A stated that the caregivers perform all of the housekeeping job tasks.

Record review of the facility's Disclosure of services, undated, under the section titled, "Housekeeping", showed, "All assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean, and comfortable condition". The facility served residents with dementia (progressive brain disorder that affects ones ability to think, remember, and ability to perform daily tasks) and mental health.

In an observation on 12/06/2023 at 11:10 AM, in the first public bathroom of Cottage B, there were no paper towels available for use.

In an observation on 12/06/2023 at 11:17 AM, in the third public bathroom of Cottage B, the soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed.

In an observation on 12/06/2023 at 12:03 PM, in the third public bathroom of Cottage C, there were no paper towels available for use.

In an observation on 12/06/2023 at 12:43 PM, in the third public bathroom of Cottage D, in the toilet paper holder, there was no toilet paper available for use. The paper towel dispenser was empty. The soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed.

In an observation on 12/06/2023 at 1:52 PM, in the laundry room of Cottage C, the soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed. There were no paper towels or any other item available for use to dry your hands. The trash can did not have a trash bag.

In an observation on 12/06/2023 at 1:55 P, in the third bathroom of Cottage C, the soap dispenser was empty. The lever of the soap dispenser was expressed with no soap dispensed.

In an observation and interview on 12/06/2023 at 1:58 PM, in the third bathroom of Cottage B, there was large amounts of brown matter on the wall near the toilet. Staff A, Executive Director, stated the brown matter looked like feces. Staff A stated they would wash their hands with soap and water when they were asked how to wash their hands. Staff A was unable to wash their hands in the bathroom as there was no soap or paper towels for use.

In an interview on 12/06/2023 at 10:49 AM, Staff A, Executive Director, stated the facility did not have housekeeping staff. Staff A stated that the caregivers perform all of the housekeeping job tasks.

Statement of Deficiencies	License #: 2443	Compliance Determination #:33402
Plan of Correction	The Cottages at Lacey	Completion Date
Page 6 of 10	Licensee: Lacey Special Care Community LLC	01/16/2024

In an interview on 12/06/2023 at 3:24 PM, Staff A stated they had 24-hour caregiver coverage and if a caregiver on their shift was unable to complete their cleaning task it was to be carried out by the next shifts caregiver.

In an interview on 01/16/2024 at 11:10 AM, Staff A stated the caregivers on each shift were responsible to ensure all bathrooms and sink areas were stocked with necessary toiletry items and supplies necessary to use the bathroom and wash your hands.

Refer to WAC 388-78A-3090 (1)(a)(d) for additional information.

This is a recurring deficiency previously cited on 08/22/2023 for parens 388-78A-2610 (1) and 03/27/2023 for parens 388-78A-2610 (1)(2)(c).

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) 3/4/24.

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

Administrator (or Representative) — Date: 1/31/24

In an interview on 12/06/2023 at 3:24 PM, Staff A stated they had 24-hour caregiver coverage and if a caregiver on their shift was unable to complete their cleaning task it was to be carried out by the next shifts caregiver.

In an interview on 01/18/2024 at 11:10 AM, Staff A stated the caregivers on each shift were responsible to ensure all bathrooms and sink areas were stocked with necessary toiletry items and supplies necessary to use the bathroom and wash your hands.

Refer to WAC 388-78A-3090 (1)(a)(d) for additional information.

This is a recurring deficiency previously cited on 06/22/2023 for parens 388-78A-2610 (1) and 03/27/2023 for parens 388-78A-2610 (1)(2)(c).

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)_____ .

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

_____ _____

Administrator (or Representative) Date